Emergency Management Principles and Practices for Health Care Systems, 2nd edition

Unit 3:
Healthcare System Emergency Response and Recovery

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Unit 3.

Healthcare System Emergency Response and Recovery

Unit Summary

This unit describes in detail a healthcare emergency response and recovery system description and concept of operations. It explains how the Incident Command System (ICS) is specifically applied in the development and implementation of an effective EOP for healthcare systems, such that ICS is completely and seamlessly integrated into the EOP and customized to the healthcare setting.

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Module 3.1

Healthcare System Emergency Response and Recovery: The Operational System Description

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Lesson 3.1.1 Emergency Response and Recovery: Overview and Command Function

Lesson objectives

- *List the ICS sections and describe their general roles in healthcare incident response.*
- *Describe the responsibilities of the Command Function and explain the relationship between the Healthcare System Incident Commander, the Agency Executive, and any Emergency Policy Group.*
- *List position descriptions and requirements for Healthcare System Command Staff.*

Overview

While a "system description" becomes absorbed into the "concept of operations" in many formal emergency operations plans, the importance of a very clear and operationally accurate system description cannot be over-emphasized. During the EOP development process, appropriate attention must be paid to this construct before delineating how the system will operate. For this reason, this text advocates documenting a distinct "system description" that precedes or is the initial segment of the usual concept of operations.

The System Description should be consistent with NIMS/ICS principles.

The system description for any healthcare organization should be based upon standard ICS principles as described in Lessons 2.1.1 and 2.1.2. This becomes increasingly important for healthcare organizations in light of the National Incident Management System (NIMS), which promotes consistency among the many response organizations and disciplines through the universal use (in the United States) of ICS during response and recovery. As in other organizations where emergency response is not the primary mission, the day-to-day operations in individual healthcare systems are comprised of very differently named operating units, resources, and specialty care areas. Therefore, the system description should be constructed around the five core functions described in ICS: Management, Operations, Logistics, Planning, and Finance/Administration (see Exhibit 3.1.1.1) and their sub-divisions. The adaptation of ICS to healthcare systems involves specific considerations as alluded to in Lesson 2.1.2 and explained in more detail here.

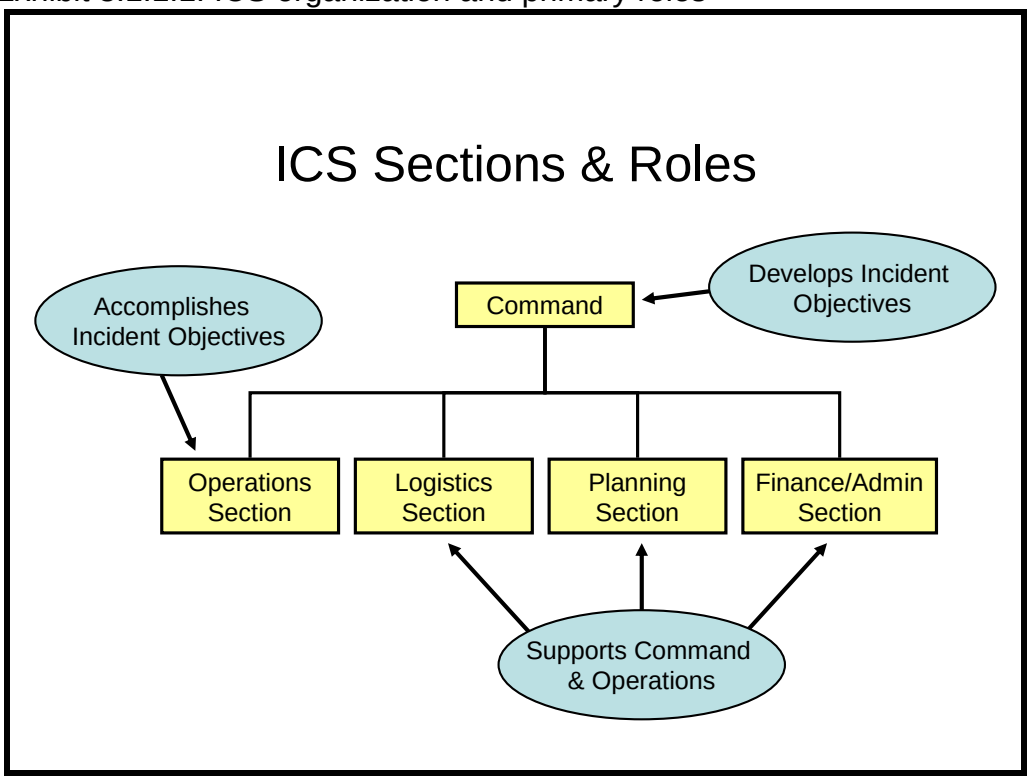
Lessons 1.5.2 and 1.5.3 addressed the Emergency Operations Plan (EOP) format and the purpose and format of the EOP system description and concept of operations. This lesson provides a brief review of this material, and then explains in greater detail the important elements of the

emergency response system description for a healthcare organization. Unit 3.2 addresses the concept of operations in similar detail.

The basic ICS structure and roles is presented in Exhibit 3.1.1 to refresh the materials from Lesson 2.1.2.

Exhibit 3.1.1.1: ICS organization and primary roles

ICS organizes response roles by their relationship to incident objectives: developing incident objectives, accomplishing incident objectives, or supporting the elements that address incident objectives.



Overview: System Description Format

Various formats for a system description have been promoted, but several key concepts should always be incorporated.

- A significant level of detail is important: An important purpose of the EOP is to convey understanding to personnel across the organization during system implementation and instructional activities. The system description, therefore, should impart a clear picture of the response structure and the response relationships between every-day operating units. It is important that this presents the relationship between the incident management team and the Agency Executive as discussed in Lessons 2.1.1 and 2.1.2. Attachments to this section of the EOP base plan can be used to summarize guidance during actual response (e.g., operational checklists for designated positions).

- Functional breakdown overview: The system description should include an outline of how incident personnel are organized according to the five core functions described in ICS. The purpose and construct of each function should be delineated. While the Operations Section may vary from incident to incident, a generic, all-hazards template may be described with common branches and groups. Hazard-specific or incident-specific variations are later presented under the relevant Hazard-Specific and Incident-Specific Annexes of the EOP.

- Position descriptions/position qualifications: Within the defined organizational structure, specific positions are designated and a position description is delineated for each. This level of specificity can be provided in the base plan system description or, depending upon the EOP complexity, later described in the functional annexes. For healthcare facilities, position descriptions for Command and General Staff, at a minimum, should be provided in the base plan. In addition, it is advantageous to provide the position qualifications for these, specifying the competencies that the position must have in order for the function to be accomplished under incident conditions (these can be attachments or appendices to the EOP). This approach should discourage the assignment of personnel who are not specifically qualified to staff critical response positions. Healthcare facilities do not consider staffing unqualified personnel for day-to-day operations, and similar discipline in assignments should be followed during emergency response and recovery.

- Specific positions beyond the base plan and functional annexes: Any "all hazards" position is most appropriately located in the base plan or functional annex. Healthcare emergency planners may, however, find that specific positions (with associated descriptions and qualifications) may be better placed in areas other than the base plan or functional annexes. One example is the positions on the decontamination team or task force, where the positions and their descriptions are best presented in an incident-specific (contaminated patient) or hazard-specific (hazardous materials response) annex. In addition, healthcare organization emergency management personnel should exercise caution in describing too many positions that are unlikely to be utilized or staffed. This can unnecessarily increase the complexity and implementation requirements of the EOP.

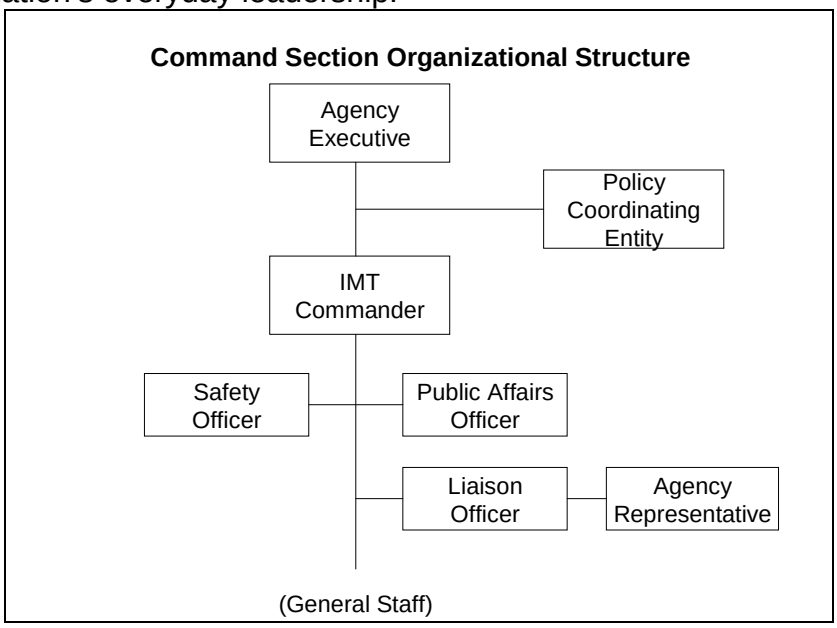
In the end, the system description (with supporting material from functional annexes as required) should provide actionable guidance for how resources are organized during emergency response and recovery. References for use during actual response typically exist in the form of

attachments to either the base plan or functional annexes (e.g., ICS forms, operational checklists as described in Lesson 1.5.2).

System Description: The relationship between the IMT and senior leadership in the organization

The system description should clearly delineate the position of the IMT within the administrative structure of the overarching organization. The senior position that the IMT Commander reports to is designated in ICS as the "agency executive" as described in Lessons 2.1.1 and 2.1.2. This may be the Chief Executive Officer (CEO) or a designee in a healthcare organization. That agency executive may also have a defined group of personnel upon which he/she relies for policy advice during incident response. For example, the Veterans Health Administration guidance for VA Medical Centers includes a "Policy Coordinating Entity" that provides this service (see Exhibit 3.1.1.2). As with other elements of the response organization, it is important to delineate this group and how it comes together for this service under the urgent conditions of the emergency context. Personnel will then easily understand that this is different from everyday mechanisms.

Exhibit 3.1.1.2: The VHA approach to interfacing the IMT with the organization's everyday leadership.[1]



[1] U.S. Department of Veterans Affairs. *Incident Management System Operational Procedures, Attachment 1 to Appendix F, VHA Handbook 0320 (October 2007)*. Veterans Health Administration. Washington DC.

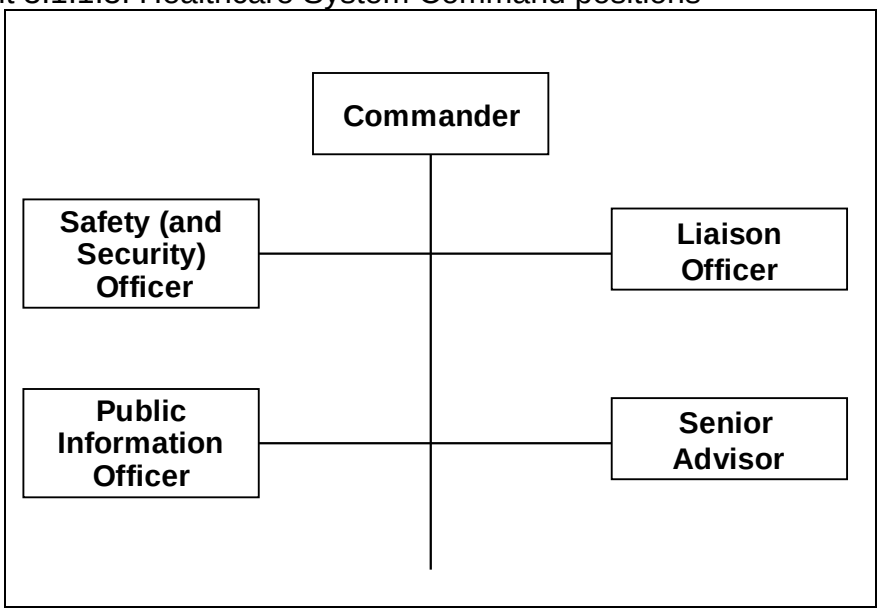
System Description: The Command Function

The Command function carries the overall direct responsibility for managing the healthcare system emergency response and recovery. In accordance with NIMS, Command provides guidance by establishing the healthcare system's response and recovery incident and operational period objectives and major strategies. This important task can only be achieved if personnel assigned to Command avoid micro-management of the other functions and delegate most tasks. Conversely, Healthcare System Commanders will only be comfortable in delegating tasks if the remainder of the system is functioning adequately and reporting mechanisms are followed as required (through an adequately functioning Planning Section). For example, Commanders should not be involved in individual personnel assignments within a specific section. Instead, they should be kept abreast of the overall adequacy of the staffing of the respective sections.

Healthcare System Command is responsible for the entire organizational response and for setting the organization's response objectives.

The initial management of a healthcare system during an incident will inherently be reactive to the immediate situation but should also include the execution of predetermined activities as outlined in EOP tools such as operational checklists. For example, during initial stages of an incident that may impact a facility with incoming patients, the emergency department should execute specific actions to maximize surge capacity. These actions include determining which of the current patients are eligible for early discharge or immediate admission, determining and reporting available bed capacity, and designating or requesting personnel resources from elsewhere in the organization. As the incident progresses, Command becomes more proactive by establishing response and then recovery incident and operational period objectives and strategies that coordinate the activities of the various sections and provides guidance for further activities. For incidents of significant duration (more than a few hours) and complexity (beyond response where **direct** management of all activities can be accomplished), formal incident action planning is instituted and a cyclical process of refining response and recovery objectives and strategies is undertaken (see Lesson 3.2.7).

Exhibit 3.1.1.3: Healthcare System Command positions



Specific positions within Healthcare System Command Staff are depicted in Exhibit 3.1.1.3. With the exception of the healthcare system incident commander, positions are staffed according to need during any specific incident as with any ICS consistent system description. The positions include:

A common misconception is that the CEO must always serve as the Healthcare System Incident Commander.

- Healthcare System Incident Commander: This important position oversees the Command function and thus the healthcare system response itself. A commonly held belief in many healthcare organizations is that the CEO or the agency administrator should always serve in this position, when in fact other arrangements may be more effective. A senior manager with extensive knowledge of the **healthcare system EOP** is usually best suited for this position. These personnel are more likely to have time to achieve competencies related to the EOP and this position. In some healthcare systems, the director of the EM program (the emergency program manager) or some other senior manager or administrator may be the ideal choice. The senior executive may still participate in all important decision-making activities as noted in the next bullet. There are rare situations in which the entire organization is involved in the response to the hazard (e.g., complete evacuation) in which the CEO or agency administrator could be considered the most appropriate Incident Commander.

- Authority of the CEO or Agency Administrator: In situations where the command position is not filled by the senior executive for the organization, the CEO or Agency Administrator retains ultimate authority to meet his/her responsibility for an effective response.

Decision-making authority for the response itself is essentially delegated to the Healthcare System Incident Commander (see discussion of this issue for the "agency administrator"[2] in Lesson 2.1.2). At the same time, the CEO may retain authority for key decisions, but otherwise remains available for other important duties, such as speaking with the media, liaising with senior political or response authorities, and **continuing the management of the overall healthcare system**. Even walking through the facility, thanking and encouraging staff who are working under difficult conditions could provide enormous benefit to performance.

- CEO or Agency Executive participation in ICS: The CEO may participate in any or all command meetings that establish objectives and strategies and that involve major expenditures. This person's focus should be at the strategic level, and he/she may be primarily focused upon the critical role of assuring the continuation of normal healthcare operations as the incident evolves. This type of arrangement has been utilized with great success in other disciplines (see Textbox 3.1.2.1).

- Oversight by board of directors or other overseers: The CEO or Agency Executive may retain the role of keeping these bodies informed. If input is requested from them, or they wish to have a formal role, the use of an "emergency policy group" or other titled structure may allow for formal policy-level input from the board and/or other senior leadership without opening up the IMT to micro-management.

Textbox 3.1.1.1

Selection of the Incident Commander: The 9-11 Pentagon Response Example

During response to the Pentagon terrorist event on 9-11, the Arlington County (Virginia) Fire Chief appointed his Assistant Fire Chief as the Incident Commander. The Assistant Chief focused his efforts on the complex activities involved with managing the incident while the Fire Chief remained available to interact with political authorities (local, State, and Federal), provide media briefings (in conjunction with the PIO), monitor the overall system performance, and address other Arlington County issues as they arose.

[2] National Wildfire Coordinating Group. Incident Command System, National Training Curriculum Module 17: *ICS For Executives (October 1994) Instructor Guide*, pp. 17-5 to 17-7.

Given the position's critical responsibilities, the assigned Healthcare System Commander should possess the requisite command competencies.

- Healthcare System IC and position competencies: Individuals assigned as the Healthcare System Incident Commander (IC) should possess certain competencies. These include the knowledge, skills, and abilities to:[3]

  - Incident recognition competency: Identify specific criteria or potential situations that indicate the need for the full or partial activation of the healthcare system EOP.

  - EOP activation competency: Activate or support full or partial EOP activation for appropriate situations.

  - Mobilization competency: Ensure rapid healthcare system mobilization that transitions day-to-day management and operations to a response organizational structure and processes.

  - Command process competency: Ensure that Healthcare System Command is effective, utilizes EOP procedures and processes, and uses a pro-active "management by objectives" approach.

  - Incident planning competency: Manage continuous incident planning through iterative planning cycle procedures that develop strategic and general tactical guidance to facility personnel.

  - Information management competency: Manage efficient information processing regarding response activities.

  - Safety oversight competency: Assure that safety issues for personnel and current patients and visitors are being addressed (usually through a safety officer position).

  - IMT oversight competency: Assure that a functional assessment of the organization's regular operations is conducted and manage resolution of any issues threatening or compromising continuity of operations.

  - Information dissemination competency: Provide information on the healthcare system's response and recovery activities to agency executive, patients, patients' families, facility personnel families, media, and the general public as appropriate (usually through the public information officer).

  - Resource management competency: Monitor the response and

[3] Adapted from Barbera, J; Macintyre, A; Shaw G; et al. *VHA Emergency Response and Recovery Competencies: Competency Survey, Analysis, and Report;* accessed December 6, 2009 at: http://www.gwu.edu/~icdrm/

recovery needs of the healthcare system's functional areas, and if needed, provide support with additional facilities, equipment, communications, personnel, or other assistance.

- Administrative and financial management competency: Establish appropriate measures to document, track, or reimburse financial costs associated with the healthcare system response and recovery.
- Regulatory compliance competency: Manage healthcare system response so that it adheres to appropriate regulations and standards or seeks relief as required.
- Problem-solving competency: Problem-solve issues that aren't resolved lower in the management structure, but avoid micro-management.
- Continuity competency: Ensure that Business Continuity Program considerations are incorporated into the healthcare system incident action planning process.
- Demobilization competency: Ensure rapid and effective demobilization of the healthcare system response during the transition to recovery operations.
- Transition to recovery competency: Ensure recovery is accomplished to restore the healthcare system to baseline operations and to capture important lessons for organizational improvement.
- Availability and qualification: A Healthcare System Incident Commander must have prerequisite training and be onsite to perform his/her duties.
- IC position 24-hour coverage: For extended Incident Operations or incidents that require 24-hour staffing, a Deputy Incident Commander may be selected to extend the coverage of this important position (this concept is used for other key ICS positions as well).

- Healthcare System Safety Officer: This position traditionally has focused on the workplace safety and occupational health[4] of the

Healthcare System Safety Officer provides critical input to the Commander.

[4] Occupational health can be defined as the science of designing, implementing and evaluating comprehensive health and safety programs that maintain and enhance employee health, improve safety and increase productivity in the workplace (Federal

responders within an organization. This includes both preventive measures as well as reactive interventions if an injury or illness occurs. For healthcare system emergency and disaster incidents, security "safety" is also a vital component of this position's responsibilities. The actual tasks that address these issues are performed by personnel in the appropriate ICS sections. Many healthcare systems use the regular day-to-day position of facility safety personnel to staff this position. Alternatives include security personnel or others. Due to the types of activities the Safety Officer could be involved in, they may be positioned in the command post or in areas of actual operations. The Safety Officer should evaluate a wide range of issues to promote the health and safety of healthcare system personnel. In doing this, the safety officer position may draw upon a wide range of expertise from within their healthcare organization. **Assistant safety officers may be assigned to other areas of the IMT to monitor activities with significant risk for healthcare personnel and/or patients.** Areas of potential Safety Officer focus include:

- Input to Command decision making: Providing input to all Command decision making as it relates to workplace safety, preventive medicine, and security of healthcare system personnel. This necessitates participation in the development of the healthcare system incident action plan.

- Monitoring fatigue of responders: During extended healthcare operations, personnel may be required to work longer than normal hours. This is especially true of Command and General Staff positions and these positions require special attention. Adequate breaks and rehabilitation may have to be mandated.

- Monitoring safe patient movement practices: During operations involving the large scale movement of patients (e.g., evacuation), a safety officer is responsible for monitoring safe patient movement practices as it relates to both the patients and the providers.

- Monitoring responders' nutrition and hydration: Personnel may require monitoring for adequate nutrition and hydration depending upon their activities (e.g., personnel working in hot conditions or wearing restrictive PPE).

- Monitoring for adequate hygiene and infection control: In the healthcare system environment, regular hygiene and infection

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Occupational Health, U.S. Department of Health and Human Services, accessed October 30, 2009 at: http://www.foh.dhhs.gov/Public/WhatWeDo/OHDefinition.asp).

control should be maintained and in some circumstances (e.g., unusual infectious disease) extra-ordinary procedures may be required, such as specific environmental cleaning or the use of additional PPE.

- Monitoring for incident stress and its effects on responders: Incident stress, particularly during unusual or extremely traumatic events, is increasingly recognized as a cause for poor response performance, increased illness and injury among responders, and post-incident personnel problems. Intervention during response may be the most effective management strategy for this issue, and the safety officer should be monitoring this throughout the incident. For example, an incident involving multiple severely injured pediatric patients can be particularly stressful for healthcare system personnel.

- Personal protective equipment (PPE): The type of PPE and the context in which it will be used should be monitored by the Safety Officer for adequacy of equipment for the circumstances, as well as adequate application and adherence to guidelines by responders. This time-intensive duty will likely be performed by an assistant safety officer acting as the DECON safety officer or some other designation.

- Monitoring of injuries and illnesses: Injuries or illnesses during response should be evaluated from an epidemiological perspective, looking for any indication that a change in response methodology or safety practices is warranted.

- Healthcare System Public Information Officer (PIO): Personnel assigned to this position develop the healthcare system's message for release to the media. Because the "public" includes patients already under care, and their families, the PIO must assure that messages are crafted and disseminated to them as well. For example, it could be important in some situations to communicate to pre-existing patients and their families that healthcare system response actions have not impacted the safety and quality of medical care being provided for current patients. This expanded purview of the PIO is consistent with early ICS descriptions of this position, which was titled "Information Officer" (see Textbox 3.1.2.2 for an example of the information officer from 1994 ICS literature). This position is also responsible for monitoring media messages to ascertain whether the healthcare system response is adequately presented, and that other relevant information is available and accurate. Much has been written about effective crisis communications, including guidance for health

The Healthcare System Public Information Officer (PIO) manages the healthcare system's messages for the public.

Healthcare System PIOs should monitor the media for message content and should ensure that the Healthcare System's messages are not in direct conflict with the message of other response entities.

response.[5,6] Issues specifically relevant to healthcare systems include:

- Avoid technical answers to questions: The provision of care to patients and the public can at times be highly complex and technical. Utilizing common language and explaining things in lay terms will facilitate communications with the media and the public.

- Maintain immediate access to expert information: Due to the complexity of information that may be covered in the media briefing and follow-on questions, having subject matter expertise readily available may prevent being caught off guard, while projecting an air of responsiveness to reporter's inquiry. If expertise is not immediately available or the answer is not clear at that time, obtain expertise through the healthcare system's IMT structure and maintain a responsive posture with the inquirer by providing an accurate and "cleared" answer.

- Define the issues for the healthcare system: It may be important for the healthcare organization's to define their incident objectives so that the public has a clear understanding of the healthcare role. When the incident involves more than just the healthcare system (i.e., a community-wide incident), the healthcare system's media message should be limited to activities within the healthcare system's purview. These comments should be consistent with media messages from jurisdictional authorities and other healthcare organizations (to prevent public confusion or distrust) and should avoid speculation and debate. For example, differing screening and treatment protocols between healthcare facilities during an infectious disease incident could precipitate a negative reaction from the public. All information in an evolving healthcare incident should be presented as the best available at the time, but subject to change as additional details emerge. All actions should be explained as the best possible practice based upon currently available information.

- Provide accurate information with context: The provision of honest information is important, and attempting to hide "bad news" will ultimately be detrimental. Providing the context for all actions and

[5] U.S. Department of Health and Human Services. Communicating in a Crisis: Risk Communication Guidelines for Public Officials. Washington, D.C.: Department of Health and Human Services, 2002; accessed February 28, 2010 at: http://www.riskcommunication.samhsa.gov/RiskComm.pdf

[6] U.S. Department of Health and Human Services. *Terrorism and Other Public Health Emergencies A Reference Guide for Media (2005)*; accessed February 28, 2010 at http://www.hhs.gov/disasters/press/newsroom/mediaguide/HHSMedisReferenceGuideFinal.pdf

explanations from the outset (e.g., "This is a truly extreme situation") can be helpful in conveying understanding of difficult circumstances to the public.

- Locations of briefings: Always provide media briefings in controlled locations, away from clinical areas or other sensitive locations where patient care or other incident operations are occurring.

Textbox 3.1.1.2

Information Officer[7]

The Information Officer is responsible for developing and releasing information about the incident to the news media, to incident personnel, and to other appropriate agencies and organizations.

Only one Information Officer will be assigned for each incident, including incidents operating under Unified Command and multi-jurisdiction incidents.

The Information Officer may have assistants as necessary, and the assistants may also represent assisting agencies or jurisdictions.

Position Descriptions

Responsibilities: Agencies have different policies and procedures relative to the handling of public information. The following are the major responsibilities of an Information Officer and would generally apply for any incident:

- Determine from the Incident Commander if any limits exist on information release.
- Develop material for use in media briefings.
- Obtain Incident Commander's approval of media releases.
- Inform media and conduct media briefings.
- Arrange for media "pool" tours and other interviews or briefings that may be indicated.
- Obtain media information that may be useful to incident planning.
- Maintain current information summaries and/or displays on the incident and provide information on status of incident to assigned personnel.
- Maintain Unit Log.

[7] National Wildfire Coordinating Group. *Incident Command System National Training Curriculum: ICS Position Descriptions and Responsibilities* (October 1994), accessed November 1, 2009 at: http://www.nwcg.gov/pms/forms/compan/pds.pdf .

Healthcare System Liaison Officers provide strategic links to the larger response community.

- Healthcare System Senior Liaison Officer: This position is responsible for establishing and maintaining coordination with the Command functions of external response organizations, such as public health, fire, EMS, law enforcement, other hospitals, or public health. In addition, the Healthcare System Senior Liaison Officer may interact with local emergency management authorities. These interactions are best managed through pre-established essential elements of information that should be sought and shared between the healthcare system and external organizations (as are required by The Joint Commission accreditation requirements for healthcare organizations). For example, the use of an ICS 209 Incident Status Summary Form, completed on a regular basis during emergency response, can provide an excellent healthcare system update to external entities. The senior liaison position is responsible for addressing a common problem for healthcare systems: managing emergency operations through day-to-day relationships with external organizations, which can prevent important information from ever reaching the level of Command. Examples include:

    - EMS communications with the Emergency Department: Tactical information (such as numbers of patients being transported) is appropriate for the Emergency Department to receive and maintain, with relay of this information to the Senior Liaison. Strategic discussions between EMS and the healthcare system (such as actual or anticipated changes in EMS response procedures as the event expands) or incident specific strategic information should be relayed to the Healthcare System Senior Liaison Officer for processing and inclusion in healthcare system incident action planning.

    - Patient test results: In some situations, multiple parties may have a public health or public safety interest in the outcome of a specific patient's test results (e.g., blood culture for anthrax in an index case).[8] Local public health, State public health, and Federal health and medical agencies may all have statutory or regulatory responsibility to collect this data and may individually attempt communication with the healthcare system for this purpose. Rather than allowing all these agencies direct contact with a healthcare system lab or clinical care provider, these calls may instead be referred to the Healthcare System Senior Liaison Officer. This approach provides a mechanism for addressing privacy and

[8] The communication of this information to appropriate external agencies generally would not violate HIPAA as the diseases often have potential for major public health impact. Legal counsel and relevant public health authorities should provide guidance on this issue during the preparedness phase.

related concerns, and provides a forum for organized and documented transfer of follow-up responsibility from the healthcare facility to appropriate public health authorities.

- Senior Advisor/Technical Specialist Officer: This position provides **strategic advice** to the command group and is established only as needed. This assistance is distinguished from the usual "technical specialist," who is an individual providing tactical level expert advice and who is usually attached directly to the Planning Section or to the Operations Section. The Senior Advisor position may be variably staffed. One example might be a physician providing strategic guidance for what the healthcare system will need to have in place 24 hours later to treat the medical problems in an unusual illness or injury (such as radiation sickness). Alternatively, **the position could be staffed by an ICS expert, providing strategic advice on the optimal use of ICS by the IMT that is a novice to ICS experience.** Some organizations may elect to staff the Senior Advisor position with their emergency manager who should have the most extensive knowledge of the EOP.

Healthcare System Senior Advisors commonly possess specific knowledge that is useful for incorporating into strategic decision-making.

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Lesson 3.1.2 Emergency Response and Recovery: The Operations Section

Lesson objectives

- *Define the responsibilities of the Operations Section in healthcare systems and describe how the organizational structure can vary according to the type of incident.*
- *List the functional elements of the Healthcare System Operations Section as proposed in this text.*
- *Define a flexible organizational arrangement of the Healthcare System Operations Section that addresses continuity issues.*

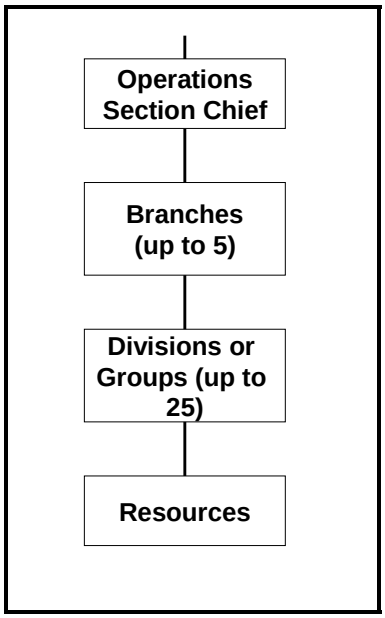
System Description: The Operations Section

The Operations Section of the healthcare system is tasked with all activities designed to directly achieve the objectives set by Command. The personnel assigned to, and the organizational structure of, the Operations Section can vary significantly based upon the incident's primary objectives. At the same time, the EOP should present a general all-hazards configuration for the IMT's Operations Section, so that configuring for a specific incident can begin from an established "pre-plan." The all-hazards operations section may best be organized to achieve the generic incident objectives described earlier in this text, and to perform the major response capabilities of a healthcare organization during emergency response (i.e., protection/security, continuity, medical surge, and support to external requirements).

- General organization of the operations section: The breakdown or structure of supervisory and resource positions within the Operations Section should follow ICS principles which are briefly repeated here and in Exhibit 3.1.2.1:
    - Branches: Can represent either geographical or functional divisions of labor.
    - Divisions: Always refers to geographical divisions within a branch.
    - Groups: Always refers to functional divisions within a branch.

The Healthcare System Operations Section, as required, should be further divided organizationally

Exhibit 3.1.2.1: Operations Section as described by NIMS.[9]



- Designation of specific resources within ICS: Specific resources are best described using the terms Strike Team (shortened to "Team") or Task Forces. These resources have some internal management element. Strike teams consist of personnel performing a single function, whereas task forces may incorporate multiple functions within the resource. Examples include:

  - Traffic control team: A cohort of personnel who re-set the traffic pattern and shape vehicle and pedestrian traffic according to the incident-specific pattern.

  - Patient Surveillance and Follow-up Task Force: Personnel with varying functions that enters appropriate patients into a registry, follows the status of patients given prophylaxis after a biological exposure, and calls patients back for a change in medications or other alterations in care (until the responsibility is transferred to public health).

- Staging areas: An additional organizational element for consideration in healthcare facilities is the concept of a **staging area**. In traditional ICS, staging areas are part of the direct responsibility of the Operations Section Chief as they contain assets that are assigned to

[9] U.S. Department of Homeland Security. *National Incident Management System*. (December, 2008). Washington, DC. pp. 97 – 102; accessed December 6, 2009 at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

Operations but have yet to be deployed or utilized. This is in distinction to the Logistics Section responsibility of finding, screening, and ensuring the adequacy of unassigned resources. Though a subtle distinction, this would argue for the placement of a **personnel pool**, as traditionally configured by healthcare organizations, under the Logistics Section but the placement of staged and assigned personnel (such as surgical personnel awaiting work) into Operations Staging functions. This point becomes important when discussing the **Labor Pool** (see below).

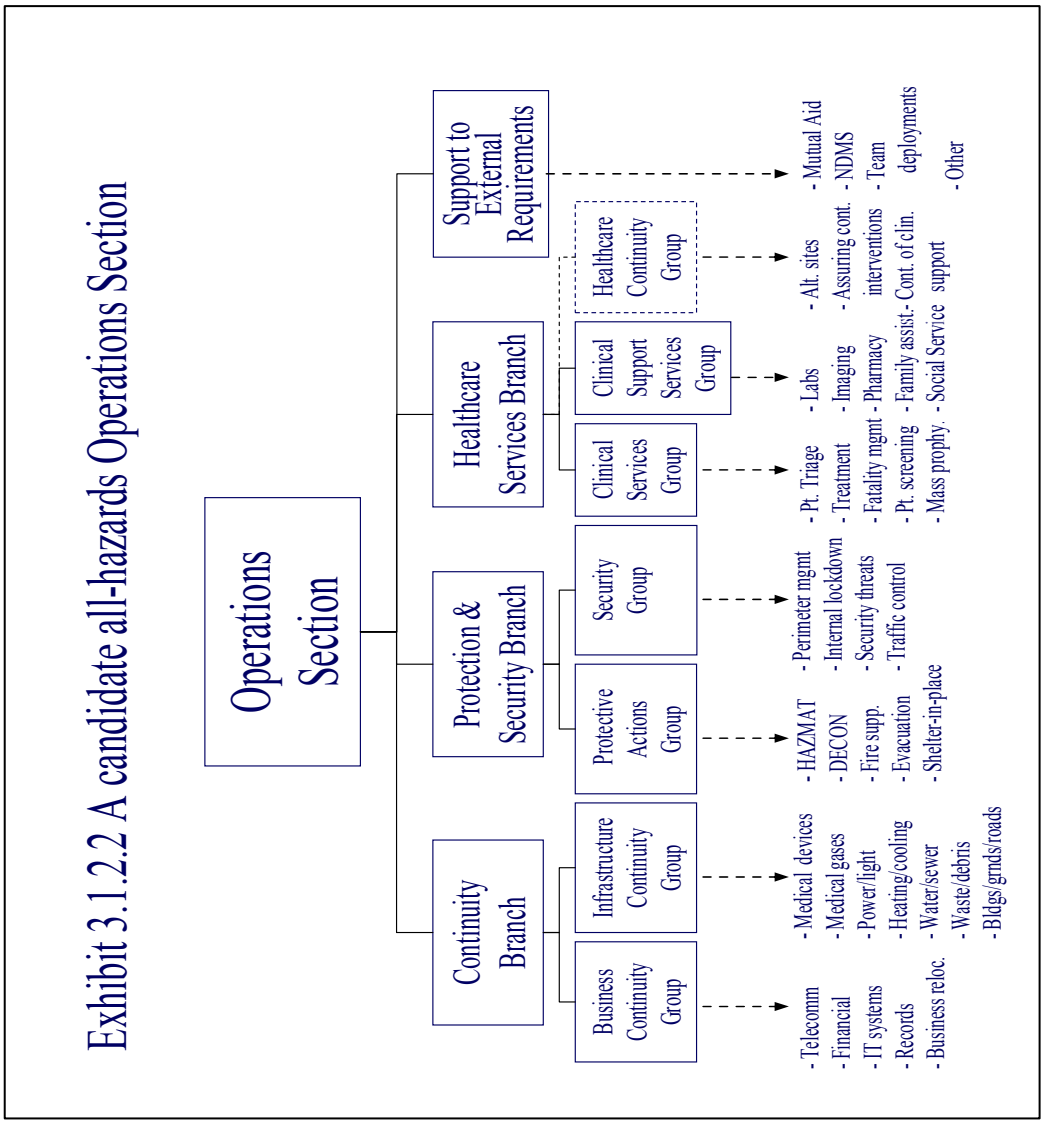
- Selection of the Operations Chief: The Operations Section Chief should be chosen based upon having the position competencies and the incident/hazard type, and therefore the most appropriate skill set for the major focus of the response. Regardless of their day-to-day role, the operations section chief should have the demonstrated competencies designated for that position. For example, the Operations Section Chief position may best be filled by a trained individual from facility engineering during an incident involving loss of water pressure or other traditional infrastructure compromise.

- Addressing the flexibility of the operations section structure: In addition to the VHA examples provided above, there are other variations on how to organize the healthcare system Operations Section. Given the potential complexity of the Operations Section, the assignments, construction of, and documentation of the Operations Section remains a critical and primary task for command and the operations section chief. **While the configuration of the operations section is flexible, the requirement that the configuration of Operations be delineated and appropriately disseminated at the outset of every incident (establish, document, and disseminate) should be rigidly enforced.** The structure and configuration of the entire organizational response system, and staffing of senior positions, should be re-evaluated at the beginning of each planning cycle as an action item in the management meeting (see Module 2.1).

- A candidate Operations Section configuration is proposed below and outlined in a diagram (Exhibit 3.1.2.2). This is not prescriptive, but an example of how a healthcare organization's operations section may be functionally structured.

  The full layout of this section is presented in Exhibit 3.1.2.2

The Operations Section directly addresses the hazard-generated needs, accomplishing the operational period objectives set in the Planning Meeting.



Protection and Security Branch: This functional area may be considered a branch that has two major groups[10]:

- Security Group: This group **addresses the security issues in a major emergency or disaster that requires potential actions beyond the everyday security activities**. Perimeter management, traffic re-direction, crowd control, response to localized security threats during the emergency are some of the potential tasks. This group may include personnel beyond the usual Security or Police Officers, with supervision of these other assigned personnel as they conduct their designated tasks.

[10] Note: two different groups are described though using traditional ICS principles, it is understood that there may only be one group under this branch depending on the incident.

- Protective Actions Group: This functional group conducts specific emergency procedures that address protection of staff, patients and visitors. It may be viewed as **the specific operations branch that facilitates implementation of Occupant Emergency Procedures and coordinates them across the facility during the emergency.** This could include activities such as supervising shelter in place actions or facilitating evacuation of staff and patients when a partial or full evacuation order is given. Evacuation actions could include ensuring clearance of a facility or securing elevators for prioritized patients during partial or full evacuation. Other tactical activities this group might conduct could be internal lockdown for active shooter, fire suppression, internal hazmat response, as well as other actions that must be closely coordinated with security. While the Protective Actions Group's organization and concept of operations could be generically described in a Functional Annex in the EOP, many of its tactical activities may be better described in incident specific/hazard specific annexes. As an example, an Evacuation Task Forces may be described in an evacuation annex to address the above-described evacuation measures.

  The Protective Actions Group may also be assigned the role of receiving and decontaminating arriving victims with chemical, biological, or radioactive contamination prior to their entry into the healthcare facility. Assuming supervision of this complex task allows the clinical services group to focus upon patient care as the patients are rapidly processed.

Continuity Branch: In the healthcare service industry, continuity generally has three major areas of focus: Business Continuity, Infrastructure Continuity, and Healthcare Services Continuity. Because healthcare services continuity is very closely tied to other healthcare delivery (including surge), the ICS principle unity of command suggests that this element be tied in directly with the healthcare services group. The other two groups may function effectively as a branch.

- Business continuity group: This group focuses on maintaining the following mission critical functions:
  - Regular telecommunications.
  - Regular Information Technology services.
  - Healthcare records preservation.
  - Administrative, financial and other records preservation.
  - Billing and collection services.
  - Conference and other ancillary services (e.g., a profit center that conducts continuing education services).
  - Business relocation.

- Infrastructure continuity group: This group focuses on maintaining the following mission critical functions:
  - Electrical utilities preservation
  - Heating/cooling systems maintenance
  - Water/sewer maintenance
  - Sanitation/hygiene services
  - Waste (biohazard, other hazmat) and debris management
  - Bio-Medical devices maintenance
  - Medical gases supply/re-supply
  - Buildings/grounds/roadways maintenance.

Continuity of Operations Plan versus incorporating continuity concepts into the EOP: Continuity has been addressed in the past in many organizations through stand-alone plans that are distinct from the EOP. In modern emergency management, it is usually more efficacious to incorporate these into the "all-hazard" EOP, while perhaps maintaining a descriptive plan for accountability and training purposes if required (see Textbox 3.1.2.1). Alternatively, a crosswalk from the EOP to continuity requirements can serve to meet regulatory purposes and other mandates. This will typically result in response guidance that is more usable for the organization.

Textbox 3.1.2.1

Continuity Planning in Relation to the EOP

A well-written EOP incorporates the major issues related to continuity of operations throughout the EOP. Continuity of operations is, in essence, about preserving the normal business of the organization. For healthcare facilities, this relates to the preservation of leadership and business processes (also referred to as "business continuity") as well as preserving healthcare services and products and, by extension, mission critical infrastructure. The following EOP considerations demonstrate how the concepts of continuity planning are integrated throughout the healthcare system EOP:

- EOP Base Plan and Functional Annexes: In the model provided above, continuity activities can be commonly addressed under one branch (with the notable exception of healthcare services as discussed above). Generic structure and processes for this branch and associated groups could be described in the Base Plan and Functional Annexes.
- Incident-Specific/Hazard-Specific Annexes and Service Level Appendices: In some incidents, the prominent activities may focus upon the restoration or maintenance of specific mission critical systems. As an example, the emergency response

focus may include the restoration of IT capabilities or the recovery of power. Guidance for these "continuity" activities would be presented in Incident-Specific/Hazard-Specific Annexes to the Base Plan. Therefore, a power outage annex to the EOP could be expected to have robust response guidance for responding service units. The guidance may be organized specifically for each group (business, infrastructure, and healthcare continuity groups under an Operations Section). Collectively, these individual hazard specific checklists also provide a basis for developing the general and specific service unit guidance.

Other EOP continuity issues are delineated at the policy level and then carried out by the IMT during emergency response if indicated. These could be documented in the Base Plan and include:

- Order of Succession: This is a policy statement by the organization that is implemented through the Emergency Management (EM) Program. The policy describes the personnel (or selected day-to-day positions) designated to assume the organization's leadership positions in case persons filling those positions are unable to continue their duties. Selected personnel may receive training through the EM Program; they are contacted during emergency response by the IMT as indicated, and supported by them as needed as they assume agency leadership role.
- Devolution of control and direction: The transfer of authority and responsibility for essential functions from an organization's primary operating staff and facilities to other organization employees and facilities, and to sustain operational capability for an extended period. This is a policy level directive, but the actual transfer of authority and the evacuation procedures and activities necessary for continuing healthcare services at non-routine sites (alternate treatment facilities) in case of evacuation are described in the EOP, commonly under an incident-specific annex.

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The purpose, therefore, in having an independently written continuity plan is not primarily for operational guidance during an incident. It may be necessary to have a separate continuity plan for accountability purposes (e.g., regulatory requirements such as FCD 1 and 2 for Federal facilities) or for training purposes. In situations in which it is permitted, a suggested method for accomplishing this without writing a completely new document is to provide a cross walk of the EOP to the required elements of a continuity plan.

* Terminology used in the business arena often refers to "recovery

activities" when discussing restoration of services, even though these commonly occur under the response phase of comprehensive emergency management.

Health and Medical Services Branch: This functional area of the Operations Section addresses the surge capacity and capabilities related to health, medical, and psychological services for incident patients. As noted above, it may also include activities related to healthcare services continuity. It includes clinical and clinical support services. Common activities might include:

- Clinical Services group: Multiple functional areas may be required to be supervised and coordinated within this group.
    - Patient reception and triage: This functional area receives casualties as they arrive and performs the relevant triage procedures to assign patients to the appropriate level and location of care.
    - Acute medical evaluation and intervention: This functional area manages the medical surge capacity needs when they severely challenge or exceed the ability of the usual patient care management methodology. It also addresses the specialty capabilities that are not usually provided in the healthcare organization. This branch or group oversees healthcare services care in conventional patient care or surge locations, each with its own service-level plan that dovetails with the Base Plan and appropriate functional annex. These areas include:
        - Emergency care.
        - Pediatric services.
        - Surgical care.
        - Critical care.
        - Psychiatric care.
        - Specialty services (dialysis, hematology, and others).
        - Outpatient health, medical and mental health services.
    - Discharge and Follow-up services: This is likely to be a separate functional area that assures patients are discharged to appropriate settings and followed up as indicated by the incident situations, confirming that their specific medical or mental health issues are addressed.
    - Fatality services: This functional area supervises activities needed to manage fatalities that exceed the usual capacity and capabilities of the healthcare organization's mortuary services. The additional

capabilities include supporting the medical examiner in establishing identities of the deceased under mass fatality conditions, overseeing decedent storage, providing tactical interface with the forensic and medical examiner authorities and other issues not normally encountered in everyday healthcare operations. Critical activities include:

- Mortuary services.
- Mass victim identification services.
- Tactical coordination with the medical examiner, coroner, funeral homes (e.g., if mass fatalities from natural causes) or other relevant entities.

- Clinical Support Services Group: This functional area groups services that provide direct support to clinical services. This group interfaces with usual clinical support services as well as services such as Patient Family Assistance. It can be configured much differently from the everyday service entity. As an example, patient tracking can be a critical activity with dedicated personnel during a mass casualty situation (even with electronic medical records, a Task Force might be required to conduct this activity). This function activates positions, processes and procedures to augment facilitate and empower the support services so that they are better able to meet surge needs or address continuity issues (e.g., maintenance of lab testing when this has been primarily impacted by the hazard). The functional structure also should seamlessly interface with the service level guidance for each of the relevant services:
  - Laboratory services
  - Imaging services
  - Pharmacy services
  - Blood products service
  - Patient transport
  - Patient family assistance and pastoral services
  - Other.

- Healthcare Continuity Group: Though it may be considered as a separate group under healthcare services or healthcare support services, the reality is that in many situations these activities would be conducted by the same service units that are conducting surge in response healthcare services. Grouping these activities under a continuity branch may be indicated to address specific continuity issues for healthcare services or healthcare support services that are separate from the supervisory elements of surge. For example, establishing an outside resource for lab services until the hospital's laboratory can resume normal services may be a reason to activate a Healthcare Continuity Group. The functional annexes should describe how positions performing specific tasks may report depending on the

specific incident. Typical continuity activities for a healthcare services branch might include:

- Sustaining regular medical care to patients already under the care of the healthcare system prior to the hazard impact (e.g., patient care during power outage)
  - Re-locating regular medical services (evacuation, moving patients, providing medical care in an alternate location)
  - Actions to maintain mission critical healthcare support services such as pharmacy, laboratory, and imaging services.

Support to External Requirements Branch: This functional area of operations provides guidance for all activities that directly support outside commitments made by the healthcare organization during preparedness activities. Though not all healthcare systems may have prearranged outside commitments, these activities require very different management methodologies than the other described Operations branches. They may include:

- Information sharing and action coordination with other healthcare organizations: Coordinating emergency information and response strategy and actions with community response organizations, particularly other healthcare facilities through a coalition of healthcare organizations.[11] While this may be accomplished by the IMT senior liaison position during low intensity incidents, a task force may be needed to conduct these activities (such as deploying resources for mutual aid) during more complex emergency situations.

- Resource sharing: Meeting resource sharing commitments (personnel, equipment, supplies, or facilities such as patient care and administrative space) under mutual aid, cooperative agreement, or other established instruments. Particularly if personnel are being deployed to an off-site location, a task force should be activated to support them until their return.

- Rendering expert advice to incident authorities: Providing medical advice to the jurisdictional response managers, as requested or otherwise indicated.

- Providing healthcare and psychological support: Providing medical and psychological services and/or advice to the jurisdictional responders if requested.

[11] Barbera JA, Macintyre AG (Knebel A, Trabert E, *eds*). *Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery* (May 2009); CAN Corporation for US Department of Health and Human Services; accessed February 15, 2010 at: http://www.remm.nlm.gov/MSCC_Healthcare_Coalition_May_2009.pdf

- Contracted and other committed services: This may include providing health and medical services to private businesses, re-supplying EMS vehicles, supporting specific long term care facility needs under emergency conditions, or other services that the healthcare organization has agreed to provide during emergencies and disasters.

Structuring the Operation Section for specific incidents

The type and number of staff assigned to the Operations Section is dependent upon the hazard impact or threatened impact and the organization's response objectives.

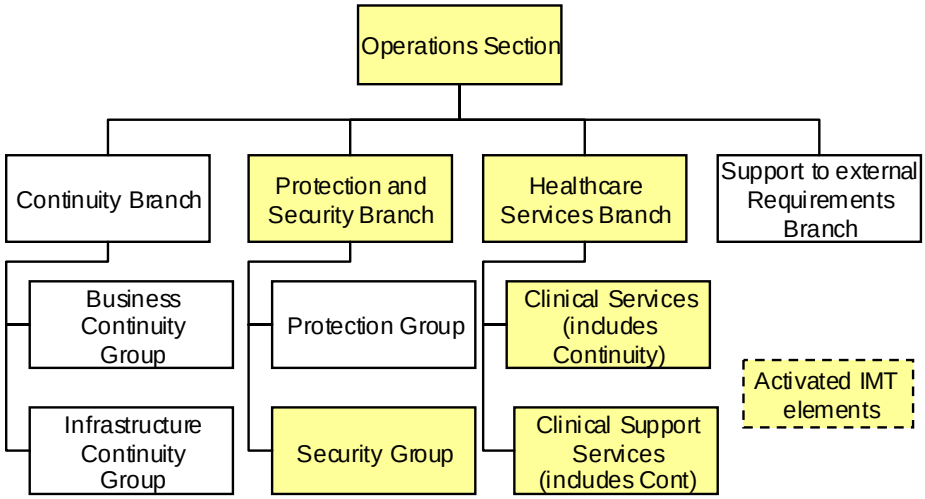
As an incident begins to unfold, the general Operations Section organizational structure may be customized to the specific incident, considering the hazard, the impact size, the response tasks for the healthcare organization and other factors.

Experienced ICS users have long recognized that the Operations Section is organized from the hands-on scene upwards, adding additional supervisory position as the response needs become more complex. This is in distinction from the other IMT sections, which are established in a proactive fashion from the Section Chief down according to the expectations for the specific type and scope of the incident.

Example incidents are described below with accompanying organizational charts based on Exhibit 3.1.2.2.

- Bombing incident external to the healthcare system resulting in mass casualties: In this example (see Exhibit 3.1.2.3), the Operations Section will mainly be comprised of personnel assigned to the Healthcare Services Branch.

Exhibit 3.1.2.3 Bombing incident initial Operations Section staffing



- Clinical Services Group: The major focus of Operations Section activities would be through this group.
  - Patient reception and emergency care: Patients received and triaged according to injury. Emergency treatment and surgery provided.
  - Inpatient care: Personnel assigned to the care of patients who cannot be treated and released.
  - Outpatient care: For some healthcare systems, outpatient treatment areas can be utilized to evaluate and treat minor injuries.
  - Fatality care: The storage and processing of patients who die after arriving at the facility.
  - Healthcare services continuity: Ensuring continuity of medical care for patients already under care at the organization, despite re-allocation of some resources for the surge needs of incident patients.
- Clinical Support Services Group: This group would also play a major role in medical surge capacity and capability.
  - Patient diagnostics: Radiological and laboratory personnel assigned to the mass casualty care areas would receive direction from the Healthcare Services Branch Director or

designee in developing priorities for their diagnostic services, and in turn receive support from the IMT (additional personnel for non-technological tasks, etc.) beyond that experienced in the everyday setting.

- Patient tracking: The real time documentation of the location of incident patients with the developed information forwarded to the Planning Section for inclusion in incident action planning and other critical uses.

- Patient family assistance: The provision of information and assistance to the family's of patients or to families searching for patients.

- Protection and Security Branch: This branch also performs critical services as an activated branch.

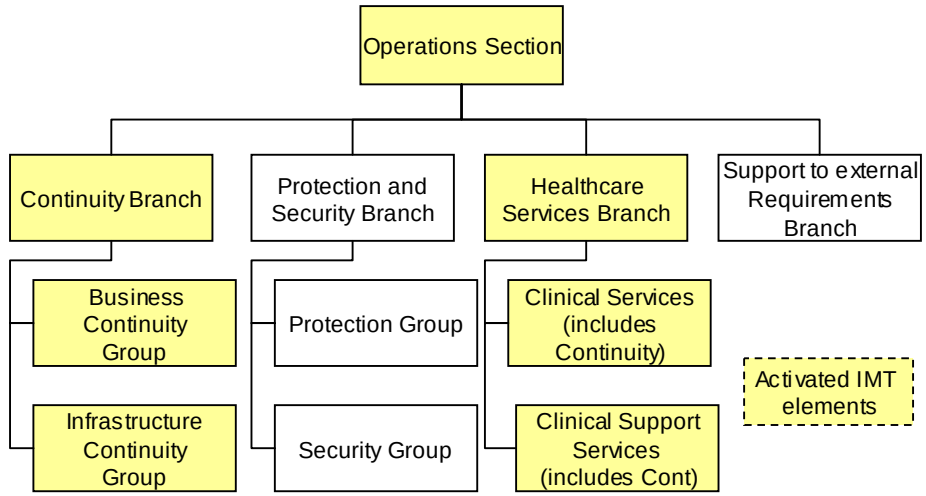
  - Protection Group: Personnel securing external perimeters (e.g., from unwanted or unnecessary visitors) and internal perimeters (e.g., maintaining appropriate privacy and avoiding excessive staff in patient care areas).

  - Security Group: In conjunction with local law enforcement, these personnel may sweep the exterior area of the hospital campus and control vehicle traffic to detect or deter sequential bomb strikes at the healthcare facility.

- Winter storm: Objectives for this type of incident primarily focus on continuity of operations.[12] Therefore, the healthcare system Operations Section might primarily activate elements as presented in Exhibit 3.1.2.4.

[12] It should be noted that the need for continuity planning activities is common in many other types of incidents as well.

Exhibit 3.1.2.4 Winter storm incident initial Operations Section staffing

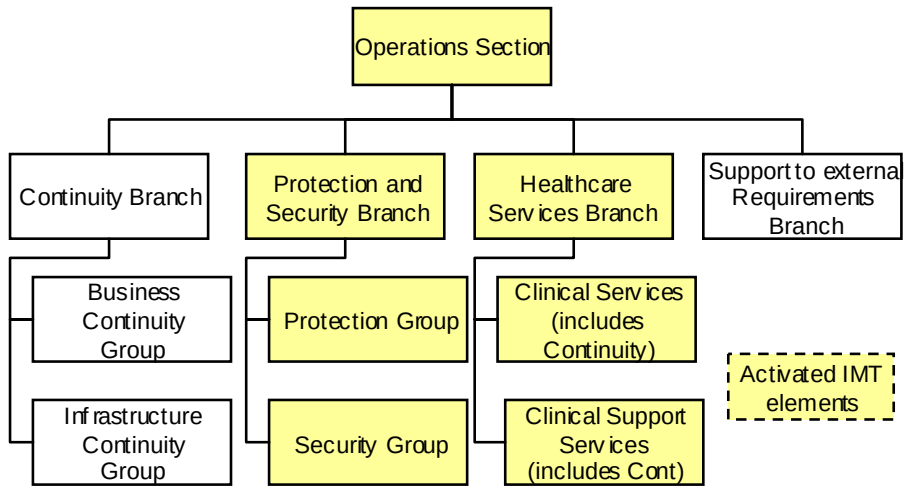


- Healthcare Services Branch:
  - Healthcare continuity: Both the Clinical Services and Clinical Support Services Groups may be activated to assure adequate personnel staffing and supplies for the duration of disruptions caused by the weather. Re-scheduling of medical appointments and medical procedures may also be addressed through this branch. For many facilities, these activities may be relatively routine due to winter storm frequency, and the two groups would be combined or each staffed with only a single individual.
- Continuity Branch
  - Infrastructure Continuity Group: Activities to maintain the electrical, heating and water supplies, as well as surge in services for clearing roads, parking and walkways around the facility and avoiding dangerous roof loads from accumulating snow. Much of this specific guidance is likely to be already in an incident specific annex. The all-hazards elements of staff surge and reporting to the Operations Section Chef is detailed in the operation section functional annex.
  - Business Continuity Group: Activities within this group vary according to the additional business activities of the healthcare organization. Activities may include administrative support in re-scheduling conferences and meetings or identifying alternate meeting sites. Maintaining accounting, financial systems, and other business operations may also require

attention if disruption is caused by weather conditions.

- Release of anthrax into the community mail system with unclear exposure of public: This type of the incident would require that the Operations Section be configured slightly differently than the one for bombings listed above. Additional considerations (see Exhibit 3.1.2.5) would include:

Exhibit 3.1.2.5 Anthrax contamination incident initial Operations Section staffing



  - Protection Group
    - Perimeter management: Controlling access to the facilities to prevent contaminated victims, mail or carried items from entering.
    - Processing potentially contaminated victims: Personnel assigned to the decontamination areas to process persons acutely exposed to aerosolized powders.
    - Preventing internal releases: Potentially, personnel may be assigned to screen incoming mail and/or to isolate facility areas where suspicious mail has been received.
  - Security group:
    - Maintaining a rapid response capability: Keeping personnel ready to respond to any internal or perimeter security issues while maintaining the appropriate personal protection.

- Law enforcement investigation interface: Focused upon forensic issues (e.g., chain of evidence) and tactical coordination with investigators and other relevant law enforcement elements.

○ Clinical services group

- Evaluation of potentially exposed patients: Establishing and following a consistent approach to assessing patients presenting with concerns about exposure or with symptoms or signs of relevant illness. This may include dispensing the appropriate prophylaxis for patients deemed to have significant exposure risk.

- Follow-up services: Personnel assigned to contact patients who have been screened and discharged to verify compliance with prophylaxis or to inform them of a change in public health recommendations regarding their prophylaxis.

○ Clinical support services group

- Diagnostic testing: Screening procedures may require laboratory procedures, creating a significant surge need for these services and for appropriate supplies.

- Pharmacy services: Acquiring appropriate medication and medical delivery services, including packaging for individual dispensing and tracking medication stocks may be indicated.

This potential for the Operations Section to vary depending on the type of event is significant for healthcare systems compared to some other types of response resources such as the fire service. "Pre-plans" or standardized operations procedures specific to each type of hazard (contained within the Incident Specific Annexes) may simplify this issue by providing guidance that can then be customized to the very specific situation.

Lesson 3.1.3 Emergency Response and Recovery: The Planning Section

Lesson objectives

- *Define the responsibilities of the Planning Section in healthcare systems and describe its common organizational structure.*
- *List the functional elements of the Healthcare System Planning Section as presented in this text.*
- *List the responsibilities of the Planning Section and describe the role of each of its functional units as applied to healthcare systems.*

System Description: The Planning Section

The Planning Section supports the response through information processing and Incident Action Planning.

The Planning Section supports the healthcare system response through the management and processing of incident information and through the development of incident action plans. The Planning Section, therefore, plays a critical role during emergency response and recovery and yet it is often poorly understood and under-utilized by healthcare systems.[13] The complexity and volume of incident information in healthcare emergencies will almost always require an efficient Planning Section. In any conceivable partial activation of the healthcare system EOP, therefore, the Planning Section should be staffed at least to a minimum level, unless the healthcare system Commander intends to accept all Planning Section responsibilities (see example in Textbox 3.1.3.1).

The Healthcare System Planning Section should be staffed for almost every disaster or emergency.

Textbox 3.1.3.1

Planning Section Activity in a Partial EOP Activation: An Example

Hospital X is located in a jurisdiction in which credible environmental samples have recently indicated the potential presence of aerosolized anthrax in three mailrooms in local businesses. Further tests are pending and local authorities have initiated prophylaxis of specific populations deemed "at risk." Hospital X partially activates its EOP to include Command staff (Commander, PIO, Safety, and Liaison) as well as an Operations Section Chief and a Planning Section Chief. No other personnel are assigned at this point. The **Planning Section Chief is responsible for tracking and**

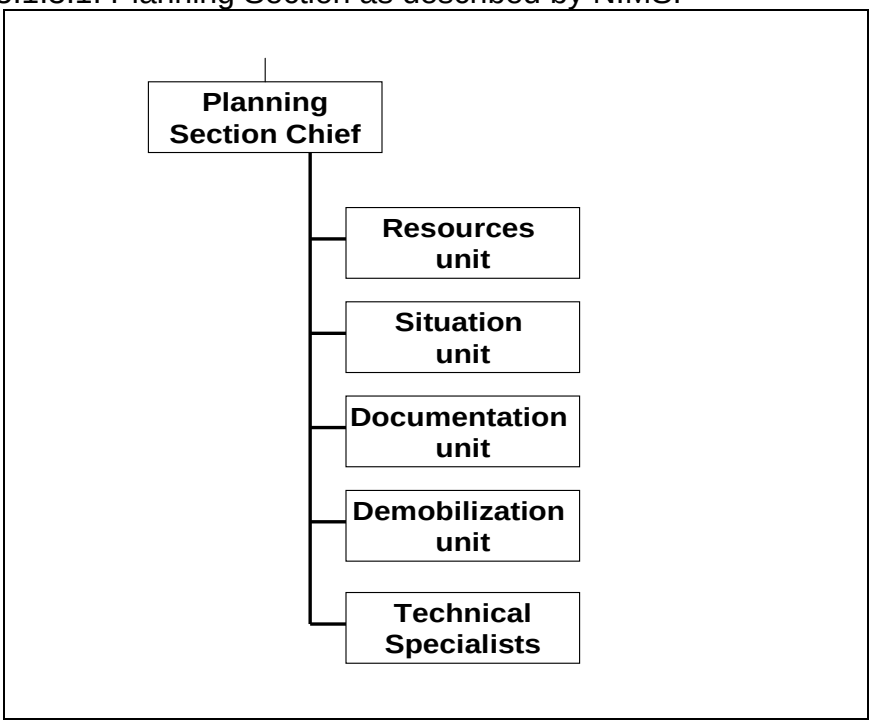
[13] In fact, many ICS veterans, when given the choice between assignments as Incident Commander versus Planning Section Chief, will often choose the latter as they recognize the tremendous influence that this position has on the overall response (authors' observations).

documenting jurisdictional information as it becomes available. This is processed and formatted by the Planning Section Chief for dissemination to all areas of the healthcare system, including clinical care areas that have the potential to receive patients concerned about exposure to anthrax. The strategy for addressing these patients' concerns (work up, written recommendations, referrals, and treatment as necessary) is established by the Operations Section Chief in conjunction with Command and **documented by the Planning Section Chief**. This strategy is disseminated internally within the organization (to provide a consistent approach) and externally (so that other hospitals in the jurisdiction and public health are aware of Hospital X's approach to these patients). If Hospital X's strategy is significantly different than that recommended by public health or that performed by other hospitals, it should either change its approach or provide explanation to patients about the difference in strategy.

NIMS/ICS describes the Planning Section Chief as having several responsibilities. This individual not only oversees all planning activities, including information gathering, processing, and dissemination, but also is responsible for development of the healthcare organization incident action plan[14] and for the development of alternative strategies for consideration by Command. Within the Planning Section in traditional ICS (Exhibit 3.1.3.1), several "units" are described. These are repeated from Lesson 2.1.2 with more detail provided here as applicable to healthcare systems:

[14] In ICS, it is generally recognized that there is only one official Incident Action Plan for the incident (the frame of reference for this is usually the jurisdiction). This does not negate the need for the conduct of this incident action planning at the healthcare system level. The resultant action plan, however, may be designated as "Hospital X Action Plan" and qualified by the time period where it applies.

Exhibit 3.1.3.1: Planning Section as described by NIMS.[15]



The Healthcare System Planning Section can be organized into traditional ICS units to cover the required types of information processing and incident planning.

- Resources Unit: In NIMS/ICS, the Resources Unit is responsible for tracking the status of all resources within the response system. Resources can include personnel, major items, and facilities (i.e., "people, places, and things"). For healthcare systems, other resources besides staff may require tracking. Other important resources such as the status of critical pharmaceutical items, ventilators, available blood products, and the status of certain facilities all may become important to track for Command. It is the responsibility of Command to determine what resources should be tracked at the beginning of any incident and to convey this to the Planning Section Chief. NIMS provides three status categories for classifying resource status: assigned, available, or out of service. To accomplish its assigned responsibility, the Resources Unit may utilize the following ICS forms (note: a summary purpose for all common ICS forms is found in Exhibit 2.1.3.6):

    - 211, Check-in Form: This form can be used to account for the personnel on duty and assigned to the ICS organizational structure. For complex responses, the organization may wish to have separate 211's for Command Staff and different functions. The critical point is that the 211's are collected and tracked by the Planning Section (resource unit if assigned).

[15] U.S. Department of Homeland Security. National *Incident Management System*. (December, 2008). Washington, DC. pp. 103 – 106, accessed December 6, 2009 at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

- 221, Demobilization Check-out Form: This form provides accountability for individuals demobilizing from the ICS organizational structure and can guide personnel through any necessary out-processing steps. As an example, each individual's 221 could have steps listed such as 1) participate in any indicated out-brief; 2) return assigned equipment; 3) submit applicable 214s (see below); 4) receive any post-incident medical check (e.g., after decontamination activities); 5) receive timing of return to regular job duties. In a checklist format, these activities can be verified for each individual. As with the 211, these are the responsibility of the Planning Section.

- 214, Unit Log: This form tracks the activities of all units within the healthcare incident response system. Each major function and complex individual resource can be requested to use 214s to account for major activities achieved. This form is most useful during prolonged, complex incidents and is also collected by the Planning Section.

The Healthcare System Situation Unit collates and disseminates patient tracking information, but the actual collection of this information is better suited to the Operations Section.

- Situation Unit: A traditional Situation Unit is responsible for the tracking and processing of all information relevant to the incident. It may also develop forecasts for likely incident activities. Incident Status Summaries (ICS Form 209) can be prepared and disseminated on a regular basis by the Situation Unit (as determined by Command). For healthcare systems, situation data likely to need tracking includes information external to the system (e.g., number of trains bombed, jurisdictional response, numbers of patients trapped, etc.) or information internal to the system. A critical information component to be processed internal to the system would be patient tracking during incidents that generate human casualties. Tracking may include total casualties, pending operative cases, etc., that allow Command and General Staff to assess the progression of the incident response in accomplishing its objectives. While the actual counting and reporting of this data may be accomplished by the Operations Section personnel, the information is forwarded to the Planning Section for processing (aggregates, categorizing, analyzing for trends, etc.), incorporation into incident action planning, and for further dissemination to relevant functions (e.g., forwarding names to the patients' family care areas to inform families whether an individual is being cared for at the facility). The importance of formally capturing this type of information creates the imperative that a Planning Section always be staffed, even for a minimal EOP activation.

- Documentation Unit: NIMS/ICS devotes a unit within the Planning Section to maintain files and documents relevant to the incident. This

may include copying, organizing, and filing incident-related documents, while keeping them easily available for reference and other use within the incident response. Depending upon the complexity of an incident, healthcare systems may wish to assign personnel to a Documentation Unit or, alternatively, assign this responsibility to another Planning Section Unit.

- Demobilization Unit: NIMS/ICS assigns personnel to the early development of demobilization plans. This has tremendous advantages as some assets may be demobilized early in an incident, as soon as they have accomplished their objectives or otherwise are no longer needed. A plan for full system demobilization defines the processes, procedures, and responsible parties to facilitate the process. For healthcare systems, which have day-to-day responsibilities to the community, an efficient demobilization process is critical to allow rapid restoration of everyday services. For any significant response involving the assignment of numerous everyday healthcare system resources, a Demobilization Unit is critical in achieving this rapid turnaround. The Unit may develop plans to address "return to readiness" (rehabilitation of personnel and supplies, repacking of response cache, etc.) and the backlog of everyday medical workload that accumulates during the period of response (rescheduling staff, expediting the rescheduling of urgent and elective procedures, etc.).

- Technical Specialists: ICS and NIMS describe Technical Specialists as individuals with skills or knowledge that can be utilized to address incident specific parameters. They are utilized only as needed and can serve in a variety of ways or locations within the organizational structure. For example, Technical Specialists can be assigned to report directly to the Command staff (see Senior Advisor earlier in this lesson), to the Operations Section, or to a support section. It should be noted that they serve only in a technical capacity for which they have the skills and knowledge. They are, therefore, usually only providing advice. An example for healthcare systems might be an infectious disease specialist who provides strategic advice to Command about the expected future characteristics and treatment needs for a certain infectious disease. This person would not assume any other Command role unless specifically certified and qualified for a Command staff position. If enough Technical Specialists are assigned to a given activity, they may form an independent Technical Specialist Unit within the Planning Section (for example, a radiation injury Technical Specialist Unit that provides treatment advice and chelation regimens to guide the actions of the healthcare system's clinicians).

Healthcare System Technical Specialists provide advice to the organization at the strategic or tactical levels. They do not automatically qualify as Commander of a response based upon their technical expertise.

- Planning Section summary of responsibilities: An easy way for healthcare personnel to interpret the Planning Section's responsibilities is to categorize the responsibilities as "**information processing**" and "**incident action planning**." These two critical sets of activities can mean the difference between a successful or unsuccessful response, even for a small incident. For healthcare systems, the information processing activities are addressed by the Planning Section's units described above. The incident action planning itself, however, is traditionally a responsibility of the Planning Section Chief. An experienced Planning Section Chief will present Command with several options to choose from for each operational period's objectives and strategies, based upon the overall incident objectives. Chosen operational period objectives and strategies (along with assigned resources) are then documented on ICS Forms 202 and 204 for inclusion in the incident action plan. **This dynamic necessitates that the Planning Section Chief has mastered most of the competencies in conducting incident management listed for the Commander** and, hence, their position qualifications should be similar (see those listed for Hospital Commander above). In addition, the Planning Section Chief conducts all Command and General Staff meetings. Defined methodology for these meetings ensures an efficient process and should be utilized in all healthcare system incident action planning (see Concept of Operations in module 3.3).

Lesson 3.1.4 Emergency Response and Recovery: The Logistics and Finance/Administration Sections

Lesson objectives

- *Define the role of the Logistics Section and list its component units, providing a description of each one as it relates to healthcare systems.*
- *Define the role of the Finance/Administration Section and list its component units, providing a description of each one as it relates to healthcare systems.*

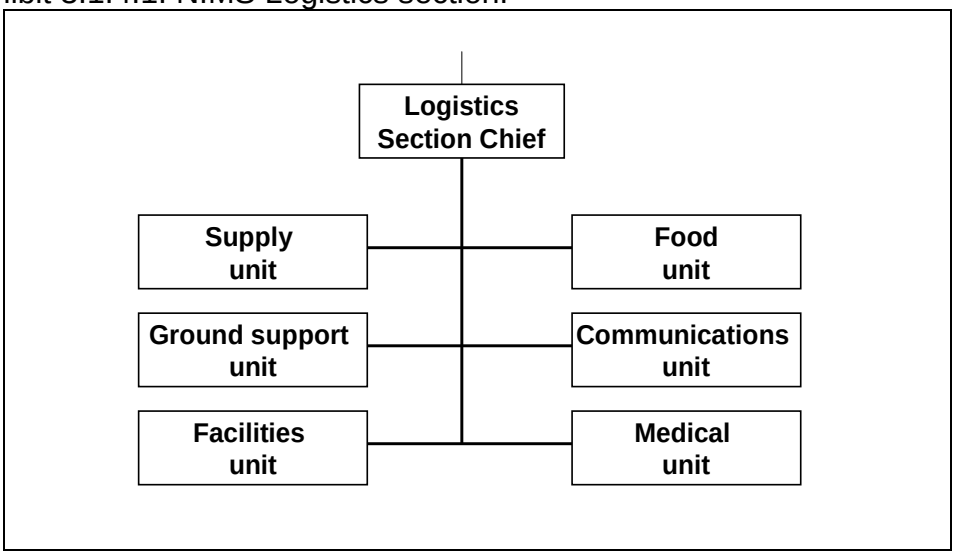
System Description: The Logistics Section

The Healthcare System Logistics Section supports the response with "people, places, and things."

The Logistics Section provides support to the other ICS sections in the form of personnel, equipment, supplies, and response facilities. Logistics is in charge of these assets until they are assigned to a particular position within another ICS section, or to that section's staging area. Upon delivery of the assets to their assigned position, they become the responsibility of that section. For example, if the Logistics Section is able to identify and provide a nurse to a branch within the Operations Section, then that nurse reports to the responsible party within Operations and is considered a part of the Operations Section. Volunteers, for example, are the responsibility of the Logistics Section until they have been screened, credentialed, equipped, and staged (assigned, awaiting to perform tasks). Upon reporting to their assignment, they become the responsibility of their supervisor. This assignment of responsibility is often confused by health and medical providers but should be well understood by personnel staffing the senior positions in the healthcare organization's IMT.

The Logistics Section in traditional and NIMS/ICS is comprised of several units (see Exhibit 3.1.4.1). These are repeated from lesson 2.1.2 with more detail provided here as applicable to healthcare systems:

Exhibit 3.1.4.1: NIMS Logistics section.[16]



- Supply Unit: In NIMS/ICS, the Supply Unit "orders, receives, processes, stores, inventories, and distributes all incident-related resources and supplies."[17] It provides these resources as they are requested and, in fact, should anticipate needs so that they may be rapidly addressed. Once assigned, resources become the responsibility of the section where they are assigned, and are sent to staging areas if no other location assignment has been made. For healthcare systems, there are several important considerations that apply to a Supply Unit:

  - Labor Pool: Many healthcare systems in the past utilized a "Labor Pool," a location where unassigned personnel or those with no current responsibilities position themselves awaiting an assignment.[18] According to ICS principles, the responsibility for this would fall under the Supply Unit. Some personnel may, in fact, be automatically assigned (through a pre-established deployment tool) to staging areas under operations (for example, to an area proximate to the emergency department to await

[16] U.S. Department of Homeland Security. *National Incident Management System*. (December, 2008). Washington, DC. pp. 107- 111; accessed December 6, 2009 at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

[17] U.S. Department of Homeland Security. *National Incident Management System*. (December, 2008). Washington, DC. P. 108; accessed December 6, 2009at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

[18] In today's healthcare environment, all personnel are fully committed to everyday tasks, and so few personnel are "unassigned" and available to go to a "pool" and await assignments. An efficient method for developing a Labor Pool, therefore, may be to have physical, telephonic, or electronic reporting to the labor pool supervisor and document reliable contact information for those responding to a Labor Pool request. Personnel are then released back to their usual workstation pending assignment from the Labor Pool.

assignments for transporting patients, for incorporation into a patient care team, or other tasking). Otherwise, as requests come in, the personnel pool may deploy workers to the emergency department staging, the operating suite staging, pharmacy staging, or other areas. Some organizations consider the Labor Pool as the "staging area" under the Operations Section, and therefore the responsibility of Operations, but this may be problematic for the Operations Section Chief, given his or her other foci of responsibility. Both configurations are acceptable, but the one in use must be clearly delineated so that proper supervisory responsibility is established.

Some personnel reporting to the labor pool may be immediately assigned to logistics tasks (for example, transporting supply carts from central supply or pharmacy) or to logistics staging (for example, reporting to the loading dock to anticipate tasking for unloading a pharmaceutical cache or other supplies).

- Volunteer Management: Unsolicited health and medical volunteers have always been and remain a challenge both in the field and at healthcare facilities. The "convergence" of those wanting to help, but who have not been formally requested or credentialed, appears to be increasing in frequency and scope. Since 9-11, numerous efforts have been initiated to recruit and verify the credentials of medical volunteers prior to an incident response (Medical Reserve Corps,[19] Emergency System for Advanced Registration of Volunteer Health Professionals or ESAR-VHP,[20] as well as numerous State and local initiatives). This is in an effort to provide structure and discipline to volunteer response. Any healthcare system should anticipate both the need to incorporate volunteers into the response and the need to manage unsolicited volunteers where no assignment is indicated. In certain circumstances, it may be helpful to establish a dedicated mechanism for processing volunteers.[21] An essential component of medical surge capacity is having a mechanism established to obtain qualified personnel when needed (see "qualification" terminology textbox in Lesson 2.1.2).

  - Solicited volunteers: Obtaining staffing beyond the healthcare

Volunteer Management has become increasingly important for all response entities.

[19] Office of the US Surgeon General. *Medical Reserve Corps*. Web site accessed February 11, 2010 at:http://www.medicalreservecorps.gov

[20] Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); information accessed November 1, 2009 at http://www.hhs.gov/aspr/

[21] ICDRM/GWU. *The Standardized Volunteer Management System for Public Health & Medical Emergency Response & Recovery* (October 2006). Institute for Crisis, Disaster, and Risk Management, The George Washington University); accessed February 12, 2010 at: http://www.gwu.edu/~icdrm/projects/eVMS/index.htm

organizations' regular personnel may best be accomplished through a mutual aid system between healthcare resources, such that "volunteers" are identified and accepted from pools of similarly accredited healthcare assets.[22] Accepting the credentials and privileging from another accredited healthcare institution may decrease the burden on the impacted staff in terms of verifying identification and credentials. It also increases the likelihood of accepting volunteers who understand their role within healthcare system emergency operations. With proper preparedness phase accomplishments, the "volunteers" should already be trained on the roles and responsibilities (reporting to host institution personnel, accepting a supervised role, etc.) prior to dispatch to the affected facility. These types of arrangements are best established through cooperative planning during Preparedness.

- Unsolicited and unneeded volunteers: If these personnel are to be used by a healthcare organization, a mechanism must be in place to register, screen (verify identity and a level of credentials commensurate with their assignments), and train them on their roles as volunteers prior to providing an assignment. It is also critical that regular staff are trained and briefed on the role of supervising volunteers. If no unsolicited volunteers are needed, convergent volunteers should be thanked, provided with a brief statement that they are currently not needed within the healthcare system response, and that continued efforts to enter the facility could be viewed adversely (i.e., trespassing). They may also be requested to register and provide contact information for future incidents. If they are needed they are processed as below.

- Credentialing versus privileging in healthcare system volunteer response: A process should be established that verifies, to the degree of certainty indicated by the situation and role assignments, the credentials of the presenting volunteers (see "credentialing" in see Lesson 1.5.3). Several current initiatives such as ESAR-VHP attempt to do this before an incident to facilitate volunteer integration into response. "Credentialing" must be distinguished from "privileging" (see Terminology Textbox). The healthcare system retains the right to "privilege" these pre-credentialed persons, or personnel credentialed

[22] D.C. Hospital Association. *Mutual Aid Memorandum of Understanding* (1995 revised 2002); available at: http://www.dcha.org/EP/dchamou.pdf, accessed November 1, 2009 or American Hospital Association. Model Hospital Mutual Aid Memorandum of Understanding (March 2002); November 1. 2009 at: http://www.aha.org/aha/content/2002/pdf/ModelHospitalMou.pdf

through their own system. A credential, therefore, never confers automatic access to an incident site.

Terminology alert!

Privileging: The process where appropriately credentialed personnel are accepted into an incident (or by an incident resource such as a hospital) to participate as an assigned resource in the response. This process may include both confirmation of a responder's credentials and a determination that an incident need exists that the responder is qualified to address. Privileging is associated with a separate process, badging (see "badging"), which indicates that a person has been privileged to access a specific incident or to access a specific location.

The Healthcare System Logistics Section should maintain a "larger perspective" beyond the usual healthcare system confines when acquiring and managing scarce resources.

- Scarce resources: The current healthcare economics have generated a just-in-time supply chain and "just-enough" staffing for healthcare systems across the U.S. It is important that the Supply Unit coordinate beyond the healthcare system confines for certain scarce items (with concurrence from Command). This may necessitate early efforts to seek assistance from external support entities from mutual aid and local, State, or Federal authorities.

- Personnel family assistance: It is important for healthcare systems to recognize that many of their personnel may have family issues arise during a response that, if not addressed, could compromise their availability or full attention to response and recovery activities. Some employees may be single parents and unable to work extended hours (or regular day shifts if school is canceled) unless childcare assistance is identified. Though these contingencies should be a part of family preparedness plans (see Lesson 1.5.9, personnel and resources may need to be devoted to this effort, especially in a complex or prolonged incident. For example, healthcare systems may wish to consider sheltering families of employees during incidents that have large community impacts (e.g., hurricanes). This can facilitate the overall response and demonstrates a concern on the part of the healthcare system for its personnel.

- Provision of Personal Protective Equipment (PPE): Response to incidents that involve certain hazard impacts may require the use of specific PPE not normally available in the healthcare setting. The Supply Unit should obtain these items and ensure that

personnel have the necessary explanation or real-time training to utilize them.

- Ground Support Unit: In traditional ICS, the Logistics Section's Ground Support Unit "maintains and repairs tactical equipment, vehicles, and mobile ground support equipment."[23] It may also move newly assigned volunteers and mutual aid assets to their designated locations. For many healthcare systems, including those within the VHA, this unit may also have the responsibility to deliver patient transport equipment during incidents that generate excessive patients. It may also support the activities that assure personnel reach the facility for their work shifts despite severe winter weather or other travel impediments. The actual activity of transporting patients is more appropriately directed by the Operations Section while Logistics maintains the capability.

The Healthcare System Logistics Section is responsible for facilities used during response.

- Facilities Unit: NIMS/ICS provide personnel whose exclusive responsibilities are to set up, maintain, and demobilize all facilities required for the incident response. For healthcare systems, this might include activities supporting areas of the healthcare facility itself. For example:

  - Healthcare System management facilities: Specific steps could be followed for establishing a well-supplied and constructed Healthcare System Command Post and/or Emergency Operations Center. In addition, Healthcare System Facilities Units may assist with maintaining this facility.

  - Rehabilitation and living areas: For incidents in which some personnel may not be able to leave the facility after a shift, the Facilities Unit may establish sleeping areas for use between assignments.

  The Facilities Unit should be distinguished from the typical role that Plant and Engineering services provide to specifically address the hazard impact on the organization. The latter typically address continuity of operations. Hence, it is more appropriately situated under the Operations Section where its continuity roles will be maximally supported.

- Food Unit: As ICS traditionally dealt with numerous personnel deployed for extended periods in austere field conditions, the Food Unit was critically important for providing safe and regular meals. For

[23] U.S. Department of Homeland Security. National Incident Management System. (December, 2008). Washington, DC. p. 108; accessed December 6, 2009 at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

healthcare systems, a separate Food Unit may be required in extreme circumstances or could be tasked with supporting "rehabilitation"[24] needs in a specific geographical area (i.e., decontamination area).

- Communications Unit: NIMS/ICS describes the Communications Unit as those personnel assigned to the maintenance and distribution of all communication equipment that supports incident operations. This must be distinguished from information processing, which is a central Planning Section function. It is also distinguished from any major repair effort of communications equipment that is damaged by the hazard impact, since this would be an incident operations function. The Communications Unit may also staff a Communications Center if one is established. The Communications Unit develops the Communications Plan (ICS form 205), which documents contact methods for important personnel and is included as a supporting plan in the healthcare system incident action plan. For healthcare systems, these activities can translate to overseeing the phone systems, distribution of portable radios, management of beepers or intra-facility phones, and support of intranet/Internet services. If radios are to be utilized in the healthcare system, just-in-time training for personnel receiving radios should be provided as radios are distributed.

Healthcare personnel require briefing on the use of radios to avoid communication problems.

- Medical Unit: NIMS/ICS places a Medical Unit within the Logistics Section. The Medical Unit's primary responsibility is described as the treatment and processing of all **response personnel** injuries or illnesses, as well as responder fatalities. A component of these responsibilities should be monitoring (with the Safety Officer) the responders' health. The Medical Unit develops the Medical Plan (ICS form 206), which outlines how care can be provided to responders across the incident. This is also included in the healthcare system incident action plan. For healthcare systems that deal primarily in a day-to-day setting with the treatment of injuries and illnesses, these important activities are often overlooked during response and recovery. An example might be the provision of prophylaxis or vaccination to healthcare system employees. While most healthcare organizations have an occupational health unit within their normal operating organization, it should not be assumed that they are fully able to meet response needs of organizational personnel. Careful examination of their capability and capacity, including their hours of operations, should be undertaken. At the very least, incorporation of the occupational health unit into the ICS structure is necessary to integrate it and promote adequate performance during incident response.

While the Healthcare System response may be focused upon the care of incident victims, medical care for response personnel should be adequately addressed as well.

[24] Rehabilitation ("rehab"): Response terminology for rest, rehydration, feeding, and other activities so that responders may resume safe and effective operations.

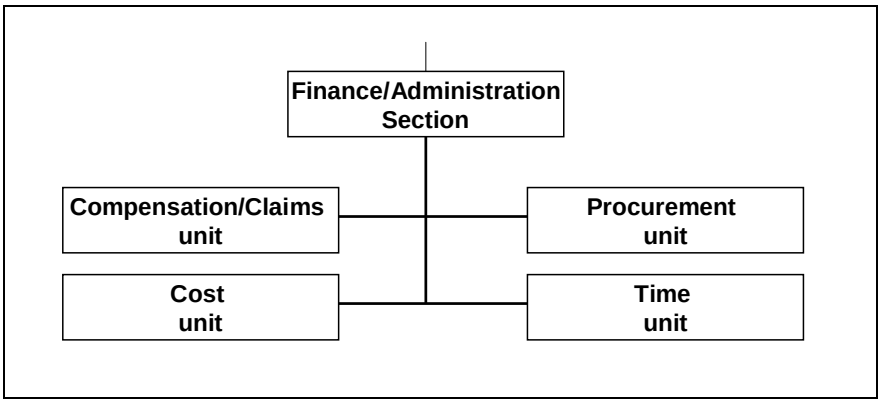
- Incident-specific unit activation: As with other ICS sections, only the required units within the Logistics Section are activated to meet incident needs. For example, for a large-scale incident involving numerous patients over a prolonged period, activation of all units within the Logistics Section should be considered. For a brief decontamination incident, perhaps only partially staffed Supplies, Facilities, and Medical Units would be required.

The Healthcare System Finance/ Administration Section addresses response costs, regulatory compliance, and claims.

System Description: The Finance/Administration Section

The Finance/Administration Section exists in NIMS/ICS to address financial reimbursement and other administrative issues that result from response to an emergency incident. The need for activating this section can vary from incident to incident but in its fully staffed form, it traditionally is configured as in Exhibit 3.1.4.2.

Exhibit 3.1.4.2: NIMS Finance/Administration.[25]



If only one activity is occurring under the Finance/Admin. Section, it is permissible to fold this section into the Planning Section as a Technical Specialist Unit.

- Compensation/Claims Unit: In traditional ICS, this unit processes all injury claims from response personnel and also handles investigation of all civil tort claims. For healthcare organizations, the latter activity is well understood, but the capability to collect information surrounding any incident of concern should exist even in the hectic environment of incident response. In healthcare, this unit may also track regulatory compliance. For example, if the hospital may exceed the patient

[25] U.S. Department of Homeland Security. National Incident Management System. (December, 2008). Washington, DC. pp. 113 – 114; accessed December 6, 2009 at: http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf

capacity allowed by its licensed number of beds, an exception can be justified and sought through jurisdictional authorities.

- Cost Unit: Provides cost data and analysis for the system response. This can be a critically important continuity planning function, keeping the healthcare organization's leadership apprised of the financial burden being accrued and providing the documentation that allows successful reimbursement requests through appropriate authorities.

- Procurement Unit: Addresses all financial matters related to vendor contracts. For healthcare systems, this could have application to certain types of emergency (i.e., "contingency") contracts, such as emergency generators, water supply, or restock of critical supplies items. It may also be responsible for assuring reimbursement for assistance obtained through cooperative agreements or reimbursed mutual aid.

- Time Unit: Accounts for all personnel time, which serves both financial (i.e., "pay") and personnel liability coverage functions.

- Additional administrative and financial issues to be considered by healthcare systems: These include:

  - Monitoring for compliance with the wide range of healthcare regulations.

  - Seeking emergency modification of certain State and Federal regulatory requirements.

  - Developing claims for cost recovery from local, State, and Federal resources.

These functions, if established, should be assigned to existing units or newly created units within the Finance/Administration Section.

In the next module, the reader will learn how the above-described functions can operate together across the different stages of an incident.

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Module 3.2

Healthcare System Emergency Response and Recovery: The Concept of Operations

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Lesson 3.2.1 Concept of Operations for Healthcare Emergency Response and Recovery: Overview and Incident Recognition Stage

Lesson Objectives

- *List the successive stages of the incident response as described in this text.*
- *Describe the healthcare emergency management processes that are critical during the Incident Recognition stage.*
- *List the possible sources for initial incident information important to healthcare systems.*
- *List the key characteristics of the Baseline Situation Unit and describe its delineated procedures.*

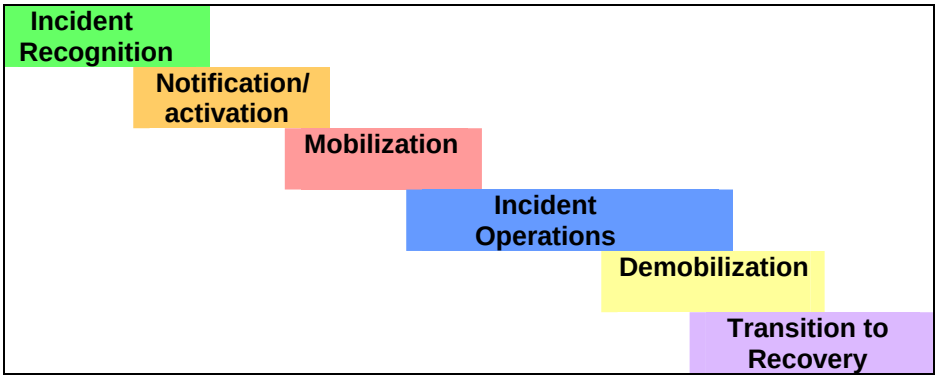
Overview

As mentioned earlier in this unit, the Concept of Operations provides guidance for the various processes and procedures important during the successive stages of an incident. The Concept of Operations is designed to follow a Systems Description in the EOP. The System Description delineates the structure of the response organization and describes the individual elements as demonstrated in Unit 3.1. The follow-on Concept of Operations then describes how that response organization and its many elements operate cohesively through each stage of incident response.

The Healthcare System Concept of Operations provides specific procedures and tasks grouped according to stages of response.

While there is significant temporal overlap between incident stages, the complexity of the concept of operations created by the wide range of response and recovery tasks can be simplified by organizing the response phase according to these stages. From a management perspective, the stages also emphasize grouped activities that may best be managed in like fashion. Exhibit 3.2.1.1 summarizes the stages of an incident and demonstrates the areas of potential overlap between each stage.

Exhibit 3.2.1.1: Stages of the Response Phase of an Emergency Incident, explained in detail in the subsequent lessons in this module.



A smoother and more rapid transition from baseline to response mode, and modulating any tendency for delay or overreacting, is promoted through a continuously functioning Baseline Situation Unit.

The transition timing between stages is not always distinct, but several stages have important transition processes and procedures that should be specifically accomplished. A critical early "transition" is from baseline, everyday operations, into actions guided by the EOP.

- Importance of timely incident recognition: To begin the incident recognition process at the earliest possible time, a mechanism must be in place for immediate aggregation and analysis of details as they emerge. Information management is therefore a critical task from the very outset of the healthcare incident. The Planning Section is responsible for this important role and so should be capable of immediate mobilization into a functional incident response state. For this reason, healthcare systems should consider maintaining a functional Situation Unit that is operational, at a baseline level, **at all times**.[26] It can therefore be upgraded, rather than implemented from a cold start, at the time of a potential response. Methods to address this important issue are presented later in this lesson.

The Incident Recognition Stage

Incident recognition is the first stage of Emergency Response. Incident recognition is the process that identifies an "anomaly" that could be the onset of an emergency situation (independently or through communication from others), develops a situational assessment of the anomaly and related details, and determines whether the situation constitutes an "incident" for the response organization. Since incident response is governed by the EOP, this stage focuses upon the decision to activate the organization's EOP for "incident response." The level of

[26] This important role is best assigned to an everyday position of authority that is continuously staffed in the healthcare system (see examples below).

response is then determined in the follow-on stage of "Activation/Initial Notification."

Recognizing when a set of circumstances indicates a specialized or very high capacity response from the healthcare system can be straightforward or, at times, very difficult.

The Incident Recognition Stage: actions to determine whether a baseline anomaly indicates t5.6"he need for an organization to initiate "incident response" and hence, activation of its EOP.

- Obvious incidents: Some emergencies present themselves at the outset with clear signs that the impact will challenge day-to-day healthcare operations or present a difficult array and/or number of casualties. A large earthquake in the surrounding community, for example, would immediately create a widely recognized impact directly or indirectly on the facility. In this example, incident recognition is immediate, even though the extent of impact and hospital continuity disruption has not been ascertained. Some incidents present with pre-impact indications, such as tornado warnings and other weather hazards. Rapid pre-impact incident recognition may provide enough time for the healthcare system to conduct certain incident-specific mobilization and protective actions prior to the actual hazard impact.

Hazards that have the potential to impact Healthcare Systems are sometimes difficult to identify.

- Surreptitious incidents: Many incidents evolve with initial signs that are not nearly as clear-cut, and so the incident may be well underway before being recognized and appropriate healthcare system response initiated (i.e., the impact may be either subtle or misinterpreted during initial stages). For example, an infectious disease outbreak with the sentinel case presenting to the facility may not even be diagnosed initially as a case of concern. The disease course may take time to differentiate it from other, less dangerous illness (e.g., unexpected patient deterioration, or unexpected bacteriological culture results). Even after diagnosis, the full impact to the healthcare system operations may not be immediately obvious.

- Initial information sources: To further complicate matters, information important to the incident determination decision may not initially be widely available. Healthcare system personnel may need to actively seek additional information. Sources that could be queried because they may have access to early warning or early information about an evolving hazard are presented in Textbox 3.2.1.1. Communication between the healthcare organization and these sources must therefore be well developed as part of the preparedness planning process.

Information indicating a possible Incident for Healthcare Systems can come from a variety of sources.

Textbox 3.2.1.1

Possible Sources for Initial Incident Information Important to Healthcare Systems

Information sources external to the healthcare system include:

- Emergency Medical Services: EMS is the traditionally recognized source for notification of an "external" hazard impact that may adversely affect a healthcare system. Though this won't always be the case, EMS remains an important early interface during community response to specific incidents. For healthcare systems, it is important that EMS information be rapidly and accurately conveyed beyond the Emergency Department, which is the usual point where this information is received (i.e., to the Baseline Situation Unit and then directly to administrative personnel responsible for activation or other major EOP decisions).

- Media: Healthcare system personnel may receive initial notification of a situation at the same time as the general public through media outlets, such as television or radio announcements, or through direct communications from concerned parties via cell phones, twitter, or other social media. An important consideration is the verification of initial information presented through these sources and rapid transfer of this information to appropriate healthcare system authorities.

- Public health: Local or State health officials may provide notice of an evolving hazard with potential to impact a healthcare system. This notification is often accompanied by requests for specific actions such as reporting of suspicious cases. Public health notification can at times come to individual practitioners or departments within the healthcare system and it is the responsibility of those receiving this information to ensure that it has been appropriately disseminated internally (e.g., through a Baseline Situation Unit).

- Law enforcement: Representatives from a range of law enforcement agencies could provide information that represents a direct or indirect threat to the healthcare system. In some situations, the information may be considered "sensitive" but does not preclude the healthcare system from disseminating a carefully worded general message internally, describing the potential hazard and appropriate protective actions.

Withholding security-related threats from staff will be indefensible if the threat is carried out without an opportunity for protective actions. When promulgated within a pattern of regular advisories and updates for weather warnings, large-scale community events, and other hazard advisories, the protective actions advisories for security threats may be considered more routine. They may therefore be received without undue apprehension, but still initiate an appropriate level of concern.

- Emergency Management Agency: Local emergency management authorities may provide information regarding potential threats or actual impact as they occur. Some of these (such as notice of planned mass gatherings) do not require EOP action, but the information should be passed on to staff as advisories or updates, depending upon whether directed actions are communicated with the information.

- Other healthcare systems: Other participants in the community's healthcare delivery may identify an issue of concern (clinics, local Red Cross chapter, healthcare coalitions, others).

- Utility Services Control Centers: Control Centers for various utilities (water, power, gas, etc.) can provide a variety of information about hazard impact and can be invaluable sources for projecting the extent or length of the utility outage.

Information sources internal to the healthcare system include:

- Medical care providers: In the day-to-day management of individual cases, medical care providers could potentially identify a single case of concern or a pattern of cases that warrant response from the healthcare system, even if the response is only a rapid and focused investigation of a potential sentinel case. It is important that the senior administrators of the healthcare system be kept informed of any evolving issue (through the Baseline Situation Unit) so that impact may be anticipated and appropriate external notifications made.

- Clinical support services: Departments that provide support services to clinical areas may identify a case or cases of concern (e.g., microbiology lab identifying anthrax in a blood culture from a patient). This information becomes relevant not only to the personnel providing care to the patient, but also to administrative and emergency management personnel due to its potential impact on the healthcare system. Both should be informed expeditiously.

- Infrastructure personnel: Security, plant operations, and others could all potentially identify issues of concern within the organization. For example, a loss of water pressure within the facility could initially be identified by plant operations personnel.

- Staff with contacts outside of the healthcare system: Designated representatives to local community response organizations or to local emergency preparedness organizations may obtain information regarding a potential hazard impact to the healthcare system. As with other sources of information, it is important that this be conveyed to appropriate personnel within the healthcare system.

- Alarm systems: Healthcare systems may have automated alarms that may provide the first indication of a hazard impact (e.g., a fire in an unoccupied section of the facility).

- The need for a defined healthcare system position responsible for Incident Recognition actions: The above issues spotlight the need to have a **single, always available, and competent position** to receive reports of anomalies, cases of concern, or other recognized hazard threat or impact. This position must be able to rapidly acquire pertinent information and efficiently conduct the incident recognition process described in this lesson. The position should have the following requirements:

  To facilitate Incident Recognition, the Baseline Situation Unit should possess certain characteristics such as 24-hour availability and specified procedures to follow.

  - Twenty-four-hour availability: The designated position should be one that is continuously staffed and onsite, with reliable communications (e.g., cell phone and pager). The contact information (telephone and pager numbers) should remain constant, irrespective of the individuals assigned to the position and should be disseminated widely internal and external to the organization.

  - Broad understanding of the healthcare system operations: Personnel in this position must be experienced with healthcare system's operations, so that an informed judgment may be made in projecting whether the reported hazard information could require incident response actions.

  - Recognized authority within the healthcare system: This position may need to make rapid inquiries and ask for information from within the healthcare system or from senior personnel in organizations listed in Textbox 3.2.1.2. The position must carry

enough authority for this activity to be rapidly accomplished.

- Adequate visibility: The role must be widely understood and so should be assigned to a visible position within the organization. Supervisory employees at all levels of a healthcare system and relevant community response personnel should then be educated to this position and the 24/7/365 contact methods. Training should emphasize the fact that potential incident information, even if deemed "preliminary," should be communicated immediately. Personnel assigned to this function must also be responsive to the reported concern and provide timely feedback to the reporting source as the investigation unfolds.

A hospital can incorporate these considerations by assigning this role to a 24-hour administrative staff position(s). For example, the emergency program manager (acting as the organization's emergency manager) could manage this centralized role of receiving and analyzing information that could indicate the need for incident response and disseminating important information for the healthcare facility related to potential emergency situations. The emergency manager would transfer this responsibility (and point of contact) to the House Operations Supervisor or other onsite administrator (e.g., "Duty Officer," Police Desk, others) when leaving the facility. Alternatively, the House Operations Supervisor position (usually a nursing supervisor role that oversees clinical staff operations) may have this assigned as a duty on all shifts.

- Titling this position using ICS nomenclature: This entity functions essentially in the ICS role of the Planning Section Situation Unit Leader (see Lesson 3.1.2). The position is functional during periods of **non-response** and so could be distinguished from the incident response Situation Unit by calling it the **Baseline Situation Unit Leader** or simply the **healthcare organization's Duty Officer**.[27]

- Situation Unit Procedures: Pre-activation procedures for the Baseline Situation Unit Leader or Duty Officer should be well delineated in the EOP. These include:

  - Information gathering and processing: The information that is important to determining whether a set of circumstances indicates

[27] If a situation warrants healthcare system incident response, the person(s) assigned to the Baseline Situation Unit could become the initial Incident Commander or the Planning Section Chief until relieved by other personnel as the incident management team mobilizes. At the same time, the baseline Situation Unit Leader position transitions to the incident Situation Unit Leader position in the IMT.

an incident should be outlined in a simple document. This serves as a guide to the individual assigned to the position and when completed essentially becomes an initial Situation Assessment. The ICS Form 201, or Incident Briefing Form, is a good model to follow for this purpose. This instrument was originally developed in ICS to provide initial incident information to an IC arriving to assume leadership of an evolving incident. ICS Form-201 can be adapted for use by the healthcare system, incorporating prompts for essential elements of information that are important to initial healthcare command staff. The completed form may also be used as the initial healthcare system report that informs appropriate authorities.

- Incident determination: Once information has been received, the task of determining whether it indicates an actual or potential hazard impact for the healthcare system becomes important. Guidelines for deciding that the circumstances are significant and prompt EOP activation and response system notification should be developed as a decision-support tool.

  - Trigger parameters: Parameters that trigger an immediate EOP activation should be clearly delineated (for example, hazards that present an immediate danger to staff, patients, or visitors and other patients should prompt appropriate activation of the EOP). Parameters to consider for inclusion in a simple algorithm are presented in textbox 3.2.1.2.

Textbox 3.2.1.2

Considerations when evaluating initial incident information*

- Probability of actual occurrence of a threatening hazard
- Potential impact on the organization as the situation evolves:
  - Safety of personnel (protection and security).
  - Safety of existing patients/visitors.
  - Increased patient load (surge capacity).
  - Patients with unique or specific needs (surge capability).
  - Continuity of healthcare services operations.
  - Continuity of business operations.
- Need for enhanced information gathering and tracking.
- Need for enhanced information dissemination within organization.
- Potential duration of incident.
- Potential need to support external organizations.

* *Adapted from the George Washington University Hospital Emergency Operations Plan v 1.0 2007*.

- System leader interaction: Most situations, however, require some interaction with healthcare system leaders to determine the need for initial or expanded healthcare system emergency response.

- Casualty numbers: **The most frequent mistake made in public health and medicine is to narrowly define an incident based upon casualty numbers**.[28] Many situations generate few or no patients but still have potential to significantly impact a healthcare system's normal operations and should be considered an "incident" in terms of **priority and response management methods**. For example, the isolated loss of a **mission critical system** such as electrical power could cause a severe impact on the healthcare system healthcare services. A good rule of thumb is that any situation with significant **potential** to impact the day-to-day operations should be considered an incident for the healthcare system.

Healthcare System incidents are not exclusively defined by casualty numbers.

- Unusual situations: For unusual situations where it is not rapidly clear whether an incident response will be necessary, the "incident" may, in fact, be "to determine if the current circumstances are an incident." The EOP may direct a partial activation, staffing only a minimal number of command, operations, and planning positions to focus upon evolving information, to initiate appropriate notifications, and to develop/review contingency plans until an incident determination can be made. This may provide an efficient way to "lean forward" while conserving attention and resources for everyday operations.

  - Information dissemination: Finally, the type of information to be disseminated from the Situation Assessment within the healthcare system, and the communication method, should be described (see notification in Lesson 3.2.2).

- Back-up mechanisms: Back-up mechanisms should exist in case the individual assigned to the Baseline Situation Unit is unavailable or the usual communications methods fail.

- Importance of training: All personnel assigned to this position must be trained to an operational level of proficiency on information gathering and processing, the decision-making process, and information

[28] This appears in part to be tied to concerns over the cost of activating an "all-or-nothing" EOP response. See discussion in next lesson.

dissemination. If developed, this can be a critically important position for optimizing the healthcare organization's resilience and timely response to any emergency/. Hence, some effort should be invested in this area during preparedness planning.

Lesson 3.2.2 Concept of Operations for Healthcare Emergency Response and Recovery: Notification/Activation Stage

Lesson Objectives

- *List the important concepts related to EOP activation for Healthcare Systems.*
- *List the general activation-related options for Healthcare Systems for incidents with pre-impact warning and describe specific incident examples.*
- *Define the importance of initial notification messages and list considerations for content development and message dissemination.*
- *Outline the categorization scheme proposed in this text and describe the purpose of each category in emergency response.*
- *List the different types of notifications methods and explain their relationship to the category of notification.*

Introduction

At the conclusion of the Incident Recognition stage, a determination has been made about whether the evolving circumstances constitute an incident (i.e., that the situation indicates that "incident response" may be required by the healthcare organization). The level of the organization's response is determined in the follow-on stage of "Activation/Initial Notification."

The decision on activation of the EOP and the notification of this determination to appropriate personnel should occur almost simultaneously. They are therefore presented together as a single response "stage" in the Concept of Operations.

The Activation/Initial Notification Stage encompasses the activities that determi5.6"ne the level of EOP activation and inform organizational personnel of both the incident circumstances and the organization's response status.

Activation decision making

Important concepts related to EOP activation include:

- Activation authority: Preparedness planners must recognize that full healthcare system EOP activation can have significant financial impact, as well as business disruption, for healthcare systems. Many response actions that accompany full EOP activation can be costly, such as canceling elective procedures or admissions, diversion of staff from normal operations, holding staff beyond their shift change or calling in additional personnel, mobilizing equipment/supplies, and converting normal space to functional areas like the Healthcare System Command Post. The decision to activate the EOP, therefore,

is usually reserved for appropriate administrative personnel within the facility, with exceptions for life-threatening situations (see examples in next paragraph).

- Warning versus no warning: In some incidents, the impact occurs without notice and is immediately severe enough that the decision to activate the EOP is clear. Most incidents, however, begin with manifestations that don't necessarily indicate the immediate need for incident response by the organization. In these, standardized decision making and initial incident notification should be conducted.

  - Situations without warning - Immediate activation situations: Pre-established procedures should allow full or partial activation (even if on an interim basis) by mid-level personnel in unusual circumstances that carry no warning. The fire alarm evacuation signal is a common example, triggering EOP activation of a pre-planned management and information component. Similarly, a hazard impact could result in the sudden, "no-notice" presentation of significant numbers of contaminated patients to the facility's emergency department. An unusual hazard impact may be noted by facility engineering, such as a hazmat spill or potential explosion hazard, where rapid protective actions must be undertaken. In these cases, activation is initiated within the healthcare system to implement timely protective actions, while administrators are simultaneously notified and consulted. All information relevant to a potential hazard impact should be conveyed to the designated senior administrator(s) as rapidly as possible in order to allow for timely follow-on decisions.

Positions with responsibility for EOP activation should be clearly delineated.

  - Situations with warning - Activation determination procedures: In many incidents, early anomaly detection or early warning occurs, but rapid situation assessment does not indicate that immediate activation is indicated. A "meeting" between the Baseline Situation Unit Leader and senior organizational leaders should occur,[29] possibly including consultation with technical experts and/or government authorities, to develop an activation determination for the organization. The meeting first examines the current status and a projection evolution of the incident based upon the situation assessment. The current and projected impact on the organization is also considered. The organization's immediate course of action and accompanying strategy is then decided. General activation-related options include:

[29] This "meeting" may be a physical or virtual gathering of the personnel. It may be considered equivalent to a combined management/planning meeting from incident action planning and conducted in a similar manner.

- Full EOP activation.
- Partial EOP activation.
- No activation but increased organizational readiness (i.e., alert).
- No activation or organizational alert, but advisory information and recommendations for individual actions by organizational personnel.
- No activation or other actions are indicated or anticipated.

These action options and accompanying strategy are more fully explained below.

- Evolving Situations and pre-activation procedures: In situations that evolve with some warning, but haven't reached a point indicating EOP activation, it is important to have designated specific actions that can be undertaken to ready the healthcare system for activation. These readiness actions may be conducted under the direction of on-duty administrative and clinical supervisory personnel who possess the necessary authority (see below under initial notification). The alert procedures are usually initial, low-impact mobilization steps, such as beginning set-up of the Healthcare System Command Post, notification of certain personnel, and preparations for perimeter control (signage and barrier placement, etc.) while awaiting an activation determination.

- Flexibility in EOP activation - a step-wise approach: Timely notification and activation of the EOP may be promoted by having a range of activation options beyond the "all-or-nothing" choice. This hurdle can be minimized by establishing an **EOP activation mechanism that creates flexible levels of activation, from a minimal partial activation to full response**. Initial cost and disruption to the organization can therefore be appropriately minimized. Continuity of operations can also be more readily addressed with this approach, activating only those elements needed to address the compromise to normal operations. In addition, the **initial management team should have the ability to efficiently demobilize the response if early incident issues are rapidly addressed or otherwise resolve.**

Partial EOP activation levels are cost-effective, efficient ways to react to unclear or small-scale incidents.

- Partial EOP activation strategy: Since the majority of incidents that confront a healthcare system should only require activation of specific components of the EOP, mechanisms must be in place for

an **appropriate** partial activation. It is the responsibility of the individual or group making the EOP activation decision to also determine what EOP components should be initially activated and what mobilization strategies should be applied to the situation (this may be expedited through guidance in the incident specific annex). An example of an important mobilization strategy is the instruction provided to offsite personnel (see Textbox 3.2.2.1).

Healthcare System Activation strategy (and notification) should include consideration of off-site staff.

Textbox 3.2.2.1

Offsite Healthcare System Personnel: Activation and Notification Strategies

Personnel who are not present in the healthcare facility at the time of EOP activation but who are needed to staff a full or partial EOP activation should be rapidly identified and notified. This should occur through a process requiring minimal skilled labor, such as incorporating personnel contact information into an automatic process like a page group. Who to activate may be pre-developed for the specific level of activation and/or specific incident type (based upon the incident specific annex guidance for that hazard type). For example, in activating the EOP for an expected long response, some departments may wish to instruct a cohort of personnel who are not present onsite to remain at home pending further information. This creates a reserve of personnel for staffing follow-on shifts. Alternatively, the offsite personnel may be called in later to relieve response personnel as normal activities resume, so that those involved with the response can demobilize the response system and undergo "out-processing" (see demobilization stage).

Example incidents with partial EOP activations are presented for illustration:

- SARS: A case of SARS has been diagnosed and confirmed in a healthcare facility located in a neighboring jurisdiction (information received simultaneously from the jurisdictional department of health and from the media), but no known cases have presented to the organization's healthcare facility. In this situation, the Baseline Situation Unit in consultation with the healthcare system administration decides that a partial EOP activation is indicated. The Incident Management Team (IMT) is activated with limited personnel assigned to staff the Command Group, the Planning Section, and the Operations Section. No delays or interruptions in regularly scheduled healthcare system activities occur. Some of the assigned

activities would include:

- Efforts to gather more incident information (Command and Operations Section).
- Efforts to disseminate, through an advisory to healthcare system personnel, the known details about the incident at this point in time (Operations Section).
- Contingency planning (for example, what types of activities would be necessary if a patient or staff member with symptoms suspicious for SARS presents to the facility or reports to work? (Planning Section, with assistance from Technical Specialists from Infection Control/Infectious Diseases.)
- Efforts to determine whether any patient already being treated within the healthcare system is potentially infected with SARS (Operations Section).
- Efforts to screen patients at points of entry into healthcare system for potential SARS infection, utilizing both demographic information provided by public health and physiologic parameters, such as unexplained fever (Operations Section).

- Hazardous Materials Incident: The healthcare facility receives notification through the Emergency Department of the imminent arrival of five patients who have been contaminated with a liquid hazardous material. The emergency department staff relays this information to the Baseline Situation Unit and immediately activates the contaminated patient incident annex. The informed administrator-on-duty, in conjunction with the senior administration, decides to partially activate the EOP to support the patient reception and decontamination function. With a properly sited decontamination facility (fixed, external to the healthcare buildings, easily mobilized), no delays or interruptions in regularly scheduled healthcare system activities occur, other than a temporary securing of the immediate vicinity around the decontamination area. The IMT is activated with limited number of personnel staffing positions in Command, Planning, Logistics, and Operations Sections. The Healthcare System's Commander in this incident could be an emergency department clinical supervisor or administrator, with the Operations Section Chief serving also as the Decontamination Branch Director. Some of the activities performed would

include:

- Attempts to gather more incident information, such as the specific type of hazardous material (Command and Operations Sections).
- Efforts to disseminate to healthcare system personnel and current patients that a limited EOP activation is occurring; that the only indicated action from staff not involved in patient decontamination is to avoid the decontamination area (Operations Section and Public Information Officer).
- Procedures to mobilize the decontamination area (Logistics Section – Facilities Unit, accomplished by Engineering or Plant Operations).
- Procedures to secure decontamination area (Logistics Section – Facilities Unit).
- Addressing the receipt, triage, decontamination, and treatment of the five patients (Operations Section).
- Efforts to find expert information on the contaminant if it has been identified (Planning Section – through experts designated as Technical Specialists).
- Demobilization and cleanup of the decontamination area, with out-processing of decontamination area workers (Logistics Section).

In both examples listed above, the importance of information management becomes obvious early in any incident and therefore, for any partial activation of the EOP, it is recommended that some component of the Planning Section be activated.

Categorizing Healthcare System notifications can help message recipients understand what they should do with the information.

Healthcare System Initial Notification and Activation Messages

In the initial stages of a potential or actual incident, notification (see Terminology Textbox) and activation messages convey the information necessary for the receiving parties to understand the actions they should undertake.

Terminology alert!

Notification: Information distributed to relevant personnel that contains important information regarding an actual or potential hazard impact and the response status of the organization. Four generally used categories of notification in emergency management are: **update, alert, advisory, and activation**. The National Weather Service uses **watch** and **warning**.[30]

- Content of the emergency notification: Emergency notifications should provide the "who, what, when, where, and why" for recipients. These messages are best understood if they contain plain terminology and avoid "codes" or specialized terms. For simplicity sake and because of the current size limits in some text messaging services, the message should begin immediately by identifying the notification category and presenting the critical information. Within many U.S. Federal agencies, a generally accepted categorization scheme used for notification messages is presented below. Regardless of the scheme utilized, it is important that all healthcare system personnel are educated to what specific notification categories mean. Local jurisdictional agencies must have an understanding as well, so ideally, all healthcare facilities within the jurisdiction would use the same scheme and it would be consistent with that used by jurisdictional response agencies. If codes are going to be used, all parties must have immediate access to the code translation. For example, if the healthcare system uses a color-coded scheme (which some utilize to indicate hazard-specific incidents), then all personnel should have easy access to documents that translate the meaning of each color.[31]

- Responsibility for message development: As with the Incident Recognition stage actions, the responsibility for the development of notification messages rests with the personnel maintaining the Baseline Situation Unit, in conjunction with senior healthcare system administrators when indicated. Other position-related considerations include:

  - Who is sending the message: The EOP should assign

[30] Other terminology has been used, but the most widely accepted terms with accepted descriptions are highlighted in this text.

[31] Though this methodology is popular with some health and medical systems, the authors do not generally support the use of color, numbers, letters, or other codes to indicate type of hazard impact or level of response. This can be confusing, and with NIMS implementation, plain English is rapidly becoming the accepted standard.

responsibility to specific position(s) (available 24-hours/day) to disseminate the notification/activation messages. Though the Baseline Situation Unit may receive initial information and coordinate with healthcare administration on activation decisions and what the message will actually contain, the responsibility for sending notifications may rest with another position. For example, some healthcare systems assign the dissemination of messages to page center managers or to emergency communications center managers. If they are participating in developing the messages, they should be trained on the pre-established templates and how the content is rapidly approved (through the Baseline Situation Unit leader or administrative position) prior to dissemination.

- Who is receiving the messages: The recipients of incident notifications should be based upon functional positions, not primarily upon named individuals. The recipient list should be organized according to the specified levels of EOP activation and the specific incident types. To facilitate this process, guidance or operational checklists in the hazard-specific or incident-specific annexes should contain predetermined lists of response positions for notification. Even though only specific components of the healthcare system may be activated or directed to conduct pre-activation actions, all areas of the healthcare system should receive a message that an incident is occurring. Consideration should be given to what non-activated personnel may need to know (for example, telling personnel to avoid the Emergency Department receiving area that may be secured while decontamination operations are ongoing). Conveying this situation report facilitates the "common operating picture" for the organization and can convey important safety and operational information.

Recipients of Healthcare System notifications can vary depending on the type of incident and level of EOP activation. Even "non-activated personnel" should receive communication that an incident is occurring.

- The rationale behind standard message categories: Emergency notification can be grouped into standard categories that simplify message development by providing specific templates for each category. It also simplifies training and understanding by all message recipients (i.e., the message starts by specifying the notification category, allowing the recipient to immediately understand the gravity and urgency of the message content). This can also be helpful in preventing "notification fatigue" as responders are more likely to pay immediate attention to higher severity categories. Finally, many current and off-the-shelf technologies permit the different categories of messages to be received in different manners (e.g., low acuity – email only, high acuity – pager and cell phone).

- Initial and Follow-on Notification Message purpose:

- Initial Notification messages: These messages are sent to make administrators and key healthcare system personnel aware of developing information, the activation status of the EOP, and any indicated pre-activation actions. Urgent messages can:
  - Keep healthcare system personnel apprised of any rapidly evolving situation.
  - Improve response time if activation is warranted later.
  - Prompt immediate activation actions, as soon as the decision is made.
  - Promote organizational cohesiveness.
- Follow-on Notification Messages: The same categories of messages may be used throughout an incident, conveying changes and new developments with the same levels of urgency.

- Notification Message categories described:
  - Healthcare System **Advisory Notification**: An Advisory (see Terminology Textbox) provides a brief description of an impending or threatened hazard impact or one that has occurred but is unlikely to require the organization's EOP activation. It may convey recommended actions that are usually accomplished on an individual basis rather than through the organization's incident command system. Advisories may be used regularly for incidents, such as weather warnings, intentional threats (e.g., telephone calls), and certain types of public health information (e.g., influenza detected in the region). Depending on the situation, advisories may contain incident summary details and then action guidance such as:
    - Anticipating possible emergency response: This explanation suggests that response actions may be necessary in the near future if conditions evolve.
    - No activation is expected: These include description of the current circumstances but indicate that no response will be necessary. For example, if a newsworthy hazard (e.g., a store roof collapse secondary to snow) has impacted a nearby business, but no significant patient load is generated, an advisory may relay this information. This "lack of incident activation" is important to counter the predictable media

Healthcare System Advisories convey information that may or may not need to be acted upon.

sensationalism, removing concern on the part of personnel that could distract them from regular duties or prompt off-duty personnel to call-in. It also informs system personnel so that they can appropriately respond to patient and telephone inquiries.

- Personal action is indicated: An advisory may also contain information on how the hazard may impact personnel and provide actionable information for the individuals (e.g., traffic disruption and expedient travel alternatives for reaching the healthcare facility).

Terminology alert!

Advisory: A notification category that provides urgent information about an unusual occurrence or threat of an occurrence, but no activation of or response by the notified entity is ordered or expected at that time. The advisory notification may convey actionable information for individual personnel even though the response entity is not being activated or directed to address any specific organizational activity. For example, a weather advisory that includes recommended travel precautions for individuals.

Healthcare System Alerts convey urgent information that should be acted upon.

- Healthcare System **Alert Notification**: An alert (see Terminology Textbox) provides information on unusual occurrences that indicate probable or anticipated EOP activation. For many situations, an initial Alert directs specific pre-activation actions that should be accomplished (e.g., situation assessment for facility work areas such as bed and staff accountability, holdover of staff about to go off shift, activation of some phone tree notifications, and others). As not all incidents present clear initial indication that EOP activation is warranted, this important message category allows some ramp-up of healthcare system activities without a full system commitment. It is important to recognize that this Healthcare System Alert can incur costs for the healthcare system, which should be documented for potential reimbursement (see Finance/Administration Concept of Operations). Alert messages are also commonly used throughout the response and recovery phases, conveying both urgent information and recommended or directed actions.

Terminology alert!

Alert: A notification category between "advisory" and "activation" that provides urgent information and indicates that system action may be necessary. An alert can be used for initial notification that incident activation is likely and for ongoing notification throughout an incident to convey incident information and directed or recommended actions.

- Healthcare System **Update** Notification: All non-urgent information conveyed through emergency management mechanisms is considered an "**update**." Since emergency management updates are usually of less critical importance than advisories or alerts, they are often sent via a different mechanism (e.g., regular e-mail as opposed to a text message page or urgent e-mail tag). At the same time, using the "Update Notification" message category helps to distinguish important emergency management information from other message traffic. **Updates can be utilized during preparedness and mitigation phases as well as response and recovery.**

Healthcare System Updates are reserved for general EM program messages and non-urgent incident information.

- Healthcare System **Activation** Notification: Activation messages (see Terminology Textbox) convey to the notified entity that emergency response by the organization is indicated. Activation notifications should be accompanied by a **request for confirmation of receipt of the message** and may also ask for a **status report** for the notified unit. The aggregate of the returned unit status information may rapidly provide the initial resource status report for the organization.

Using a range of activation levels provides cost-effective and efficient means for addressing hazard impact without over-committing resources.

Terminology alert!

Activation: A notification category that provides urgent information about an unusual occurrence or threat of occurrence and orders or recommends that the notified entity activate its emergency response (usually via its emergency operations plan). An activation may be **partial** (stipulating the components of the EOP to activate or some other indication of the level of commitment to be made by the notified entity) or **full** (stipulating full activation of the notified entity's EOP). It usually includes actionable information directing the notified entity on initial actions for mobilization, deployment, and/or response.

- Level of activation: When the EOP is activated, the message should contain the level of activation and as appropriate refer to the components of the EOP that are being activated (using the incident-specific annexes as appropriate for guidance).
  - Partial EOP activation: Partial EOP activation can be complex and involve major activities, but the activation is not usually disseminated as a single message to all components of the healthcare system. Instead, all are informed of the incident and the components of the system being activated. This provides a brief description of the incident and the components that have been activated and direction to the rest that no activity is requested from them at the current time. A follow-on message to the activated functional areas and key personnel may provide more specifics about the incident and expected actions. Non-activated components are kept informed with **advisories** as the incident progresses.
  - Full EOP activation: The initial message to all employees contains the same information, but specific positions and units may subsequently require more details. The initial actions that personnel undertake for full activation should be well outlined in the EOP (e.g., surge capacity or facility protection/evacuation as outlined in the incident-specific annexes), so that very few detailed instructions need to be conveyed under the duress of initial response.

- Format of notification and activation messages: Healthcare systems should pre-script a template for these message categories and stipulate the essential elements of information that should be included in them. Since some pager and text message systems truncate messages, critical information should be conveyed at the beginning of the message. The format should include:
  - Identifier and category of the message ("[____ Healthcare Organization] advisory/alert/ activation/update.").
  - Brief description of the hazard/impact.
  - Brief description of expected impact on the healthcare system.
  - Directives on how components of the healthcare system should react, what activities are indicated, and, as relevant, what portions of the EOP to reference.
  - Reporting locations as appropriate to position (e.g., to regular areas of work, to personnel pool, others).
  - A reminder to wear/carry personal identification, if indicated.
  - Information on any pertinent healthcare system infrastructure changes/impacts (such as changed access to the facility or changes in parking for arriving personnel).
  - Request for confirmation of receipt of the message (as appropriate for position). This may also request a status of the notified operating unit ("normal," "at capacity," "operations compromised by the impact," or other short but descriptive message).
  - A time and date stamp, so personnel know when a message was conveyed.
- Message detail: The appropriate level of detail in any notification message can be challenging to establish and, to a certain degree, is dependent on the method used to disseminate the notification (see below). In general, when the technology permits, more detail is better than less detail. When the initial notification is limited by technology, other methods should be available to provide the remaining critical information (such as a call-in line and/or Internet/intranet message boards). **Unverified information should be qualified as such.** The types of detail provided about the incident can have important operational implications as the following example suggests:

The format and message content of Healthcare System notifications have tremendous significance and deserve special attention.

- Examples of notification messages are presented in Textbox 3.2.2.2.

Textbox 3.2.2.2

Examples of Healthcare System Notification Messages

Updates

"This is a Healthcare System **Update**: There will be a meeting of the EM committee this Monday in the hospital boardroom. All committee members are expected to attend and bring their respective work products related to the recent after action report for the June 23 exercise."

"This is a Healthcare System **Update**: The city is planning a large terrorism exercise next week. The hospital is participating only at the radio communication level. Be aware that heavy presence of police, fire, and EMS resources is expected at a focal point downtown during the indicated period."

"This is a Healthcare System **Update**: Recent major revisions to the EOP have been accepted and are in full effect. The changes most affect the Emergency Department (ED). All ED personnel should read and understand the revised plan. Questions may be sent to XXXXX."

Advisories

"This is a Healthcare System **Advisory**: The National Weather Service has posted a blizzard warning for the metropolitan area tomorrow. Personnel should review the healthcare system inclement weather policy. A follow-on advisory will be provided at 1800 hours."

"This is a Healthcare System **Advisory**: A local activist group is planning a large demonstration on Main Street this week. Though expected to be peaceful, activity may compromise commuter traffic between 0900 -1400 weekdays. Secure routes are being planned for emergency vehicles and essential travel. More information will be forthcoming."

"This is a Healthcare System **Advisory**: The media is reporting a large explosion at the local refinery. EMS reports no casualties: NO PATIENTS ARE EXPECTED AT THIS TIME and no actions by the hospital are indicated. Administration is monitoring the situation and

will provide more information as it becomes available."

Alerts

"This is a Healthcare System **Alert**: The National Weather System is predicting 3 feet of snow for the metropolitan area tomorrow night. Light snow is expected to start at 1900 tonight. The Facility EOP, Inclement Weather Annex, will be activated at 2200 tonight, including personnel holdover. All personnel should consult the Inclement Weather Annex to the EOP for action guidance. Department managers must participate in a teleconference at 1700 using the regular Emergency Management teleconference number. Situation updates will be provided on a regular basis."

"This is a Healthcare System **Alert**: A local community protest is underway with approximately 1,000 protestors gathered at city hall - unverified reports of violence and looting. The following departments are asked to provide a situation assessment relevant to their areas (and as outlined in the EOP) and to hold staff beyond change of shift: X, Y, and Z departments are affected. Further information will be provided at 1400 hours."

"This is a Healthcare System **Alert**: Reports indicate that the local refinery explosion has resulted in a hazardous materials release. On-scene public safety authorities are evaluating the extent and content of the release. The hospital is not considered to be within the zone of release and is not considered in any direct danger. Southeast sections of the town may be affected and evacuation mandated. Happy Times Retirement Community is within the potential zone of release. The following departments are asked to provide a situation assessment relevant to their areas as outlined in the EOP: X, Y, and Z departments. If evacuation of Happy Times is ordered, these departments will hold staff beyond change of shift. Further information will be provided in 30 minutes."

Methods used to send Healthcare System notifications can vary depending on the category of notification being sent.

- Notifications methods: Notifications (especially Healthcare System Alerts and Activations) should be based upon reliable **processes** and **technologies** that are regularly tested. As noted above, the method of dissemination may depend upon the type of notification or the intended recipients. In many situations, multiple methods are utilized simultaneously.
    - Overhead announcements: Public address systems in a healthcare facility are often used for major announcements.

These are limited by the amount of information that can be conveyed, the lack of penetration into all areas of the facility, and the sensitivity of information that can be conveyed in a public forum. Overhead announcements are best utilized in conjunction with other notification methods and should be limited to briefly announcing an EOP alert or activation, with advice on where to obtain more information (call-in line, intranet, mass e-mail, from supervisor, etc.). Consideration should be given to using speaker systems that are installed as an element of fire alarm systems. These typically have better penetration throughout a facility than traditional overhead systems.

- Pagers: The use of pagers can be beneficial, especially if they can provide text messages and pager groups have been established during preparedness activities. Many pagers have limitations to the number of characters contained in any single page. Information that has been truncated in a message can sometimes present confusing instructions (e.g., **"This is notification of a full EOP activation for"** [with additional text "**exercise**" ~truncated] instead of **"This is an exercise – full EOP activation"**).

- Posted messages: Notifications may be posted on Websites or presented on callback lines (recordings), allowing individuals to access the information, as they are able. This requires instruction to prompt appropriate individuals to access the information. The advantage is that more information may be contained within the posted message than in pages or public address announcements. If special numbers or access codes are provided during training (or ideally in pocket cards or other easily retained hard copy), the content can be restricted to intended personnel, even though a public address announcement was used to prompt access.

- Phone calls: Technology is now widely available to send recorded voice or text messages to multiple pre-identified mobile communication devices at the same time. This may have more utility for contacting offsite individuals at the time of the notification. Many systems have a feature that permits the recipient to acknowledge receipt of the message thus providing accountability. Conducting individual telephone calls to those personnel can be time consuming, require extra staff, and may not be logistically possible through an overwhelmed or compromised public telephone system. "Telephone trees" directing a cascade of telephone notifications have been used, but the reliability of these is suspect unless carefully developed with sustained personnel training. All telephone tree communications should be conveyed from written down, short, specific, clear, and concise messages

(i.e., similar or identical to pager messages). Reporting back by telephone tree callers of both confirmed contacts and non-contacted personnel is important to maintaining accountability. Much of this activity could be accomplished by offsite personnel, freeing up onsite responders for other tasks. These considerations should be factored when establishing notification algorithms.

- Radios: Some healthcare systems dispense radios to key positions within the facility. Though advantageous for real time notification of these positions, there are several potential drawbacks. It should be recognized that the average healthcare employee has not had training on "radio etiquette" (see Textbox 3.2.2.4). These critical concepts should be provided during initial training and should be reinforced as radios are distributed. Radios, unless they are encrypted through digital or other technology, can (and will) be monitored by outside sources, particularly media. Personnel must remain cognizant of this critical issue for privacy and security reasons.

- E-mails: E-mail can provide large amounts of information efficiently. They should not be used as a primary method of notification unless other methods are available to prompt recipients to check their e-mail. Proprietary products are also available that can prompt computer screens to display an emergency signal.

- Face-to-face notifications: This type of communication may be necessary if the hazard impact severely compromises communication technologies or if only limited components of the healthcare system require message exchange.

- Notification to external organizations: Methods also should be in place for immediate notification to local emergency authorities, the healthcare coalition response system point of contact, and other relevant organizations according to the EOP procedures. This is addressed further in the Liaison Officer discussion in Lesson 3.2.4.

Textbox 3.2.2.4

Radio Etiquette
for Healthcare Systems Personnel

The radio etiquette should reflect the organization's policies and be presented in operational level training.

- Transmissions are kept brief to avoid tying up channels.
- Do not begin speaking until you have pushed the talk button and the microphone indicates it has been "keyed" (usually by an electronic sound).
- No names are used (especially patient names!).
- To begin a transmission, identify the unit you are calling first then identify your position (e.g., "Planning Chief, this is Logistics Chief."). Await confirmation before proceeding (confirmation often comes via "This is Planning Chief, go ahead." or some similar phrase).
- The announcement of "priority traffic" requires the cessation of all other conversation as an urgent message is about to be transmitted.
- Confirm with the receiving party that they received your transmission: "Copy?"
- End the conversation with "clear" or some other communication that indicates you are breaking off the radio conversation.

Lesson 3.2.3 Concept of Operations for Healthcare Emergency Response and Recovery: Mobilization Stage

Lesson Objectives

- *List the main system management processes that should occur during mobilization.*
- *List the key considerations for the mobilization of response personnel in Healthcare Systems.*
- *List the key considerations for the mobilization of response facilities and list the main functional areas that may require attention in Healthcare Systems.*

Introduction

During the mobilization stage, appropriate personnel, facilities, and supplies transition from baseline to an incident operations state. This may have to occur rapidly, with incident operations beginning before mobilization is complete, or at a slower pace over a longer period of time (e.g., in anticipation of an impending hazard impact). Full EOP activation, and therefore full mobilization of the healthcare organization, is generally reserved for major impact such as:

Mobilization is the Response stage that transitions the Healthcare System from baseline to incident operations, assuring an "operational" ability to address the hazard-generated and response-generated needs of the incident.

- Loss of mission critical systems threatening continuity of operations.
- The influx of large numbers of patients.
- Significant numbers of patients with very unusual medical needs.
- Facility threats that could require evacuation or other major life safety interventions.

All aspects of the healthcare facility could mobilize in some fashion to focus upon these types of incidents. Partial EOP activations, which are typically more common, specify that only the designated components of the healthcare facility mobilize for incident operations.

Mobilization of personnel resources

- Mobilization considerations: All personnel should clearly understand their assigned incident role and their section or functional role in EOP mobilization. Response considerations related to personnel resource mobilization are presented below.

- On-duty versus off-duty: Command and General Staff should, as an early action, evaluate the currently available personnel onsite and calculate staffing needs based upon current and projected incident parameters. Additional staff should be called in as indicated. Consideration should be given to staffing requirements that may occur later in the incident and thus some staff could potentially be requested to stage offsite or at home during the initial period. Another common strategy for addressing personnel surge requirements is to hold staff over as a shift is ending, effectively doubling staffing in many areas of the hospital by adding the incoming shift. In some situations, only a specific type of personnel will be required and these are mobilized as a group (e.g., decontamination team).

- Volunteer personnel resources: Some incidents could require the use of volunteers. Pre-planned mechanisms for processing and integrating volunteers could require early mobilization. In other situations, the healthcare organization may need to mobilize capabilities to handle unsolicited volunteers.

- Personnel Check-in: As recalled staff members arrive to the facility, or reassigned staff report to new areas within the healthcare system, a brief check-in process should occur. Arriving staff are acknowledged and specifically assigned to a team or activity. A short briefing (see below) is part of this interaction.

  - Staff arriving from outside locations: Staff reporting for duty from outside locations should have a designated entrance separate from those for volunteers, visitors, patients, and the media. Security personnel may be needed to screen incoming personnel for current identification (ID) badges (see Security concept of operations). A process to confirm personnel arriving without their badges should be established. Staff should "clock-in" for general accountability at this location, receive an oral or written briefing, and be directed to their usual job reporting location or new assignment as indicated.

  - Staff assignments to sensitive areas: Admittance to high-activity, high-trust areas such as Emergency Department, the Healthcare System Command Post, or the Operating Suite should be through direct assignment only. For these functional areas, supervised admittance of personnel and the potential use of security personnel may be invaluable for assuring only assigned personnel are admitted.

  - Check-in and staff accountability: The check-in process should

assure that all personnel have their assigned participation documented. An adapted version of the ICS 211 could be utilized in each staffed area and then submitted to the organization's command post. This can provide important accountability if, for example, a sudden evacuation is ordered. It is also useful for post-incident reconstruction of activities and for documenting additional staffing commitments beyond regular day-to-day staffing (e.g., to support submission of expense reimbursement requests to State or Federal sources – see last lesson in this unit).

- Operational Checklists ("Job Action Sheets") and Job Briefing: All staff with specific assigned roles should be given or should locate their respective operational checklist for their assigned incident position (see Textbox 3.2.3.1). They should briefly review the material contained within this document and, as required, clarify any issues with immediate supervisors. Most operational checklists describe, as an initial activity, receiving a brief from the immediate supervisor to the position. Initial briefings should include confirmation of position assignment, relevant details of the hazard impact, and other instructions that may come from supervisors. The operational checklist should also list all pertinent mobilization actions for the relevant position (or refer to the relevant mobilization checklist).

Textbox 3.2.3.1:

Mobilization and Referencing Operational Checklists

Operational checklists (OCLs) can be developed for specific positions within a response organization and for specific hazard impacts. It should be noted that the vast majority of positions, however, will not have a written, pre-developed checklist. It is logistically and operationally impossible to provide pre-written instructions for every member of a healthcare organization for every hazard impact.

Emergency Managers should focus on establishing an OCL for each critical position in their EOP base plan, with additional instructions for specific hazard impacts.

Because of this lack of written guidance for many positions, it is critical during mobilization that early instructions for individual functional units be promulgated by Command and General Staff, and that job briefings are provided as personnel begin operating in new positions.

- Labor Pool: Full EOP activations often entail establishing a Labor Pool to meet emerging staffing needs. Personnel without a critical everyday or response assignment, as approved by their supervisor, report physically, telephonically, or via e-mail to a designated Labor Pool location. It is imperative that staff with the potential to serve in a Labor Pool receive pre-incident instructions to this effect. There are several considerations for effective Labor Pool management:

  - Labor Pool responsibility: A Labor Pool is a roster of personnel without a section or position assignment within the IMT's response structure, and therefore is usually a mobilization responsibility for the Logistics Section. Personnel rostered in this general Labor Pool report to the Logistics Section until they receive their assignment and they report to their assigned IMT section. They then operate under the section where they are assigned.

  - Virtual Labor Pool: It may be most beneficial to establish the Labor Pool in a fashion in which those reporting do not have to physically report or linger. If a reliable contact method can be established, those signed in and without an immediate emergency response assignment or staged for imminent assignment could return to their usual workspace until called. They should be trained to report any change in their availability status to the Labor Pool.

  - Labor Pool guidance: Procedures should be established during preparedness such that known mobilization or incident response tasks that always require additional personnel are automatically listed for immediate staffing from the Labor Pool. Qualified personnel are then assigned as they report. For example, assistance in managing the perimeter, deploying supplies to critical areas (especially during off-peak shifts), and collecting adequate stretchers and wheelchairs could be immediate staffing assignments. Sending nursing personnel to an Emergency Department staging area (under the supervision of the Operations Section) may also be an automatic deployment in patient surge incidents.

  - Task completion: Personnel should be instructed to report back to the Labor Pool upon completion of their assigned tasks or release from their assigned area, to maintain accountability and so they may be reassigned or returned to normal duty.

- Documentation: Labor pool logs, including assigned and available staff, assignments, and tasks completed, should be maintained, with copies provided to the Logistics Section Chief and the Healthcare System Command Post for incident action planning purposes.

- Mobilization of personnel resources for non-typical assignments: Across the response, multiple personnel resources may be mobilized to staff emergency response capabilities that are functionally different from their usual job assignments. One example is provided below.

- Mobilization of security: Many EOP full or partial activations will require mobilization of healthcare facility personnel to address multiple critical tasks related to security. A mobilization plan should delineate a surge capacity for security staffing (perhaps by drawing personnel from plant engineering or another source) to assure adequate staffing. For example, a chemical or radiation contamination incident warrants rapid and complete perimeter control to prevent the entry of contaminated patients. In this situation, doors must be locked and appropriate personal protective equipment (PPE) must be immediately available to trained security personnel so they can intercept patients and redirect them to the decontamination facility. Security can also be important to manage convergence of volunteers and the media.

Mobilization of Response Facilities

Specific response facilities may need to be set-up during mobilization. One of the most critical is the Healthcare System Command Post.

- Response Facility Resources: A response facility is a physical, constructed location used for designated emergency response and recovery purposes. Each functional area of the healthcare organization that is planned specifically as a facility resource for emergency response requires specific steps to mobilize the area for its emergency purpose. Standard actions should be listed on mobilization checklists, as well as action items on the operational checklists for responsible personnel.

  - Healthcare System Command Post: For both full and partial EOP activation, the need to establish a functional Healthcare System Command Post[32] (CP) is constant. The activities required to

[32] In this section, the text is treating the "command post" as the fixed facility where incident management is addressed for the healthcare system. Some may instead consider the "command post" to be the site of a forward command element that is proximate to the area of central activity, and the healthcare organization's fixed management area to be the "emergency operations center" (EOC) supporting the

establish this fixed facility should be a high priority for assigned personnel. This is usually a Logistics Section, Facilities Unit task rather than a responsibility of Command and General Staff. The management group should instead be focused on the management of the incident operations. An alternate arrangement during off-peak hours staffing might be for initial Command and General Staff to partially mobilize the Command Post with full set up completed as additional personnel arrive. Regardless of the mobilization strategy, Emergency Managers are encouraged to focus on an efficient, simple-as-possible mobilization process during preparedness so that this critical facility resource is always rapidly available.

Important considerations for the Healthcare System Command Post include:

- Location: Pre-selected areas for the Healthcare System Command Post should address important factors related to location. The ability to secure the command area is important, both for safety and for preventing interruption during meetings and other management activities. At the same time, the location should be widely disseminated and understood by personnel so that appropriate access may occur as indicated. Adequate space is required for the Command and General Staff and assisting personnel to work. The physical layout and work station arrangement should be conducive to appropriate interaction, as well as to frequent briefings during the early, reactive response period. Nearby space should also be immediately available for smaller meetings (task planning, problem solving) so they are not disruptive to the full Command and General Staff. The space should also be conducive to allowing secure conversations between Command Staff and outside agencies.

- CP infrastructure and supplies: Appropriate infrastructure and supplies should be available in the Healthcare System CP. These include but are not limited to:

  - Telecommunications equipment: The CP should be equipped with both primary and back-up telephone lines,

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incident command post (see Textbox 3.2.4.1). In the latter arrangement, the EOC contains the five ICS sections with the objectives of supporting the incident, managing incident-related issues not addressed by the incident command post, and assuring continued function of the healthcare system as much as possible. Either configuration is acceptable, but the one selected must be clearly delineated. This facility is also variably termed a Hospital Command Center or Hospital Command Center.

cellular communications, teleconference microphones, computers with Internet and intranet access, radios, and potentially direct connect devices.

- Information processing and dissemination tools: These may include high-speed printers for the computers, appropriate software (see next bullet), and compatible LCD projectors. White boards and large flipcharts with writing instruments may be invaluable for the tracking of incident information and important messages. White boards may even be organized in a pre-determined manner for information purpose (e.g., current ICS form 211 for Command Post positions, agenda items for common meetings, listings for resources, patient tracking census numbers, etc.).

- Pre-planned and installed software: All software and electronic work products (patient tracking, bed tracking, ICS forms, and so on) should be loaded on all relevant computers in a ready to use state. This includes computers beyond the Healthcare System Command Post as indicated.

- Back-up power supplies: Adequate back-up power supplies should be available in any designated Healthcare System Command Post.

- Furniture: Ideally, appropriate furniture for the sequestration of the different ICS sections as well as for group meetings.

- Restrooms: Easy access to restrooms can minimize prolonged absences from key personnel posts.

- Refrigerator (stocked): To provide fluids and refreshments when staff cannot leave their posts for refreshments and meals.

- Television and/or radio receiver: Available for monitoring the media message without intruding upon command post work activities.

- Job aids: Appropriate supplies of ICS forms and other job aids, such as call-back lists or job action sheets.

- Wall space: To maintain incident information in a visible format (via paper charts, LCD projection, and others).

- Office supplies: Notebooks, writing instruments, staplers, and miscellaneous supplies.

Specific strategies can be used to prepare clinical areas during Healthcare System Mobilization.

- Clinical facility resources: The following facilities are usually necessary during full EOP activation or partial activation for an influx of victims:

  - Clinical treatment areas: These functional areas should have explicit guidance available in checklist format as to how to mobilize for different incident types (e.g., shelter in place, evacuation, surge). More detail is provided in later lessons. They include the initial patient reception and triage areas, such as the Emergency Department and outpatient clinical areas, as well as specialty treatment areas (operating suite, critical care areas, burn treatment, and others), and regular inpatient wards and overflow (i.e., alternate treatment site) areas.

    - Applying surge capacity strategies: Procedures to "clear" and mobilize these clinical sites are necessary to optimally receive a surge of incoming victims (see Textbox 3.2.3.2 for one Emergency Department mobilization strategy). Procedures may involve the suspension of elective surgical and other procedures, rearrangement of patient space to accommodate a higher number of patients, and the expedited discharge or transfer of stable patients (see example below for Emergency Departments).

      The expedited discharge intervention has been the subject of extensive discussion and recent research.[33] The research efforts focus almost exclusively upon physiologic parameters of patients for hospital discharge. Additional attention must be directed to the certainty that prematurely discharged patients need a supportive environment, a potentially more sophisticated outpatient care than is usually available, and a means for safe transport. These factors can be problematic for premature hospital release under emergency conditions, and so expedited discharge can become very time- and effort-intensive in assuring adequate arrangements. This can be especially problematic in any community that sustains a severe hazard impact. In the aftermath of Hurricane Katrina, several hospitals in the State of Mississippi were confronted with **delays in discharging both inpatients and outpatients** due to the lack of adequate locations for patient disposition.[34] In a major, fast-moving incident, healthcare system planners

[33] Kelen G.D., Kraus C.K, Brill J.D. Creation of Hospital Surge Capacity by the Early Discharge of Inpatients (2005). *Academic Emergency Medicine*. Volume 12, Number 5, supplement 1/23.
[34] Authors' direct field observations.

should recognize that additional patient care capacity would commonly be needed before significant numbers of in-patients can be fully discharged.[35] "Discharge facilities" may therefore be necessary (see below).

Clinical areas may best be "cleared" through internal transfers (from the ED, critical care units, and others) to staffed-up alternative treatment areas. Premature discharge may be less efficient than identifying stable patients who can voluntarily accept transfer to an equivalent, non-impacted healthcare facility. This reality has important implications when planning inter-facility mutual aid and cooperative assistance.

Textbox 3.2.3.2:

Mobilization of the Emergency Department Receiving Area for Medical Surge Incidents

In order to effectively prepare an Emergency Department for the influx of incident patients, it is helpful to rapidly re-triage existing ED patients, including those in the waiting area, during the mobilization period. Patients can be assigned to one of three action categories:

- Admission: For patients who ultimately may require admission, appropriate holding orders are rapidly written and accompany the patient to the designated inpatient ward. Follow-on therapy and completion of the diagnostic work-up occurs at these locations, with alterations in procedures so that ED-level care is approximated. This type of rapid admission process requires multiple levels of "buy in" from across the healthcare facility, and includes training for registration personnel, admissions personnel, admitting physicians, and clinical staff on receiving wards.
- Discharge: Patients awaiting completion of care and discharge from the ED should have this process expedited (this is likely the smallest group any the existing ED population). Discharge should be accomplished in a separate area (see below) to provide immediate expansion of space in the ED.
- Further workup as necessary: Patients who do not have an obvious disposition in the two previous categories could be assigned a triage category consistent with incoming incident patients.

[35] In addition, there is an ethics consideration in discharging patients prematurely without providing equivalent care post-discharge.

- Alternate treatment sites: Based on an organization's HVA, it may be necessary to establish guidance for setting up alternate care areas. Individual steps for acquiring supplies and personnel to establish these should be listed on appropriate mobilization checklists. Patient care areas may be categorized according to their expected use and therefore adequacy, but expanded capacity should be pre-planned for safe and effective patient evaluation and treatment.[36] Similar sites could be considered as staging areas for patients when evacuating a facility.

- Discharge/transfer area: Mobilizing and staffing a discharge/ transfer area that is separate and distinct from the clinical areas can facilitate the expansion of space for the care of incoming patients. Since these patients generally require less intense care than other patients, grouping patients pending both discharge and transfer can free up clinical staff, while social service and other personnel can assist in discharge and transfer planning.

  - Discharge activities: A discharge/transfer area can be established for both inpatients and for outpatients, or the two can remain separate. The important activities of arranging adequate disposition, completing registration for outpatients, ensuring adequate prescriptions and supplies, and confirming a clear patient understanding of discharge instructions should all be addressed before discharging patients.

  - Transfer activities: Patient transfers require the provision of care while patients are staged awaiting transfer to a new facility. This wait can be lengthy. Personnel responsible for accomplishing the transfer must identify an appropriate accepting facility, copy records, arrange transport, notify family, and confirm that patients have reached their hospital destination.

- Non-clinical response facilities: Other facilities that are not directly clinical in nature may require mobilization for specific types of incidents. Guidance should include locations and supplies for these facilities, especially for situations where they can not be established in their usual location (e.g., emergency evacuation of the facility).

[36] Hick, John L., Barbera, Joseph A., Kelen, Gabor D. *Refining Surge Capacity: Conventional, Contingency, and Crisis Capacity.* Disaster Medicine And Public Health Preparedness 2009 (3): pages S59-67.

- Labor Pool: As noted in the Systems Description (see Lesson 3.1.4), a Labor Pool is often required during full EOP activations. The physical space for this function should be rapidly established and its location disseminated to all healthcare facility personnel. Adequate communications should be available to receive requests at the Labor Pool from across the organization in order to dispatch personnel (many directly from their usual job location) as they are needed. Required supplies include appropriate electronic equipment and paper supplies to roster and track Labor Pool personnel, and to keep Logistics section and the command post informed.

- Patient family assistance area: For different types of incidents (e.g., influx of patients, movement of patients), it is advisable to establish a separate area to provide services to patients' families, both incident victims as well as regular inpatients. Ideally, the site is remote from clinical care areas and has space for receiving, registering, and providing information to people searching for news of family members who could have been admitted as patients. Telephone inquiries will commence almost immediately after the hazard impact, and so mobilization of the functional ability to meet this volley of calls is a critical priority. This area must be tightly integrated with the Situation Unit in the Planning Section so that patient tracking information can be relayed in real time. It also must have a communication flow with the patient care areas to convey messages to patients from their families, to provide critical health information (allergies, current medications, etc.) to clinical staff, and to obtain patient updates for family members. It and voice communication to community-wide family assistance centers may also be important. Depending on the healthcare organization, grief counselors, social workers, or psychiatrists may be helpful in this area as well. This facility may most appropriately fit within the Operations Section under healthcare services, possibly as a separate group. It should be closely tied to the patient tracking function.

- Media briefing and workspace areas: Establishing a physical space remote from patient care and family assistance areas to brief the media is mandatory. By providing frequent updates, members of the media can be engaged in this remote location, discouraging them from ranging about "looking for stories." Ideally, the space should accommodate the media, allowing them space to develop their stories and communications (usually telephones but also possibly including Internet access)

for them to file their reports. Providing this type of support has become much less important with the expansion of mobile communications devices now carried by media personnel. Planning parking areas for media vehicles with telescoping masts and booms, however, may be considered an extension of their workspace.

- Volunteer reception area: As discussed earlier, incident response commonly generates a convergence of volunteers. Establishing an area to process volunteers separate from clinical care, media briefings, and family assistance is important. Effective volunteer processing requires: staffing; equipment and supplies for appropriate registration; credential verification; assignment briefing; privileging and badging; and tracking of volunteers accepted and assigned into service.

Mobilization of equipment/supplies resources

- Emergency equipment and supplies: Specific equipment and supplies that have been pre-designated for use during EOP activation should be identified and pre-positioned for easy deployment during mobilization.
  - Prepackaged and cached: Supplies stored in a readiness state and for easy access during mobilization should also permit efficient maintenance of supplies. This includes rotation of stock to avoid shelf life expiration, re-charging batteries, bioengineering checks, and scheduled maintenance (see preparedness resource management in Lesson 1.5.5).
  - Hazard-specific supplies: Some supplies may be required to address specific hazards, in addition to the usual supplies that focus upon trauma or medical victims. As an example, supplies for the decontamination of patients can require setup during mobilization. Mobilization guidance should be available so supplies and equipment can be rapidly accessed from storage areas and placed in their immediate use configuration. During preparedness, consideration should be given to the accessibility and ease of deployment related to the supplies storage areas.
- Mobilization reporting: As with other types of reporting (see operations stage), it may be standardized across the organization's functional assets to promote comprehensive situation awareness across the organization.

- Situation and Resource Status Report: A critical mobilization step, immediately following the initial incident notification message, is for every department within the organization to begin to develop an initial situation and resource status report to the Planning Section.[37] This may be viewed as an initial activity of the "incident operations stage of response" (see next Lessons) but also may include reporting on the status of mobilization, particularly for complex mobilization activities such as mobilizing a DECON team and DECON facility. The aggregation of these reports from across the organization provides a full "snapshot" of the available operational capabilities, current activity load, and any hazard impact. This information is critical for Command and General Staff during the early stages of the event (e.g., constructing the response organization). Resource status assessment should move beyond the usual "bed counts" and should include available staffing, supplies and equipment. Situation status should include current patient load, hazard compromise to functional areas, and other incident relevant information. Pre-established forms to capture these critical parameters may facilitate the reporting process, particularly if they are formatted for rapid aggregation. Some functions, such as the blood bank, may have specific assets that should be confirmed in this initial resource status. The Planning Section is responsible for rapidly assembling a composite picture of the operational capabilities for the Command and General Staff. This information can span mobilization and be a part of incident operations.

- Completion of Mobilization Actions: Resources (facilities, personnel, equipment/supplies) that have been activated for emergency response should report their readiness status at the completion of their mobilization actions, or earlier if problems are encountered.

[37] This status report may be requested in the initial notification message.

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Lesson 3.2.4 Concept of Operations for Healthcare Emergency Response and Recovery: Incident Operations Stage – Command Staff Actions

Lesson Objectives

- *Describe the overriding management priorities to be addressed during the Incident Operations response stage.*
- *List the key activities that should take place in the Transitional Management Meeting.*
- *Describe incident action planning processes for healthcare system response.*
- *List and describe the responsibilities of the Healthcare System Command Staff during incident operations.*

The Incident Operations Stage: Overview

Incident Operations is the response stage in which the Healthcare System primarily addresses the immediate hazard impacts.

The Incident Operations stage is defined as the time interval in which the dominant organizational activity is incident management and operational response to the effects of the hazard impact. This varies from day-to-day management methods and operational interventions, and is guided by the EOP and the operational period objectives.

The overriding management priority for healthcare system incident management during the response phase is to move beyond the reactive management approach by achieving and maintaining a pro-active, management-by-objectives stance. Each section within the organization has specific ICS responsibilities related to proactive management, and these are presented in more depth below and in following lessons.

Command post location

The issues of where healthcare facility command takes place and what the command facility/location is titled have been surprisingly controversial (see Textbox 3.2.4.1). This must also be rapidly determined, ideally based upon pre-planned options in the EOP, and the location/contact information disseminated appropriately.

Textbox 3.2.4.1

Where Does Incident Command Occur?

ICS guidelines for titling incident command post, emergency operations centers, and other management areas have created confusion for healthcare organizations as to appropriate terminology for their facilities.

Traditionally, an **Incident Command Post (ICP)** is located in the field directly proximate to the incident site. This is where tactical management of the incident occurs and, by default, where specific activities such as Planning Meetings are conducted (see below – Concept of Operations). In contrast, an **Emergency Operations Center (EOC)** is usually remote from the incident site and its role is to manage coordination and provide support to those directly managing the "incident." An EOC is typically pre-established at fixed locations. In certain widespread incidents without a specific site, the ICP and the EOC may be co-located, but it is important to maintain separation between these distinctly different functions and their related activity. In this co-location situation, the physical facility would still be called an EOC, with incident management team functions occurring in a distinct area of the facility.

For healthcare facilities, several considerations are important to ensure consistency of terminology with other response organizations:

• Healthcare organizations may find utility in establishing both ICP and EOC functions but should designate them appropriately. For example, if the primary focus of the incident is in the Emergency Department, the healthcare facility ICP may be located there with support coming from a healthcare facility EOC located in a fixed location elsewhere. This would mean that inherent command activities would occur at the ICP location (e.g., direct Planning Meeting for the activities within the ICP's purview). This, for obvious reasons, is not an ideal arrangement for many incidents that create response needs across the organization.

• Healthcare organizations may choose to have command activities occur at a pre-established location titled the emergency operations center (EOC). Similar to the jurisdictional model above, command and support activities would occur in the same location but with appropriately organized and designated incident management team personnel providing management guidance to the EOC support

functions.

• To add to the complexity of this issue, if the healthcare facility were to be viewed as an integral component of jurisdictional ICS, the location where hospital command is occurring could be more appropriately termed "Hospital X Operations Center" (if the healthcare organization is performing under the Operations Section of the jurisdiction). Since hospitals have rarely been fully incorporated into the ICS organizational structure (with full logistics, finance, and planning support by the jurisdiction), this is probably not an acceptable term for many healthcare organizations. Also, it would not apply if the incident were only occurring at the facility in question (for example, no jurisdictional response, so the "incident" is managed entirely by the healthcare organization). The general title that the Hospital Incident Command System (HICS) applies to this entity is "Hospital Command Center," defined as "the place where decision-making occurs."

• Regardless of the terms utilized, **it is most important that the healthcare organization use a qualifier in its title to designate it as theirs.** For example, "Hospital X CP," "Hospital X EOC," or "Hospital X Command Center," will all convey a clear distinction to other responding organizations and agencies.

Other terms utilized to describe this management facility may not be considered consistent with NIMS/ICS.

For the purposes of clarity in this text, the command location is designated as the Healthcare System Command Post (CP).

The Incident Operations Stage: Command Staff

The Command Staff in traditional ICS is described as the Incident Commander (IC), the Safety Officer, the Liaison Officer, the Public Information Officer (PIO), and senior advisors and additional staff as assigned. **Even with a minimal activation of the EOP, it is always necessary to designate a Healthcare System IC**.

The Incident Operations Stage: Agency Executive and Advisors

The agency executive (Chief Executive Office, Chief or Senior Administrator, or equivalent) has the important responsibility of assuring adequate emergency response by the organization. This individual may

participate in any incident meetings, observe any incident actions where it is safe to do so, and can provide strategic advice and decisions to the IC at any time. It is important, however, that the executive not insert him/herself into micro-management of the incident. If the incident management is progressing well, positive feedback is always encouraging. Issues of concerns can usually be brought quietly to the IC.

An advisory group (Senior Policy Group, Emergency Policy Group, Policy Coordinating Entity or other title) may be established to provide advice to the agency executive as noted in Lesson 2.1.2. Procedures should be in place to rapidly convene this group, with members having an understanding of their advisory-only role.

The Incident Operations Stage: Command Staff Actions

Several critical issues must be addressed by the Command Staff at the outset of any incident response operations. If formal incident action planning is instituted, each of these items is decided during a brief meeting that traditional ICS refers to as a "**Transitional Management Meeting**."[38] As described in Lesson 2.1.3, this meeting should be kept brief even if the incident is complex (it is important to distinguish this from the incident recognition and activation decision processes, which are assumed to have already occurred).

For healthcare systems, a Transitional Management Meeting includes key activities such as:

- Identification of IC: The Healthcare System IC should be explicitly determined and publicized to prevent any confusion (position competencies and other considerations are provided in Systems Description discussion of this position). A deputy may be selected at this time as well to provide adequate coverage for 24-hour operations.

- Initial briefing: The selected Healthcare System IC then receives a briefing on incident parameters as they are known at that time. This briefing is usually conducted by the Situation Unit, possibly by personnel who functioned as the Baseline Operational Unit and so are familiar with incident information from the outset. To keep the briefing focused and concise, it is helpful to consider the use of the ICS Form 201. This form, if adapted to the healthcare setting, provides an orderly progression of critical incident information that should be

[38] NIMS terminology for this meeting is "initial IC/UC meeting" and extends across the "IC/UC Develop/Update Objectives Meeting and the Command and General Staff Meeting in the "Planning P" (see exhibit 2.1.3.3).

provided to the Healthcare System IC and serves to document the early incident details.

- Initial incident objectives: With the initial briefing as a basis, the Healthcare System IC establishes initial incident objectives for the organization. Both overarching incident objectives and more specific operational period objectives are established (see Lesson 2.1.2 for distinction between two types of objectives). The latter may be broad during the initial incident response and become increasingly refined and specific as incident planning progresses. In some situations where the need for operational response of healthcare medical resources is unclear, operational period objectives may revolve around gathering more incident information and initiating contingency planning (see Lesson 3.2.2). These initial objectives should be documented, usually by the Planning Section Chief. **The objectives should clearly address any significant safety, protection and continuity of operations issues as well as incident patient care expectations.** The use of an ICS Form 202, adapted to healthcare system incident orientation, will facilitate the capture and dissemination of these objectives.

- Initial IMT organizational structure: Each hazard impacts the healthcare organization in a different way, and the extent of impact is variable even within a single hazard type. This warrants the need for flexibility in defining the ICS organizational structure for each incident, within the level of activation determined in the preceding activation/initial notification stage. The next critical step, therefore, is to outline the IMT organizational management structure for the "activated" components of the organization's EOP. This critical step should designate the names of personnel assigned to all activated Command and General Staff positions, as well as the Operations Branch Directors and the Unit Leaders under each activated ICS section. Using ICS Forms 203 and/or 207, adapted for healthcare systems, will facilitate the capture of this assignment information. The rapid construction of this IMT chart is facilitated by having guidance for likely hazard types in the EOP base plan and hazard-specific or incident-specific annexes (see Lesson 3.3.2). While this organizational documentation may superficially seem laborious, it is invaluable as an instrument for organizing the healthcare system response and the reporting structure, for personnel within the organization as well as key external response agencies. A properly documented **and disseminated** IMT structure will significantly improve the ability to meet response-generated demands. Dissemination should rapidly be conveyed to section chiefs and to the Senior Liaison Officer for distribution to external agencies or to a Tier 2 healthcare coalition as appropriate.

Several critical tasks must be accomplished early during Incident Operations. One of the most important is to select the organizational structure (ICS based) that is predicted to meet the incident needs as known.

Not all incidents require formal and documented Healthcare System Incident Action Planning.

- Healthcare System incident action planning: Another critical incident decision to be made is whether formal incident action planning will be undertaken by the healthcare response organization (see discussion below under Planning Section).

  - Formal incident action planning: This requires dedicated personnel and resources and, therefore, for many healthcare systems, it can appear to be an undue burden during incident response. The following incident parameters may be helpful in making the decision as to when formal incident action planning is in fact extremely beneficial based upon initial incident information:

    - Projected incident length: Generally, in any incident with early indications that the response will persist beyond a single day, or greater than one extended operational period, formal incident action planning should be strongly considered.

    - Complex hazard impact: For incidents that appear complex in nature (e.g., infectious disease outbreaks) or in size (large geographic area or crossing jurisdictional borders), formal incident action planning can enhance internal and external dissemination of information and coordination of actions.

    - Complex, multi-agency response: If multiple external agencies will be involved in the incident response, then formal incident action planning will almost always be required to facilitate integration of the healthcare system into the larger response. It promotes external dissemination of healthcare facility incident information and provides a mechanism to incorporate outside information across the organization's response. This can be especially critical for situations where the local jurisdiction's response will be dependent upon data from healthcare organizations, such as during an infectious disease outbreak.

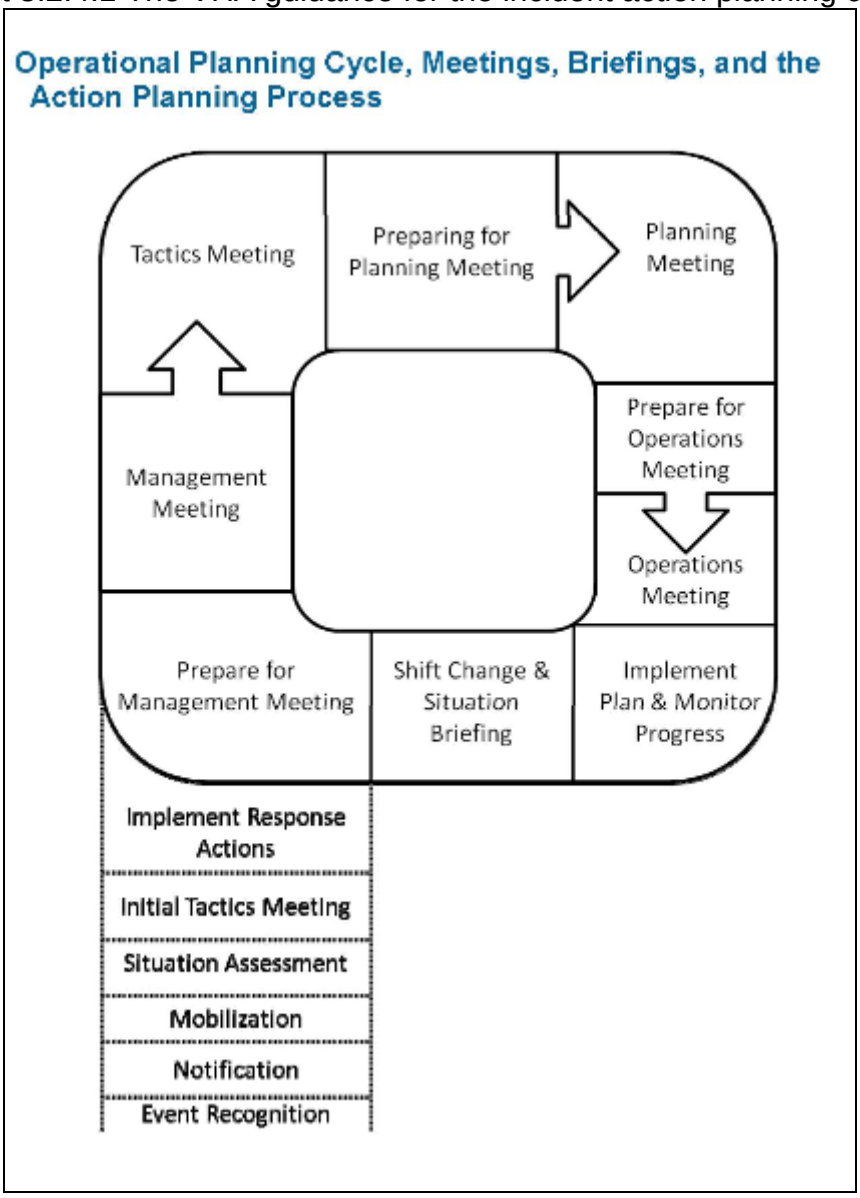
    Initial parameters may not clearly dictate the need for formal incident action planning. It is generally better, however, to assume the need for formal incident action planning, even if the incident action plans are short and handwritten.

  - The Planning Cycle for healthcare organizations: The NIMS Planning Cycle (Exhibit 2.1.3.3) was presented in Module 2.1. The Veterans Health Administration (VHA) has adapted that cycle for use by the VA Medical Centers (Exhibit 3.2.4.1)

  - Informal incident action planning: This may be the management

strategy used during the early, relatively hectic period of response. It may initially be accomplished through announced Command and General Staff Situation Updates that evolve into more formal management and planning meetings as the incident unfolds. A template for rapidly covering key areas of healthcare system management during these types of meetings is presented in Textbox 3.2.4.2.

Exhibit 3.2.4.1 The VHA guidance for the incident action planning cycle.[39]



[39] U.S. Department of Veterans Affairs. *VHA Emergency Management Guidebook (Draft 2010)*. Veterans Health Administration, Washington DC.

Textbox 3.2.4.2

Situation Update Meeting Guide for Healthcare System Command and General Staff

1. Announce meeting and ground rules (Planning Section Chief)
   - Very brief, focused reporting from designated personnel.
   - Controversies will be side-barred for resolution and report back.
   - Pagers and phones placed on silence/vibrate.

2. Current incident situation report (Planning Section Chief)
   - Pertinent incident details.
   - Overall incident response, including IMT structure being used and objectives and major strategies established by overall response that are pertinent to healthcare systems.
   - Healthcare system role in response.

3. Situation report (Operations Section Chief)
   - Incident as it has impacted the healthcare system.
   - Healthcare system objectives, strategies, and general tactics.
   - Brief review of activated components of healthcare system (e.g., current continuity and clinical/non-clinical operations, plus Family Assistance Services).

4. Planning report (Planning Section Chief)
   - Documentation issues related to information management, review of operational periods, etc.
   - Contingency, long-range, and demobilization planning issues.

5. Logistics report (Logistics Section Chief)
   - Pertinent status of facilities, supplies, and personnel.
   - Communications issues.
   - Transport issues.
   - Health issues impacting system responders.

6. Safety and security report (Safety Officer)
   - Status of perimeter control and other incident security issues.
   - General and incident-specific safety issues and interventions.

7. Medical Officer report (Senior Medical Advisor or Technical Specialist)
   - Any additional safety/preventative medical considerations.
   - Any additional strategic planning issues based upon the types

of casualties and their medical conditions (for example, anticipating 12- and 24- hour needs for burn patients, special transfer issues, and other concerns that are important for the entire Command and General Staff to understand).

- Conducting the planning cycle: If incident action planning is to be conducted by the healthcare system, then defining the "operational period" is the next important step. The "operational period" is the time interval covered by operational period objectives (see Terminology Textboxes in Lesson 2.1.3). The Planning Cycle is dictated by the timing of the operational period.

Defining Healthcare System operational periods early is critical.

  - Twenty-four-hour operational periods: For most incidents that the healthcare facility will encounter, a 24-hour operational period is often adequate. Note that the operational period and work shifts may not coincide, although it is useful to have the onset of the operational period and one work shift synchronized, so that a current operational briefing and incident action plan is used to guide the work of the incoming personnel.

  - Shorter operational periods: For some incidents that involve rapidly changing parameters, a shorter operational period such as 12 hours or shorter may be indicated.

  - Longer operational periods: If incidents move into a semi-chronic timeframe (e.g., a pandemic at a steady state), operational periods and planning cycles could be stretched out to longer time periods such as a week.

  - Changes in operational period length: The length of operational periods can be formally changed as incident parameters dictate (increase or decrease in length) but should occur deliberately through the incident action planning process with adequate notification to response participants (through an incident action plan prior to the scheduled change).

  - Operational period timing considerations: here are two important considerations for determining the operational period:

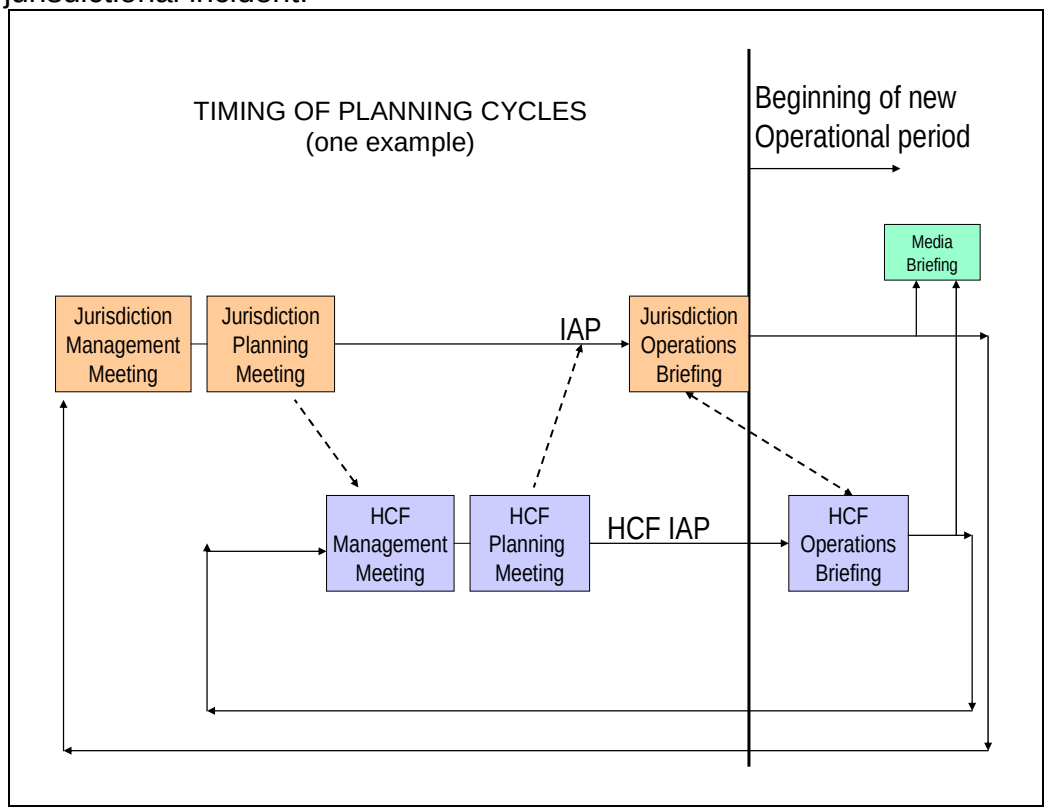
    - Jurisdictional planning cycles: In most well-run jurisdictional responses, an operational period/planning cycle will be established rapidly. For healthcare facilities, knowing the jurisdictional planning cycle can help in setting the timing of the planning cycle for the hospital. For example, if a jurisdictional health and medical authority has established a planning cycle

Coordinating Healthcare System operational periods with those of other response entities is also important.

such that it will conduct Operations Briefings to healthcare facilities every morning at 1000, then the healthcare facility supporting the jurisdiction's incident may establish its Operations Briefings internally at 1200 (see Exhibit 3.2.4.1). This will enhance coordination of information and planned actions across the jurisdiction.[40] In ideal situations, once information is disseminated amongst the various healthcare facilities, media briefings are also timed so that the incident action plans can promote consistent public messages from across the response.

[40] It is recognized that some jurisdictions may not have formally established planning cycles. This doesn't negate the importance of conducting incident action planning in a scheduled planning cycle at the level of the healthcare facility or, ideally, synchronized with other healthcare organizations through a coalition (Tier 2) platform (see Lesson 2.2.3). Also, it is recognized that some jurisdictions may delay in establishing a formal operations period. Timing of incident planning meetings may be adjusted at the healthcare facility level as the incident evolves to be synchronized with the jurisdiction.

Exhibit 3.2.4.1: Timing of planning cycles between a healthcare facility (HCF) and the jurisdictional response, where the HCF is supporting the jurisdictional incident.



- Timing of specific meetings: The timing of specific meetings that compose the planning cycle should be established early and disseminated to the appropriate internal personnel that are to attend. Initial timing of meetings can be subject to change as the incident evolves but, ideally, the organization should complete one full cycle of the following meetings, within the established time period designated as the first operational period:[41]

  - Planning Meeting.
  - Operations Briefing.
  - Management Meeting (this begins the formal planning for the next operational period).

Establishing and disseminating the timing of specific meetings is an important early Planning task during Incident Operations.

- Importance of Transitional Management Meeting issues: The critical steps outlined earlier for the transitional management meeting hold

[41] See "Incident Operations: Planning Section" for further explanation of these meetings during the operations cycle.

paramount importance for the success or failure of the healthcare system to adequately address the hazard impacts. By addressing these concerns, the organization has already begun the transition from reactive to pro-active management of the incident (see Textbox 3.2.4.3 for an example of the alternative).

Textbox 3.2.4.3

Failure to Transition from Usual Management to EOP-guided Incident Management

Hospital X is located in a large metropolitan area with a robust healthcare system and a large public health department. Two cases of inhalational anthrax have been identified at another local hospital, Hospital Z, and the media has reported the cases. Public health has rapid epidemiological investigations occurring and has briefed all the facilities on what is known regarding the situation at this point in time. Hospital X does not recognize this as an "incident" for them and therefore does not activate its EOP. No Transitional Management meeting is conducted and the hospital continues to operate using day-to-day structure and processes.

- At Hospital X, the ED, inpatient areas, and the outpatient clinics are not uniformly notified of the existence of the two confirmed cases of anthrax at Hospital Z, nor are they fully informed of the investigations other than what they have received through the media.
- As no objectives, strategies, or tactics have been established for the healthcare organization, these clinical care areas continue to operate in a usual manner with clinicians either oblivious to the current events (potentially missing cases of concern) or managing individual patients based upon traditional individual knowledge (e.g., disparate methods for diagnostic evaluation and treatment).
- No IMT has been activated so many personnel throughout the hospital are distracted from their daily activities as they try individually to gather further information.
- Agencies external to the healthcare facility struggle through traditional points of contact for Hospital X's information that could be important in the epidemiological investigation. Similarly, important information on laboratory diagnosis and recommended initial therapies are conveyed to disparate nodes within the hospital (such as infection control, lab services, and infectious disease consultants). These personnel do not normally transmit this type of information to hospital administrators in a real time fashion. Data and

recommendations, therefore, are not likely to be available in one place for hospital executives and clinical service chiefs to make fully informed and coordinated decisions.

- No planning cycle has been established and, therefore, general information dissemination is uncoordinated and not updated consistently throughout the facility.
- A media briefing is conducted by an infectious disease specialist on the Hospital X staff, without the knowledge of hospital administration or local public health authorities (since no "incident" was declared, no policy regarding incident media statements is applicable). The information conveyed in the media message contradicts the current recommendations made by local public health authorities, resulting in confusion among the media and the general public. This diverts valuable attention away from the incident investigation and threatens the public's confidence in authorities, as well as the public's respect for the competence of Hospital X.

Ongoing Command Actions during Incident Operations

The Healthcare System Commander is responsible for the organization's overall incident response.

The Healthcare System's incident objectives can provide overall guidance, while operational period objectives provide guidance for a specific operational period.

- Command: Throughout incident operations, Healthcare System Command is responsible for the entire organizational response to the incident, but not for the usual hospital activities unless specifically designated by incident objectives. The following are all responsibilities of the Healthcare System Incident Commander:
  - Proactive management methodology using organization-wide objectives specific to the incident. This includes both types of response and recovery objectives, briefly re-iterated here:[42]
    - Incident Objectives: These are essentially the organization's goals statement and are, therefore, expected to change little during Incident Operations. An example as cited in Lesson 1.5.3 would be "to maintain a medically safe and secure environment for personnel, current patients, and visitors."
    - Operational period objectives: These are more specific objectives to guide the organization's response and are developed or revised for each specific operational period. They should be measurable and achievable within the operational period. An example would be "to initiate and

[42] Objectives related to continuity of operations may exist as either incident or operational period objectives, or both.

distribute prophylaxis to on-duty hospital staff." See Textbox 3.2.4.4 for an example of incident and operational period objectives during a hurricane incident.

- Developing objectives during informal incident management: Even if formal incident action planning is not to be undertaken, the Healthcare System Incident Commander should establish incident objectives for the incident. This provides direction for the overall system response and also establishes metrics: measures of effectiveness for objective assessment of response performance by the Command and General Staff. Multiple approaches are used to develop the response objectives but all require final approval by the organization's Incident Commander:

  - Healthcare System Incident Commander: In many situations, the Healthcare System Commander will establish the incident objectives on his/her own or with input from the Operations Section Chief. These are then communicated to the Planning Section Chief during the Planning Meeting (or prior to that at a Tactics Meeting or during preparing for the planning meeting as applicable). The Planning Section Chief documents documentation and then presented to key organizational personnel during the Operations Briefing.

The Incident Commander is responsible for final selection of the objectives that guide the organizations strategic actions.

  - Planning Section Chief: Another approach is for the Planning Section Chief to be assigned the task of developing options for response objectives. During the Management Meeting, the Commander selects from the list of options to delineate the organizational objectives. These are then processed and communicated as in the above bullet.

  - Operations Section Chief: A final method may be for the Operations Section Chief to develop the list of objectives from which the Commander selects, with assistance from the Planning Section Chief.

Textbox 3.2.4.4

Example of Response Objectives Established by a Healthcare System

Hospital W is located in a coastal city in the Southeast. A major hurricane is approaching from the east and Hospital W decides to activate its EOP. Formal incident action planning is initiated as initial event parameters indicate a greater than a one-day response. Initial objectives established by Hospital W include:

Incident objectives

- Maintain a medically safe and secure environment for personnel, current patients, and visitors.
- Sustain the organization's functional integrity: business facility and usual healthcare service operations.
- Provide health and medical surge services to incident patients as indicated.
- Integrate into the overall emergency response, meeting the organization's external emergency response and recovery commitments.
- Address environmental and regulatory concerns where indicated, without compromising the higher priority objectives above.

Operational period objectives

- Prompt healthcare system personnel to review their family and personal preparedness plans for adequacy and execute actions indicated for hurricane impact.
- Ensure adequate healthcare system personnel staffing for the hurricane impact and immediate post-impact period.
- Complete healthcare facility protective action checklist to reduce vulnerability to hurricane impact.
- Verify facility ability to operate 72 hours without re-supply or outside assistance.

After hurricane landfall, the hospital remains relatively intact but the surrounding community has received severe storm surge damage. The facility is operating on generator power but has air conditioning and running water, although it is not known if the water remains potable. The incident objectives remain unchanged. Revised operational period objectives for the next operational period include:

- Provide support to staff (including lodging and food between shifts) to maximize operational status and maintain adequate staffing.

- Provide care to victims of the hurricane impact, including ensuring adequate disposition and follow-up when discharged.
- Maintain facility infrastructure using back-up generators.
- Determine whether tap water is potable and provide bottled water for drinking, food preparation, and medical purposes until potable tap water is confirmed.
- Assure public awareness that the hospital is functioning and able to care for victims and normal healthcare needs.
- Identify projected healthcare system operational status over the next 24-, 48-, and 72-hour periods.

- Incident specific/hazard specific guidance: The Healthcare System Incident Commander (IC) is responsible for the implementation and adaptation of any incident specific/hazard specific guidance as indicated.

- Problem solving: The Healthcare System IC is responsible for resolving problems that can't be addressed at a lower level in the IMT. These issues are generally related to resource needs, and the Healthcare System IC can make the determination to seek assistance through outside agencies, commercial vendors, or neighborhood business concerns.

- Participation in meetings: The Healthcare System Incident Commander participates in the following meetings if formal incident action planning is undertaken (usually the Planning Section Chief facilitates these meetings – see Planning Section later in this Module):
  - Management Meeting.
  - Planning Meeting.
  - Operations Briefing.

- Other Command activities:

  - System monitoring: The responsibility to monitor system response sits within Command, as they have the authority to implement corrective actions **during the response**. Healthcare System Incident Commanders should monitor the response system for adequacy and effectiveness. Part of this is achieved through a well-implemented incident action planning process, but other activities may be conducted as well. For example, Healthcare System Incident Commanders should evaluate the adequacy of organizational structure and other parameters to ensure the ICS is functioning as designed.

Incident Commanders hold the important responsibility of monitoring the system response to ensure that it is functioning as intended.

In addition, changes to the organizational structure (e.g., addition of a branch to the Operations Section) may be necessary during the response.

- Spokesperson for healthcare system: At times, it may be appropriate for the Healthcare System Incident Commander to speak publicly. This, however, should not be a primary responsibility, as it can detract from other critical tasks. If (as described above) the agency administrator or senior executive for the organization is not the Incident Commander, the media duties may be best addressed by this more senior individual.

- Political liaison: The Commander may serve personally as the liaison for direct coordination with senior public officials and other healthcare system's senior executives and for strategically important issues, such as funding guarantees for requested response actions. This is usually accomplished through teleconferencing or other communications method that allows the Healthcare System IC to remain onsite. In these situations, the senior liaison officer provides support to the Healthcare System IC, and monitors the exchanges closely so that they can effectively assume responsibility for follow-up issues and related liaison activities (see senior liaison officer position below).

Healthcare System Safety Officer

As described in the Systems Description, the Healthcare System Safety Officer has the overall responsibility for the safety and welfare of the organization's responders.

The Safety Officer oversees all safety considerations for the organization throughout its incident response.

- Safety Role: In a large-scale or unusual hazard event, the Safety Officer's role is complex and requires a wide range of activity:

  - Developing a safety assessment: A Safety Officer devotes time to the Healthcare System Command Post as required for meetings and other decision-making interactions, for reviewing planned actions for safety concerns, and for gathering incident information from the senior liaison and other management staff.

  - Monitor work site actions for safety issues: The Safety Officer should also be monitoring personnel actions and behavior in various sites throughout the facility, particularly in areas where personnel are performing unfamiliar or high-risk tasks. Assistant safety officers may be appointed for some of the direct monitoring

activities, and they report to the Safety Officer position in the command group.

- Review incident parameters for safety concerns: It is important for the Safety Officer to critically review incident and response safety parameters beyond traditional occupational health. Additional areas to examine include security safety, personnel fatigue, and any indicated prophylaxis.

- Monitor adherence to designated safety practices: Adherence to mandated safety practice (PPE, isolation rooms, etc.) must also be monitored closely for compliance.

- Safety input to planning: The primary vehicle for inserting safety considerations into the incident management is through incident action planning. The Safety Officer develops a safety message that is incorporated into each formal incident action plan. This can be a brief message on the facility's ICS Form 202, or it can be lengthier with complex issues and recommendations and be presented using a separate safety plan instrument, ICS Site Safety Form 208 adapted for healthcare system use.

- Safety recommendations: While the Safety Officer identifies critical safety issues and lesser concerns, other sections are usually responsible for implementing the safety recommendations (e.g., Logistics Section providing PPE, or Operations Section changing their response tactics). All safety-related recommendations, therefore, should be actionable and easily translated into achievable safety intervention by the intended recipients.

- Safety responsibility in a partial EOP activation: As with other Command Staff positions, if Safety is not specifically assigned to an individual, the safety responsibilities rest with the Healthcare System Incident Commander.

The Healthcare System PIO manages the media message from the organization throughout the response.

Healthcare System Public Information Officer (PIO)

As described in the System Description, the PIO develops the general media message on behalf of the healthcare system and develops update messages for patients and their families. All releases are subject to approval by the Healthcare System IC.

- Message timing: The timing of both types of messages should take into consideration the timing of the planning cycle for the organization. Early media messages may be released that focus more on the

incident context ("this was a horrendous event") and general healthcare system response actions ("here is what we are doing about it"), as well as continuing to provide updates ("here is when we expect to know more"). More substantive media messages should be generated after the Operations Briefing conducted by the healthcare system. This ensures that the most up-to-date and pertinent incident information has been received and processed by healthcare system personnel prior to briefing the media. It will also help prevent conflicting messages between the healthcare system and other external agencies.

The timing of Healthcare System media messages can have important implications.

- Message purpose: Usually, the media messages are for the purpose of informing the public about the incident and the healthcare system's response. In some incidents, a more specific, operationally relevant purpose may be indicated. The media may be recruited during the incident to shape the public's behavior in a manner that is beneficial to the population and also may reduce the incident impact on the hospital. For example, providing relevant health self-assessment information to patients and telephone numbers for offsite locations where they can call for questions may reduce the telephone burden on the emergency department and other clinical areas. Alternatively, the media may be used for providing direction to response personnel. For example, if a hazard impact disrupted telephone communication, thereby preventing a telephone recall of staff, the media can broadcast messages with directions for off-duty and other offsite healthcare system staff.

- Message coordination: The Healthcare System PIO should be cognizant of media efforts by the jurisdiction or other external response agencies. For example, if a Joint Information Center (JIC) has been established as part of Federal response efforts, the healthcare facility should monitor messages as released from this entity. In incident situations that are primarily health and medical in nature (e.g., infectious disease outbreak), the healthcare system PIO may benefit from closer ties, including direct contact with or potential visits to the JIC. In addition, some jurisdictions with existing Tier 2 healthcare coalitions can provide the coalition's platform for coordination of healthcare organization media messages during response and recovery.

Healthcare System PIOs should be cognizant of JICs when they are established.

- Monitoring the media message: A significant amount of effort during Incident Operations should be committed by the PIO to monitoring the media message to the general public. This can be important for several reasons:

    - Obtaining incident information: Given the nature of real-time

broadcasting, it is entirely possible that media will provide the earliest indications that a sudden change has occurred in incident parameters, well before this information is provided through official channels.

- Assessing message consistency: The general media message from other healthcare facilities and external agencies should be monitored for consistency with that developed by the PIO and healthcare facility leadership.

- Identifying misinformation: Incorrect incident information can be transmitted to the public by the media. Especially when incorrect information relates to the healthcare facility in question, this misinformation should be identified and addressed as rapidly as is possible. For example, if a specific facility has been represented by the media as being seriously impacted and non-functional when this is not the case, rapid efforts to correct this misinformation should be initiated for obvious reasons.

- Identifying image issues: The general media portrayal of the healthcare system response performance should be monitored throughout the incident. Unflattering portrayals should be addressed (by the Healthcare System's Command staff, not just the PIO) as rapidly and robustly as possible. The response to the issues raised by the media should be open and honest, correcting out-of-context portrayals with accurate facts and logical explanations. Failure to address this effectively can lead to serious business, regulatory, and legal difficulties.

Healthcare System Liaison Officers serve the important role of facilitating the two-way exchange of strategic information but may also have a role in handling tactical information as well.

Healthcare System Senior Liaison Officer

As described in the Systems Description, the Senior Liaison Officer is responsible for all **strategic information** exchange with entities external to the healthcare system. Communications can be with other response entities (jurisdictional, State, or Federal as appropriate); with Tier 2 healthcare coalition partners; and with other business, private, or voluntary organizations.

- Establishing appropriate external contacts: Early in an incident, the Liaison Officer is responsible for establishing, with technical assistance from the Communications Unit, contact with a pre-determined list of external organizations. This generally will include public safety and/or public health contacts managing the incident, the jurisdiction's emergency operations center, other healthcare institutions (ideally through a healthcare coalition, Tier 2 platform),

EMS supervisors, and others as developed during preparedness phase activities. Depending upon the incident and the healthcare system actions, certain external response agencies should be notified very early, and this may be a statutory or regulatory requirement in some jurisdictions. Adequate attention to this issue during the preparedness phase of the EM program will expedite these important coordination and information sharing connections.

- Centralized reporting and liaison: In many jurisdictions, an Emergency Management Agency will staff a 24-hour telephone line in an Emergency Operations Center, with an immediate emergency communications capability. This can provide a simple mechanism for reaching any local agency and providing a coordinating mechanism until formal jurisdictional Incident Command and Emergency Operations Center functions are established.

- Alternative reporting and liaison: In other jurisdictions, notification may be made through a "Tier 2" healthcare coalition (see Lesson 2.2.2), which subsequently forwards the message as indicated. As a general rule, healthcare systems should not bypass the local jurisdiction and attempt to contact State or Federal agencies directly during the initial stages of any incident. When State or Federal authorities communicate directly with the healthcare organization during incidents without local jurisdictional knowledge, effective overall incident management may be disrupted. In fact, many higher authorities will appropriately redirect the healthcare system liaison attempts to the local authorities.

- Appropriately disseminating organizational information: Liaison Officers may convey healthcare system response information via a range of formatted messages. Much of this can be efficiently accomplished by transmitting completed ICS forms that describe the healthcare system status; response organization; and objectives, strategy, and tactics (ICS Forms 202, 203, 207, and 205 as appropriate). To provide regular updates, the ICS Form 209 can efficiently convey important information to external authorities and to a healthcare coalition. In addition, the Healthcare System IC may direct the forwarding of a Form 209 to others, such as the organization's board of directors or the parent organization for the facility. Requests for assistance and sudden changes in incident parameters, as identified at the healthcare facility, should be transmitted rapidly to jurisdictional authorities using a **written message** (ICS general message Form 213 or as designated by the jurisdiction) to assure that accuracy and accountability is maintained. Receipt of message by the

intended recipient should be confirmed and documented by the Liaison Officer (a liaison log may serve this purpose). Some specific and regular external communications, such as sending and receiving patient information between the healthcare facility and a community-wide patient tracking service, is accomplished using the transmission format inherent to that service.

- Receipt of information: Various types of information should be received and processed by the Liaison Officer. Incident updates from the jurisdiction are one example. This information should ideally be processed for consideration in the appropriate Healthcare System's incident action plan. Due to the complexities of certain types of incidents, the healthcare systems may designate the Liaison Officer as the point of contact for more specific or tactical information as well. For example, in an incident in which diagnostic testing for an infectious agent is being performed by an outside laboratory, test results can be conveyed to the Senior Liaison Officer to ensure timely receipt and adequate internal dissemination of results.

Lesson 3.2.5 Concept of Operations for Healthcare Emergency Response and Recovery: Incident Operations Stage – Operations Section Actions in Continuity and Medical Surge

Lesson Objectives

- *List the primary responsibilities of the Operations Section during incident operations.*
- *Describe the healthcare systems potential Operations Section organization based upon different incident types.*
- *List continuity of operations considerations for healthcare systems and how the Operations Section could be constructed to address them.*
- *List medical surge considerations for healthcare systems and how the Operations Section could be constructed to address them.*

Operations Section

The structure of, and the personnel assigned to, the Operations Section is determined by the incident type and the stage of incident response and recovery. Though a healthcare system typically views itself as primarily filling a patient surge role, this is not always the case. For example, the extended loss of mission critical systems will dictate a very different configuration for the Operations Section than for one designed to manage only patient surge. Since the Operations Section is responsible for achieving the incident objectives established by Command, the Operations Section construct, its position assignments, and the selected expertise should be guided by the organization's incident and operational period objectives. The Section's configuration and assignments for each hazard or incident type may be expedited through carefully developed guidance in the Base Plan and Incident Specific or Hazard Specific annexes. The Operations Section has the highest likelihood of requiring change in configuration or staffing throughout an incident response. This is managed through the incident action planning process (see Lesson 3.2.6).

The four major emergency response issues confronting Healthcare Systems are continuity of regular operations (Resiliency), caring for new, incident-related patients (Medical Surge), occupant safety (security and protection), and support to external requirements.

As noted in Lesson 1.1.1 and 3.1.1, in almost all healthcare system incidents the hazard generated needs may be grouped into four broad categories of emergency response and recovery capabilities:

- **Protection and security**. All actions to address protection and security issues such as evacuation or sheltering in place and other occupant emergency procedures.

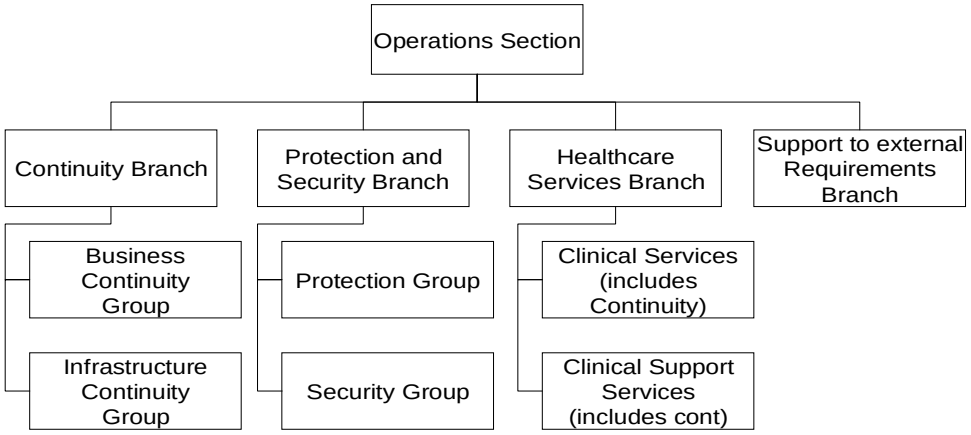
- **Continuity of operations**. Actions to maintain usual patient care services and business practices to achieve organizational resiliency.

- **Health and Medical surge**. Actions that provides medical surge capacity and capability to meet the incident-specific medical and psychological needs of the affected population.

- **Support to external requirements**. Actions to meet the organization's commitments to community response as agreed to by the organization or required by the incident specific parameters.

These predictable Operations Section task categories are the reasoning behind the candidate Operations Section organizational construct proposed in the previous lesson and repeated here in Exhibit 3.2.5.1. As noted in this lesson, the capabilities as described earlier generally correspond with the proposed Operations Section branches (e.g., healthcare services continuity of operations occurs under the healthcare services branch).

Exhibit 3.2.5.1: Proposed Operations Section organization



The pre-planned Operations Section branches can then be developed to adequately manage these major activities.

The Operations Section Chief selects the specific strategy and tactics for achieving the defined incident objectives. If formal incident action planning is conducted, the Operations Section Chief participates in the Management Meetings, the Planning Meetings and other pertinent planning activities, and in the Operations Briefings.

This lesson focuses on the healthcare system Concept of Operations for Continuity and Medical Surge. The next lesson focuses on the

Operations Section actions in Security and Protection and Support to External Requirements.

Continuity of Operations and Mass Effect Incidents

Though much attention has been placed on healthcare system response to mass casualties, mass effect incidents actually are likely to be experienced more frequently by healthcare systems. Moreover, many hazard impacts that create mass casualties are also likely to deliver continuity impact also. The following general continuity concepts are therefore important to consider.

- Continuity of operations can refer to multiple response activities. Though the Operations Section description in 3.2.5.1 outlines a Continuity Branch, other branches are also involved in **continuity efforts**. See textbox 3.2.5.1 as an example.

Textbox 3.2.5.1:

Continuity efforts of various components of the healthcare system Operations Section: electrical power outage

During a wide spread power outage, an Operations Section for a healthcare system might be engaged in the following continuity activities:

Continuity Branch:
- Business Continuity Group: Ensuring that billing and other financial records/transactions are not impacted by the service interruption. Another issue might be the impact of power on electronic medical records or electronic time clocks to account for employee work time.
- Infrastructure Continuity Group: This group would expect to play a primary role in this incident with maintenance of emergency power supplies (i.e., emergency generators) and facility/infrastructure evaluation of hazard impact.

Security and Protection Branch:
- Security Group: Additional security measures may be necessary if electronic security systems have been impacted.
- Protection Group: Additional protective measures may become necessary if Fire Alarm systems are not on back up power and the battery back-up is depleted (e.g., establishing Fire Watches).

Healthcare Services Branch:

- Clinical Services Group: Immediate and on-going evaluation of power interruption impact on patients would be important. In addition, providing corrective actions for impacted for impacted systems (e.g., addressing limited battery back up for iv pumps).
- Clinical Support Services Group: Addressing power outage on clinical support services such as loss of radiological or lab capacities.

- Mass effect incidents can occur with or without warning.
    - For those that occur without warning, the Operations Section (and at the service unit level) should have checklist guidance to provide initial reactive considerations while assessments are on-going and objectives are being established by Healthcare System Command. In the example in text box 3.2.3.1, an immediate critical action for healthcare providers would be to check electrical power loss impact on patients and their life support devices.
    - For those that occur with warning, certain activities to prepare the organization may need to occur. Examples include the physical plant, security and clinical services preparations that might be necessary with an impending hurricane.
- Initial notifications: Early notification (as in all responses) to healthcare system staff is important. However, hazard impact may affect notification systems and primary notification may be through face to face conveyance of initial information. Initial notifications should direct staff to address initial critical actions (e.g., water supply impact – initiate water conservation procedures and alternate infection control practices or refer to and follow printed checklist guidance).
- Facility assessment: An initial activity for appropriate resources in the Operations Section (continuity branch or infrastructure group) is conducting an assessment of the organization's facilities and the hazard impact on normal operations. Typically, the findings are reported to the Resource Unit in the Planning Section and, if major impact is noted, directly to the Command staff through the Operations Section Chief. The extent of hazard impact (if any) on the facility will be critical to early Command decision making.
- Mass effect incidents that primarily affect mission critical systems for the facility: In many incidents, the primary hazard effect for healthcare facilities is related to the impact on an individual mission critical system. Though not as large in scope as a hurricane or other mass

effect incident, they may still have significant impact on the healthcare organization's continuity. Examples include:

- Electrical power failure: See example cited above.

- Water outage: Multiple activities may be required in the Operations Section. These could include:

  - Continuity Branch, Infrastructure Group: This group would be expected to play a central role. The following activities could be important:

    - Isolation of the water conduit breach if indicated.

    - Immediate assessment and reporting of impact from reduced water pressure.

    - Accessing additional water sources to maintain critical pressure gradient per any pre-plan (e.g., accessing water from a backup water main or fire hydrant source).

    - Evaluation of water interruption and tactical communications with appropriate water authorities or repair resources.

    - Water conservation measures implemented. For example, rerouting of water supplies to mission critical areas, delaying some activities that use water such as patient showering, cleaning of on-patient areas, and other activities.

    - Accessing alternate water sources: For example:
      - Draining of chillers for potable water.
      - External tap hook ups for water tankers.
      - Provisions for external tap hook ups to preserve chiller function.
      - Water purification of water any back-up supply (e.g., swimming pool).

    - Establishing alternate dietary strategies (e.g., use dry foods and foods with minimal water use during food prep).

  - Security and Protection Branch, Protection Group: Additional protective measures may be necessary if fire suppression sprinkler systems are compromised by water loss (e.g., establishing Fire Watches, coordinating with Fire Department to establish external hook ups).

- Healthcare Services Branch, Clinical Services Group: Immediate and on-going evaluation of water interruption impact on patients (e.g., disconnect of dialysis patients). In addition, providing corrective actions for impacted systems (e.g., assisting patients with portable toilets, substituting alternatives to hand washing for infection control).

- Healthcare Services Branch, Clinical Support Services Group: Addressing water outage impact on clinical support services such as loss of steam sterilization capabilities or laboratory testing and equipment cleaning.

Other examples of single system failures that could have mass effect include:

- IT failure
- Telecommunications failure
- Primary HVAC failure

After any primary repair to infrastructure has been addressed in a healthcare system, the Operations Section will necessarily have to address re-inspection and/or recertification of the impacted systems. This can vary from a relatively simple process (verifying potable water coming from plumbing) to a more complex one in which multiple outside regulators are required to come and inspect the rehabilitated facility (e.g., after hurricane impact to the facility).

- Mass effect incidents combined with patient surge: For some incidents, there will be a need to address both continuity issues and patient surge simultaneously. In others, actions in these two categories may be prioritized based upon mission critical factors.

  - Incidents with an evolving focus: In some incidents, the operational period objectives may evolve from patient care to facility repair as the incident progresses (or vice versa).

  - Transitioning position assignments: In many incidents, position assignments, including the Operations Section Chief (and even the healthcare system IC), may transition as the response objectives change. For example, after a sudden flood impact in which all patients have been transferred from the facility (the initial primary operational objectives), both the Operations Section Chief and the hospital Incident Commander positions may transition from

clinically oriented management personnel to personnel with engineering/facilities expertise. This may optimally address the remaining operational objectives (removal of water and debris, returning the facility to operational status) during the follow-on response operations.

Medical Surge Capacity and Mass Casualty Incidents

In a mass casualty incident, the primary focus of the healthcare organization is usually casualty care activities. This should not be construed as minimizing the importance of facility-related impact and operations to minimize evolving impact and to restore facility integrity, as discussed in the preceding section. Major facility restoration activities would also be managed by the Operations Section, usually through the separate Continuity branch.

The following concepts delineate Operations Section tasks related to patient surge capacity and capability. This is an overview description and is not intended to be an exhaustive coverage of the topic. This is generally the healthcare emergency management element that is most associated with the concept of hospital disaster medicine.

- Patient Reception: To manage a large number or unusual types of casualties effectively, efficient patient care must begin at the point of receiving the casualties at the entrance to the healthcare facility.
    - Location of patient reception: In almost any incident, rapid perimeter control must be achieved so that arriving patients, families, media, curious bystanders, and other outsiders can be rapidly sorted and re-directed. Each arriving group must be received at a functional area ready to receive and rapidly process them. Security personnel, with appropriate PPE if indicated, may need to be assigned to facility entrances to redirect walk-ins to the appropriate areas. This is particularly important for patient reception, especially in events where patient contamination is possible. In this particular example, initial patient reception should be accomplished outside the healthcare facility whenever possible, with capabilities immediately available to accomplish patient decontamination.
    - Patient reception site considerations:
        - Victim screening: Arriving individuals may require screening to separate patients from people belonging in the other categories described above. Those identified as patients should also be

rapidly screened for contaminants, weapons (if indicated by circumstance), and other conditions that could be hazardous to healthcare responders or other patients. They must also be separated from family members, who should be re-directed to a family assistance center.

- Accepting hand-off of victims: Clinical staff must be immediately prepared to accept incapacitated patients from EMS and other public safety transporters, as well as from civilian Good Samaritans. The ability to capture important clinical information and keep it with the relevant patient may be important both to optimal patient care and to efficient evaluation and disposition of patients.

- Controlling vehicle and pedestrian traffic: Without careful attention to physical layout and control of the patient reception area, pedestrian and vehicle traffic can disrupt the smooth hand-off of victims to the healthcare system. Security personnel should be present and, if necessary, have an interface with local law enforcement to control traffic flow and prevent intrusion by onlookers. Adequate numbers of staff, stretchers, wheelchairs, and other transport devices could be important to maintaining vehicle flow through the drop-off area.

- Patient Triage: Patient triage should occur a short distance beyond the patient reception area. Even though triage may be accomplished in the field by EMS, it is usually performed for a very different purpose: to determine the order and destination of patient transport to healthcare facilities. Therefore, a triage process is repeated upon patient reception. This will capture change in patients' clinical status during transport and allow accurate assignment of patients to the appropriate patient care area according to the triage protocol in use at the healthcare facility. Important considerations include:

  - Purpose of patient triage at hospital reception: Patient triage in general is a process of sorting patients into categories for a specific purpose. The purpose of triage at this point is to match patient needs with available medical care resources, such that those selected to wait are unlikely to have their eventual outcome significantly affected. Ideally, all patients needing truly emergent care will be selected to receive it in a priority fashion, while those with medical problems not affected by delayed care will be assigned to a minor or delayed care category. How this differs from everyday emergency department triage is in the details: the triage categories and assignments likely differ from

everyday; the time for the triage evaluation may be much shorter; privacy may be compromised (as little as possible); and the mechanisms of injury may be unusual, altering the significance of the clinical findings from the triage evaluation (see triage tools discussion below).

- Triage categories: Healthcare system triage categories should reflect the need to assign patients based upon both the immediacy of evaluation/treatment need and upon the anticipated utilization of important but scarce resources. Suggested triage categories are:

  - Major: Cases that could require life- or limb-saving interventions and/or that need the immediate use of major hospital resources, such as operating rooms or critical care units.

  - Moderate: Cases that require extended physician or nursing time and urgent therapy (e.g., IV fluids or pain medications), but do not necessarily require immediate life-saving interventions or immediate use of major hospital resources.

  - Minor: Cases without life- or limb-threatening conditions that will not suffer ill effects from a delay in care. Asymptomatic patients should be included in this group, since further observation and careful disposition may be required (i.e., do not rapidly "treat and release" if the potential exists for delayed medical or psychological injury manifestation). In certain situations (i.e., immediately after a release of a hazardous chemical), the asymptomatic group may be large enough to warrant a separate category and location.

  - Expectant: This category is intended as a waiting station for patients with little chance of survival, given their injury and the scarce medical resource situation with true mass casualties. This is a very difficult designation to make, especially under the time and public view constraints of initial patient triage. The authors of this text discourage the use of this category assignment during initial patient triage in the healthcare system setting. Patients suspected to be in this category should receive a more though evaluation inside the care facility (which can be accomplished very rapidly by a senior, experienced emergency physician) before being moved to an area where only supportive and comfort care will be provided. This will avoid the potential psychological trauma to staff, patients, and other potential

Triage categories should take into account the availability of medical evaluation and treatment resources.

witnesses who do not understand the difficult triage decision realities. In addition, the Healthcare System Operations Section Chief should be specifically informed if this category is being utilized. If circumstances allow, reuniting the dying patient with family members (through the efforts of the family assistance personnel) should be accomplished.

- Deceased: Patients arriving already deceased should be assigned to a "deceased" category. Expeditious relocation of human remains must be pre-planned to minimize personnel needs while adequately addressing privacy, respect, security, and forensic issues (see Fatality Management section below).

Patient reception and initial evaluation must take into account the hazard type.

- Triage personnel assignment: Patient triage should be conducted by experienced staff, usually a registered nurse or physician. For optimal effectiveness, their pre-incident training should provide a full understanding of the healthcare system's patient care scheme during emergencies and to use the triage decision-support tools developed for the hazard agent.

An effective patient triage tool essentially provides accurate predictive power for deciding which patients can tolerate a wait for services or assignment to a lower level treatment area.

- Triage tools: An effective patient triage tool essentially provides accurate predictive power for deciding which patients can tolerate a wait for services or assignment to a lower level treatment area. Multiple guides have been promulgated to assist in these triage decisions. The selected methods should be easily remembered, relatively simple, and address the specific hazard type. For example, START[43] is an excellent pre-hospital triage guide for victims of blunt trauma. Adhering strictly to the START scheme for victims of an aerosol HAZMAT exposure, however, could be dangerous. For example, a patient complaining only of a sore throat and mild shortness of breath after toxic smoke exposure from a chemical blast would be assigned to a delayed or less urgent triage category under START. This can have serious consequences, as these complaints and the mechanism of injury potentially indicate an impending airway compromise. Similarly, small thorax skin punctures after a bomb explosion could signal life-threatening penetrating injuries, which would be missed using

[43] Simple Triage and Rapid Treatment (START) is a pre-hospital blunt trauma triage tool developed in California by Hoag Hospital and Newport Beach Fire Department. It has been adopted as the triage instrument by many healthcare facilities. A description of START is available at: http://www.sacdhhs.com/CMS/download/pdfs/EMS/EMS_Policy%207508.08%20Simple%20Triage%20and%20Rapid%20Treatment.pdf, accessed May 13, 2010.

common blunt trauma triage schemes. In this latter example, a triage methodology should include a rapid inspection of the skin surface, including under cervical collars and in the axillae. Finally, triage for specific toxins such as organophosphate poisoning might include attention to pupil diameter to assist in determining significant exposure.

- Shaping the triage instrument to fit the incident circumstances:
  - Initial triage during a sudden, no-notice event will necessarily be conducted using a pre-designated triage methodology pertinent to hazard type.
  - An important task for any Clinical Branch Director (or their designee) is to rapidly gather incident information (mechanisms of injury, expected numbers of casualties, etc.) AND response information (such as available medical resources for the expected casualty types). This comparison of expected needs versus available resources will influence the criteria used to assign patients to triage categories.
  - For unusual or rarely experienced hazard agents, (such as certain chemicals, radiation exposure, and aggressive infectious disease), additional assistance (e.g., from Technical Specialists, such as Poison Control or radiation or infectious disease experts) may be required in adjusting the triage tool to provide more accurate predictive power.
  - Incident characteristics will influence triage tool adjustments as well. For example, less injured patients are commonly transported to medical facilities first (via self-referral in private vehicles), and so rapidly filling the major and minor treatment areas with early patients can be problematic. In addition, changes in resource availability can impact triage methodologies. Having the flexibility to make post-triage patient category changes (for those already triaged) may also be a way to address this issue.
  - During incidents where the pace of patient arrival allows the triage officer several minutes for each patient, a more thorough triage evaluation may be performed (see Textbox 3.3.5.2). This approach may provide the most accurate triage assessment and may also be used for secondary triage of patients initially triaged to a minor (delayed care) category.

- While some situations have time between individual patients' arrivals, the opposite may also occur. Recent developments in pre-hospital care in some locations have favored the acquisition of large transportation vehicles to bring patients to healthcare organizations. Rather than a constant stream of patients, healthcare organizations should be prepared for the possibility of a sudden arrival of multiple casualties from the pre-hospital environment.

- Any triage tool that is utilized during response should be monitored for its efficacy. Any triage "failures" must be immediately recognized and analyzed to determine if adjustments to the triage instrument are indicated. For example, if a patient triaged to a minor treatment area suddenly deteriorates, the patient's signs and symptoms during triage should be reviewed. The significance of those findings may need to be re-defined so that follow-on patients with similar findings are triaged into a higher treatment category.

Textbox 3.2.5.2

Example Triage Evaluation Process:
Rapid Assessment of the Awake, Stretcher-bound Patients After Traumatic Hazard Impact

- Introduce self to patient.
- Ask, "What happened to you?"
  - To assess the direct hazard impact to the patient.
  - To assess the patient's mental status.
  - Complete this conversation while performing the physical assessment.
- Rapidly inspect the face and mouth for trauma. Assess skin color.
- With gloved hands, rapidly palpate:
  - Scalp and face (if indicated by the hazard impact).
  - Anterior neck through the cervical collar (for tenderness, deviation, or crepitus).
  - Thorax (for tenderness or for subcutaneous or bony crepitus).
  - Abdomen (for significant tenderness and/or guarding).
  - Pelvis (push downward on each iliac crest, then pull inward for pain/stability).
  - Roll each thigh to evaluate hip rotation and hip/femur pain.
  - Palpate pulse (for rate and strength) – this can be done while performing the next step:
- Ask patient to wiggle their fingers and toes (assess ability to

follow directions and to complete neuromuscular task).
- View under axillae and roll patient for quick inspection of back.
- Auscultate lungs for normal and equal breath sounds.

A practiced clinician can perform this evaluation in less than 60 seconds and develop an appreciation for findings that indicate potential injury or illness. Based upon this evaluation, availability of follow-on medical care, and the known casualty load, the triage officer assigns the patient to the major, moderate, or minor treatment area. If a life-threatening problem is identified during this evaluation, the triage assessment is aborted and the patient transferred immediately to major treatment area practitioners.

  - Triage limitations: The context and nature of patient triage under duress is such that it is never a perfect screening process. **Patient triage is by definition a superficial evaluation. Triage should therefore be considered an iterative activity, with repetitive examination/re-triage of each patient until a thorough medical evaluation is performed.** Additionally, competent clinical staff should be assigned to monitor the delayed category patients, with a protocol in place for rapid re-evaluation and transfer to a higher-level patient care area if concerning signs or symptoms evolve.

Patient triage is by definition a superficial evaluation. Triage should therefore be considered an iterative activity, with repetitive examination/re-triage of each patient until a thorough medical evaluation is performed.

- Patient registration: In a patient surge situation, initial patient registration should be abbreviated, obtaining only the information necessary for adequate patient identification and tracking, test ordering, and delivery of therapeutic interventions. This pre-planned, expedited process may limit patient information to name (if available) and one other identifier (e.g., date of birth or social security number). If this can't be definitively obtained, physical and other characteristics should be collected under the "John or Jane Doe" designation, so that identification may be expedited through missing person lists or through inquiries from relatives to the patient family assistance function. Pre-established charts for emergency response (either electronic or paper) may be extremely helpful for the initial processing of these patients. Some systems have pre-developed registration numbers assigned to the charts, indicating that they are members of the incident cohort. A more definitive registration can be accomplished at a later time. This adjustment is in fact an example of "engineered degradation" (see Lesson 2.1.1 and later in this lesson[44]).

[44] Emergency Managers should be cognizant that many electronic medical record (EMR) systems have been developed with financial accountability in mind and not operational

Healthcare Systems should maintain a capability to account for patient belongings.

- Accountability for patient belongings: For situations involving surge capacity and capability, special consideration should be given to processing patient belongings. One method that promotes consistent accountability despite the context of emergency response is presented below.

  - Matching numbers: Each patient receives a numbered plastic necklace or bracelet upon arrival, with the number matching the pre-designated emergency chart number and the numbers on accompanying belonging bags (see below).

  - Bagging possessions: Patient receives two plastic bags – one large and one small – with the same numbers permanently attached. The small bag is used for valuables and the large is used for clothing. In the case of contaminated patients, this process separates valuable items from common clothing, which could assist in ultimate disposal. In all cases, securing valuables separate from clothing allows the valuables to be stored in a more compact secure location (such as a safe) until they can be returned to the patient or family members.

  - Securing and chain-of-custody issues: Patient belongings should be secured by security personnel, who can provide for chain of custody and forensic purposes. This could be valuable during forensic investigations, especially for the unlikely (but possible) scenario where perpetrators are among the incident victims in an intentional hazard event.

- Patient evaluation and treatment: The Planning, Logistics, and Finance/Administration Sections should all provide necessary support to the Operations Section such that patient evaluation and treatment is as close to regular procedures as possible. It is the activities of these sections in addition to efficient Management that leverages existing resources to provide "Medical Surge." However, a significant difference for personnel may exist in reporting requirements, such that clinicians provide additional information to their superiors (e.g., to an Operations Branch Director). Reporting could include types of patients evaluated or resources utilized, so that near-future needs may be projected. Furthermore, practitioners may find directives issued by supervisors that changes care delivery. For example, the administration of certain types of medications or use of specific medical diagnostic evaluations may be dictated by information

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expediency. Modification of usual methodology may be necessary to permit rapid entry of multiple patients into a system for accountability and ordering. Demographic information may then be collected later after initial treatment is initiated.

submitted by jurisdictional authorities (e.g., work-up of potentially exposed infectious disease patients).

- Maximizing Surge evaluation and treatment **capacity**: It is critical to achieve this through a reasoned, organized approach. A range of strategies can be applied to achieve maximal capacity for evaluating and treating victims. These include:

  - Focused scope of treatment: Patient evaluation and treatment may focus initially on life- or limb-threatening conditions. Less concerning ailments (e.g., closed upper extremity fracture, simple lacerations) may receive delayed attention to treatment.

  - Additional treatment areas: The use of additional treatment areas may become necessary. These initial alternate care sites might include post-operative suites, endoscopy and other specialized diagnostic and treatment areas, then lobbies, outpatient clinics, or other areas that, ideally, were identified, assessed and prepared during the preparedness phase of the emergency management program. It is best to stratify these areas, so that "major category" cases (see triage category definitions above) are cared for in areas that commonly provide sophisticated medical care.

  - Additional clinical personnel: Additional personnel, internal or external to the healthcare system, may be integrated into Incident Operations by Command. These additional personnel assets will only be useful to the Operations Section if other components of the system have done their job in adequately requesting, screening, training, and supporting them (see volunteer management).

  - Integrating clinical personnel into unfamiliar patient treatment areas: Physicians, nurses, and others conducting patient evaluation and providing medical care will be much less efficient in a new healthcare setting than those familiar with the treatment area. This issue may be addressed by establishing "Patient Care Teams" (essentially "strike teams" in NIMS terminology), pairing one clinical staff member from the treatment area with clinical personnel brought in from elsewhere. Patients triaged to that treatment area are then assigned to specific teams. The team member who is familiar with policies, procedures, location of medical supplies, and operation of medical equipment may be designated the team leader, rather than the senior clinical provider.

  - Appropriate support to skilled clinical personnel: Another strategy that can maximize skilled care capacity (critical care units,

Healthcare System surge capacity and capability considerations must be addressed during Incident Operations.

emergency department, and other functional areas) is to provide competent personnel to perform the more general patient care tasks, allowing skilled personnel to therefore care for a larger number of patients. For example, recruiting emergency medical technicians to perform serial vital signs, assist with moving patients, drawing blood for lab work (if qualified), and other time-consuming tasks may allow critical care nurses to care for more patients than usual during the patient surge capacity crisis.

- Additional supplies: Pharmaceuticals, disposable supplies, and durable goods may be obtained by Logistics personnel through outside sources and provided to the Operations Section during Incident Operations. Similar to the concept of processing volunteer personnel, these supplies should be screened (by pharmacy, bioengineering, or other appropriate experts), and provided upon request with instructions on how to use them. Maintaining accountability will be important for financial settlement later and so should be accomplished if possible.

- Surge evaluation and treatment **capability**: In some incidents, healthcare organizations may receive patients with medical issues not commonly encountered at that particular facility (see Lesson 3.1.1). Examples include pediatric cases in a non-pediatric facility, burn and trauma patients in non-trauma centers, dangerously contaminated victims, very unusual and contagious infectious disease, and severe pulmonary cases in community hospital settings. Similar to surge capacity, carefully developed strategies for **surge capability** can maximize the quality of care, the protection of workers and other patients, and the confidence of treating personnel.

  - Obtaining expert guidance: A critical step can be obtaining expert advice on evaluation and treatment of unusual patients or unusual medical problems unfamiliar to the clinical and/or clinical support staff. This may be obtained through remote access of medical experts, nursing, laboratory or other appropriate technical experts. It may be as simple as telephone calls, video conferencing or other interactive telemedicine methods. This can be invaluable to treating personnel both in receiving advice as well as receiving reassurance that they are providing adequate care under the circumstances. Advice should be sought through institutions not impacted by the hazard or mass casualties. In ICS, this is usually the job of the Planning Section to 1) identify a source or the advice and 2) to set up a method to convey the advice effectively to the Operations Section. Communications Unit personnel may be assigned to establish and maintain the remote link between experts and clinical providers.

  - Decomposing critical care services to develop strategic plans for optimal patient care: Some specialty illnesses and injuries, such as burn cases, can be managed adequately in regular medical facilities during the initial treatment period. For example, burn victims need airway management, pulmonary support, pain control, management of body fluid and electrolyte loss, and attention to thermal regulation while minimizing infection exposure. This can be accomplished in non-burn centers for the first 24 hours, possibly longer with expert telephonic advice and possibly with physical arrival of burn experts to more closely assist in care. Burn center services such as skin grafting, tissue debridement, and other important services are necessary later, but the need varies by depth and size of the burns and the involved body surfaces. Strategic advice, in addition to the tactical patient care recommendations, may be sought to prioritize patient transfers as transport services and receiving burn centers become available. Using strategies such as this injects a logical planning basis to an otherwise overwhelming situation and may enhance patient outcomes.

- Patient transfers: During regular healthcare facility operations, the individual practitioner may be responsible for setting up the transfer arrangements for an individual patient. This may vary during emergency response and recovery, when the act of transferring a patient or multiple patients takes on new significance. The workload and focus on special circumstances, accountability, and other issues may best be addressed through a functional "Patient Transfer Group," with "safe and efficient patient transfers" as their objective. This decision should involve the Operations Section Chief, and the transfer process may involve the Senior Liaison Officer interacting with a local or regional Tier 2 healthcare coalition to identify accepting facilities, available patient care providers, and appropriate transport assets. During incidents in which large numbers of patients are being transferred (such as full evacuation), Command may choose to elevate this function and establish a "Patient Transfer" Branch with responsibility for overseeing this activity for the healthcare facility.

Patient transfers may require the establishment of a separate branch in the Operations Section depending on the volume of transfers.

- Ancillary diagnostic services: Patient surge can stress diagnostic services as well as patient care. Careful attention should be paid to developing methods for processing larger numbers of lab studies, both in patient-care areas as well as in the labs and imaging (radiology, ultrasound, MRI) areas. Expanding capacity without compromising quality, accountability, and speedy return of results is the goal. If enhanced capacity is severely challenged, consideration should be given to establishing a prioritization scheme (i.e., "triage") of

these diagnostic services. In some cases, it may be prudent to assign qualified medical personnel to triage use of these services in the clinical areas. Additionally, the expanded use of point of service (bedside) testing devices may augment diagnostic capacity.

Healthcare System capability to identify abnormal behavioral reaction to a hazard and to provide care for patients with these findings should be available.

- Patient psychological support: Psychological effects from a hazard impact are not necessarily pathologic. In fact, psychological stress is an expected reaction to many extreme incidents. The challenge is to discern which reactions are normal but may be helped through general psychological support measures and which indicate the need for mental health intervention. Furthermore, some behavioral changes can be delayed in their manifestation. For these reasons, it is essential that psychiatric and behavioral health professionals are included "real time" in surge capacity and capability response to patient-care areas. **The most valuable psychological interventions may be the provision of accurate and understandable information (best in a written format) regarding the nature of the hazard impact, the care delivered, future actions (including long-term surveillance if indicated), and the signs and symptoms of normal stress reactions.** Behavioral health interventions may be required for those with unusual reactions to the hazard impact (expected to be the minority) and for those with pre-existing psychiatric illness that deteriorates under the stress of the post-impact situation. An example scheme of psychological support measures for chemically contaminated patients is presented in Textbox 3.2.5.3.

Textbox 3.2.5.3

Chemically Contaminated Patient Psychological Support Considerations[45]

- Provide step-wise information to victims as it becomes available: what steps are being taken for the patient's care, results of testing as available, credible event information as it becomes available, and so on.
- Stress the positive actions being taken.
- Provide written information as soon as possible after decontamination, triage, and initial treatment. Include agent specific information (summarized for patients) as appropriate.
- Assure full registration of all victims (for entry into a long-term surveillance program that is established).
- Explain to observed patients that they are being monitored for delayed symptoms.
- Explain to discharged patients that a surveillance system may be instituted to assess late symptoms and to provide further information or treatment as it becomes available.
- Provide individual evaluation by mental health workers and treatment as indicated.
- Provide small group and individual counseling (as available) for those who request it.
- Provide written information on stress and on stress control resources, including resource telephone numbers.

- Fatality management: In most situations, field fatalities will not be transported to the healthcare facility (e.g., after an intentional event, fatalities are typically secured in the field as part of the criminal investigation). Despite this, an unusual number of initially live victims may expire early in their hospital course. Most traditional preparedness resources focus only on the extra space required to store human remains (and the unique requirements a specific hazard may dictate – e.g., chemically contaminated, isolation of corpses). Little discussion is traditionally offered on the unique requirements for management and disposition of the deceased, yet this is one of the most critical aspects of successful response in many incidents. Initiation of the bereavement process and community closure may

Healthcare System fatality management may require additional measures as dictated by the jurisdiction.

[45] Barbera, J; Macintyre, A; DeAtley, C. *Chemically Contaminated Patient Annex: Hospital Operations Planning Guide Final Draft*; Washington D.C.; The George Washington University Institute for Crisis Disaster and Risk Management; August 23, 2001.

only start after the successful securing, identification, and return of the deceased to their families. The healthcare facility can have a significant role in this process:

- Identification: The positive identification of the deceased may be challenging after certain hazard impacts. Securing personal possessions and having procedures to keep them associated with the human remains may be extremely helpful later during the identity confirmation process. In addition, information not typically considered important may take on new forensic or epidemiological relevance as an incident or the investigation unfolds. For example, during outbreak investigations, obtaining specific demographic information and recent activity information on the deceased from other sources may become important in defining the parameters of the outbreak. These types of activities must be coordinated with the jurisdiction.

- Disposition procedures: Depending upon the nature of the incident, disposition of the deceased may vary significantly from usual methods. These variances may be even greater after an intentional or terrorist event because of the necessary criminal investigation. If new procedures are not provided to the healthcare facility early in these incidents, it is advisable to query jurisdictional authorities for alterations from usual procedure. If the deceased are denoted as medical examiner (ME) or coroner cases, the healthcare organization may have to store the remains for an extended period as the predictably overwhelmed ME deals with field cases. In natural incidents (e.g., pandemic), healthcare organizations may have to establish processes that facilitate rapid issuance of death certificates to promote rapid release of remains to families/funeral homes.

- Notification: Tracking the deceased and providing timely notification to family members is an essential activity of the Operations Section, but should be assigned to personnel outside the clinical treatment area. Many of these considerations are similar to those for live patient tracking presented below. Conducting the process of locating family members and informing them of the death may be an appropriate duty for the family assistance area.

Healthcare System patient tracking requires coordination internally and externally.

- Patient tracking: Identifying patients and tracking their clinical conditions and location within the healthcare system directly addresses patient care and patient family assistance. This is in line with the organization's incident objectives and, therefore, the work performed in tracking patients is best situated within the Operations

Section. The information generated is transmitted to the Planning Section, Situation Unit for collation and dissemination and for inclusion in incident action planning activities. The Situation Unit is responsible for establishing the frequency of reporting. This is a critical activity during response to hazards that have generated mass or unusual casualties:

- Internal tracking: There are many ways in which patient tracking may occur, ranging from paper-based systems with runners to high-tech solutions with remote tracking devices on the individual patient's stretcher or wheelchair. Every method requires significant participation from numerous healthcare facility personnel and, therefore, the specific tracking system used should be familiar to all clinical supervisory personnel. It should be considered an important competency for all personnel staffing these positions. The information that is generated should be forwarded to both the Planning Section and to any family assistance area that has been established. Similarly, names from the patient discharge area (see above) should be forwarded on a regular basis to the Situation Unit.

- External coordination: In many incidents, an extraordinary burden is placed on hospitals by public inquiries regarding patients receiving care at the facility. Inquiries may be received in multiple different areas throughout the hospital (Healthcare System Command Post, clinical areas, family assistance areas). A uniform policy for handling inquiries should be developed early in the incident (ideally from guidance in the EOP) and disseminated to all personnel. The policy should address patient privacy (see Textbox 3.3.5.3) and other regulatory issues.

Textbox 3.3.5.3

HIPAA and the Use of Patient Information during Emergency Response

As the time this text was written, no standard variance to the application of HIPAA regulations during emergency response had been developed. The following statements are summaries of comments provided by the Department of Health and Human Services (DHHS) during recent responses to Hurricane Katrina:[46]

- Telephone calls seeking a patient by name: The healthcare system may affirm or deny that the patient is receiving care in the facility. The "general condition" of the patient may be conveyed as well.

- Information to authorized (by law) relief agencies: The healthcare system may share patient names with these agencies and "it is unnecessary to seek patient permission to share information if doing so would interfere with the organization's ability to respond to the emergency."

- Information to the general media and public: If the patient is incapable of giving permission, the healthcare organization can share information with the media and general public in order to notify family members.

- All other circumstances: For all other circumstances, patient verbal permission, at a minimum, should be sought prior to the sharing of information (this is exclusive of other usual HIPAA allowances, such as the sharing of information with public health agencies).

- Patient family assistance: This is a critical service area that requires significant attention both during preparedness and during incident response, if surge capacity is to meet incident needs. Essentially, this functional area performs all services related to family interface that are usually conducted by emergency department staff during normal operations. These include:

[46] U.S. Department of Health and Human Services Office for Civil Rights. Hurricane Katrina Bulletin #2: HIPAA Privacy Rule Compliance Guidance and Enforcement Statement for Activities in Response to Hurricane Katrina (September 9, 2005). Accessed February 4, 2006 at: http://www.hhs.gov/ocr/hipaa/EnforcementStatement.pdf

- Addressing inquiries about whether a person is under care at the facility.

- Confirming that patient inquiries are coming from family members with legitimate right to patient information (this is particularly important if public figures are involved in the casualty incident).

- Confirming that a missing family member is a patient in the healthcare facility.

- Confirming that a missing family member is **not** a patient in the healthcare facility and maintaining contact information so that if the patient arrives later, the family can be notified. While it is important to know that a specific patient is in the facility, it is just as important to **definitively know that a patient is <u>not</u> in the facility**. This can be quite difficult, especially early in the incident or if multiple unidentified patients are transported for care. Telephone inquiries could be overwhelming if not efficiently managed, which should include the use of advanced technology to register the callers for verification and possible call-back after determining whether the missing family member is present. This must be effectively addressed both for humanitarian reasons as well as to minimize the physical arrival of people looking for loved ones.

- Conveying health information from family members to patient care providers, which is especially important for incapacitated and pediatric patients.

- Conveying messages from family members to patients in lieu of a physical visit. This may include arranging telephonic communication between patients and family members.

- Providing patient condition updates for family members.

- Arranging escorted visits to patients when deemed acceptable by clinical area supervisors.

- Providing a comfortable area for family members to wait for additional information or until they can visit with the patient.

- Providing information to family members on lodging, victim services, and other potential assistance.

- Providing pastoral care and psychological support to family members as indicated.

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Lesson 3.2.6 Concept of Operations for Healthcare Emergency Response and Recovery: Incident Operations Stage – Operations Section Actions in Protection and Security and Support to External Requirements

Lesson Objectives

- *Define specific activities that may be conducted by personnel assigned to the security group in the Operations Section.*
- *List specific considerations related to the "protective" actions of sheltering in place and evacuation.*
- *List potential types of support that can be provided to external response entities during emergencies or disasters.*
- *Outline important operational considerations for Memoranda of Agreement or Understanding that could govern provision of support to external requirements.*
- *List specific personnel considerations that the healthcare organization should address during preparedness and response when deploying these individuals to support external requirements.*

Security and Protection

Security and Protection capabilities of the healthcare system can, in certain situations, be critical to emergency response success; effective response mechanisms could contribute to strategic goals such as:

- Decreased morbidity and mortality for individuals within the organization.
- Maintenance of a positive overall public image of the organization.
- Survivability of the organization itself.

As with continuity of operations or medical surge, activities related to Security and Protection may also occur in other Operations Section branches beyond the one entitled Security and Protection (see evacuation example below).

The role of the senior positions in the Security and Protection Branch, including its group supervisor positions if staffed, is to coordinate actions across the organization related to protection and security, after the decision is made to initiate security and/or protection actions.

Security Group

Example security-related issues for a healthcare system during emergency response and recovery have been raised throughout this text. They are summarized briefly here:

- Pre-planned surge of security services: Multiple security activities may be required simultaneously during an incident. Since the number of healthcare system security personnel on duty at any one time is usually limited, pre-planning should address coverage of some responsibilities with non-security personnel (as appropriate) or with assistance from outside law enforcement agencies or through mutual aid (if available).

- Perimeter management: Perimeter management is an important early responsibility in many incident types. This can be challenged by day-to-day typical arrangements in which many hospitals are actually open facilities with relative ease of access from many entrances. An initial priority in incident response may be to secure the facility and control methods of ingress and egress. This may require an initial "lock down" in which all external portals are closed to all traffic until further understanding of the situation is achieved. Perimeter management is then conducted as appropriate for maintaining control and assuring a safe internal environment.

- Perimeter categories: For healthcare organizations, three categories of perimeter should be considered, since each has distinct strategy.

    - Management of the campus and its perimeter: Some healthcare systems with large campuses should consider concepts related to limiting vehicular traffic and preventing or controlling foot traffic during emergencies. In many situations, particularly those with contaminated casualties, arriving individuals should be queried at traffic or pedestrian checkpoints external to the facility and directed to appropriate facility entrances.[47] Otherwise, prominent signage should be immediately deployed to guide people to the appropriate entrance to the external facility perimeter. Traffic direction is another important element of the campus perimeter management by personnel in the security group. Important concepts include:

        - Assuring safe and effective vehicular traffic flow to prevent bottlenecks or unsafe pedestrian crossings. Traffic marking systems and temporary barriers to guide traffic flow for drivers

[47] In some situations, this may require the use of PPE by personnel staffing the portals, such as during the receipt of potentially contaminated patients.

may be necessary; coordinating with engineering and grounds personnel may ne necessary for this to rapidly occur.

- Providing easy turn around capability (i.e., preventing dead ends).

- Providing separate traffic lanes for vehicles with patients for drop-off, and assuring that unauthorized parking is avoided. Rapid access to vehicle towing capabilities may be necessary to keep traffic flowing.

- Providing vehicular access for healthcare system personnel, with directed parking as indicated.

- Providing marking systems to make security personnel more visible to drivers may be indicated for safety.

○ Management of the external facility perimeter: In some emergency situations and for some healthcare organizations, the best approach to crowd management and protection of the organization is to separate individuals based upon their purpose for converging on the facility as the emergency evolves. Separate entry portals for each category may then be designated. Alternatively, some organizations may address this after entry into a secured area.

- Patient entry: Clearly designated and well-managed portals of entry to the hospital may be necessary for patients to be rapidly processed. In some incidents, entry will vary from usual patient entrances (e.g., mass casualties to a separate patient reception and triage area, contaminated patients to the decontamination area, incident patients to an alternate care facility if the ED has been impacted).

- Staff entry: Staff reporting for duty from outside locations should have a designated entrance separate (if possible) from those for volunteers, visitors, patients, and the media. Security personnel may be needed to screen incoming personnel for current identification (ID) badges. A pre-planned process can facilitate and expedite the time-consuming task of verifying personnel arriving without IDs.

- Volunteer entry: A separate volunteer entrance steers arrivals to the volunteer reception facility where they may be processed and staged if their assistance is anticipated. This may be especially important for volunteer convergence offering spontaneous assistance during high profile incidents, as

witnessed by multiple hospitals in the immediate aftermath of 9-11 crashes.

- Family members and other visitors: Persons seeking information regarding patients should be directed to the entrance that leads only to the patient family assistance area. Family members and acquaintances of patients seeking news regarding loved ones will generally attempt to congregate at patient receiving and patient care areas. During initial stages of an incident (regardless of hazard etiology), family members may need to be siphoned away from patient care areas as the family assistance resource is activated.

- Media entry: Vigilance to prevent inappropriate entry by media and others is important. It is not unheard of for members of the media to pose as incident patients or other roles to gain access to treatment areas, so careful screening of patients and visitors is necessary.

- Equipment and supplies entry: The loading dock or other entrances that can accept equipment and supplies in a controlled but efficient manner should be identified and marked, especially if mutual aid or unusual vendor resources are expected. This will promote rapid availability of resources from transport services not familiar with the organization's campus and physical plant.

Some healthcare systems have the luxury of electronic lock systems that can facilitate securing access to a facility. The initiation of such types of lock down must be well coordinated with the healthcare system IMT. Other facilities may recruit and assign non-security personnel to rapidly control facility entrances according to pre-planned guidance and training.

- Internal facility perimeter management: As the healthcare organization responds, particularly sensitive response areas within the facility may need to restrict access through internal perimeters. Otherwise, a frequent phenomenon is the convergence of staff at these sites ready to help, but without specific assignment. This results in congestion, privacy issues and difficulty in managing emergency operations. Effective internal perimeters constrain personnel resources and spectators to authorized staff only. Examples of facility resources where perimeter management should be considered include patient receiving areas, the Healthcare System Incident Command Post, patient reception and DECON areas, and supply receiving areas. Some issues from past

experience in controlling this often well-meaning but disruptive convergence includes:

- Incorporating procedures for maintaining control of key internal facilities: In developing the EOP, this issue should be addressed. It may be as simple as constructing a narrow entrance with a prominent sign that clearly states the criteria for entrance, or it may be an entrance staffed with personnel to screen entry.

- Allowing appropriate entry: At times, it can be difficult for security personnel to easily identify who from the healthcare system staff should have access to an internal site. Options include a specific marking system (different colored ID badges that are handed out at the beginning of the incident) or assigning a senior level staff member to work with security and can confirm the necessity of individuals to enter. This latter approach may be particularly important when the victims or victim families include celebrities or individuals requiring special security (e.g., political or entertainment figures).

- Providing understanding and direction through instructional programs: The reasoning for restricting certain areas, the procedures for conducting screening, and the method for entry when assigned should all be addressed during relevant education and training.

Security personnel should have training relevant to crowd control and peaceful means of managing such situations. In many cases, the best management of crowd action includes providing actionable information through signage, printed materials, or carefully developed briefings. This information and its delivery, however, should be closely coordinated with the healthcare system IMT. Access to equipment such as speaker phones (bull horns) is a simple but often overlooked concept. Guaranteeing access to the facility by going around or facilitating passage through the crowds for essential personnel and patients is a critical issue to address during planning.

- Response to security threats: Security threats may be the primary impetus for activating the EOP, or they may be only a sub-element in the overall incident for which the EOP is activated. A range of scenarios may be considered when considering this issue during EOP development, and may be informed by the individual HVA findings.

- Celebrities and the high level protectee: Caring for a single patient that has a special protection status (e.g., high level politician, foreign dignitary) may require limited EOP activation for perimeter management and coordination with the individual's own security team. Perimeter management (external and internal) may need to be enhanced. Security personnel should consider that healthcare system staff may be curious about the individual and attempt to access them or their records inappropriately. Coordination with other operations section branches may be necessary to address:

  - Adequate medical record monitoring to prevent or immediately identify unwarranted access.

  - Coordination of clinical and clinical support services to time patient movement within the facility.

  - Selection of pharmaceuticals that have been ordered (random lot selection) or special dietary considerations.

  Some of these considerations may also be necessary when the facility is caring for certain celebrities.

- Infant abduction: This is a major consideration for any healthcare system that cares for newborns. While commonly addressed only through security and without EOP activation, this scenario may best be addressed through activation of the EOP and an incident-specific annex. Some healthcare systems have invested in sophisticated electronic monitoring capabilities which alarm when an infant is taken from the ward. Most also have policies that monitor who has access to the newborn areas (authorized staff and parents only). Just as important is planning for the failure of these systems and implementing rapid security procedures, augmented where indicated by other personnel, once a missing infant situation is recognized.

- Bomb and other direct security threats: Hospitals are not immune to bomb threats; in fact, some may result from disgruntled employees attempting to negatively impact hospital operations. In addition, recent terrorist activities have suggested that a healthcare facility could be the primary or a sequential target during a terrorism attack. Procedures for verifying a safe environment can be critical to the continuity of regular hospital operations. Concepts include:

- If the bomb threat is identified through a caller, documenting as much as possible about the caller (exact wording, voice tone, male/female, background noise, etc.) may be important.

- If the bomb threat is isolated to a particular part of the facility, securing that area as much and as rapidly as possible, using an internal perimeter may be indicated for a credible threat.

- If the bomb threat is not isolated to a particular part of the facility, providing clear, actionable directions to staff of what to avoid and what to report as examining the facility.

- Close strategic coordination with local authorities is indicated. It is likely that law enforcement authorities will assess the credibility of the threat and conduct (ideally with the healthcare organization's trained personnel) an appropriate search for any device. If a device is located, law enforcement and its appropriate technicians will address the device and provide guidance on safe distances, resulting in evacuation and/or shelter-in-place actions.

○ Tactical interface with law enforcement agencies: Similar to the example of Emergency Department interface with EMS agencies, security personnel may be required to interface with law enforcement agencies at a tactical level (e.g., law enforcement personnel present at the facility). It is important that any information discovered or shared is formally relayed into the incident action planning process for the healthcare system to promote integration into decision making processes. Major strategic issues should be coordinated through the healthcare system IMT (e.g., the Liaison Officer position) with input from security personnel. Alternatively, during an incident with heavy emphasis on security issues, a Liaison position may be staffed by a security professional from the healthcare facility.

○ Conducting chain of custody actions: Some incidents may require the healthcare organization to perform chain of custody procedures for certain items. For example, perpetrators of some intentional incidents could conceivably end up at the hospital as a victim. Providing chain of custody for patients' belongings can be critical for court admissible evidence in later legal proceedings. Maintaining chain of custody of shrapnel foreign bodies removed from patients can also be important in unintentional technological blast incidents. Chain of custody for healthcare organizations refers to documentation of the chronological control of physical evidence from initial collection to disposition, documenting the

location the items are kept, individuals who are directly responsible for them, how they are secured to limit access, and who/how they were transferred to the next section in the "chain" until they are secured by the appropriate authorities in the legal system.

Protection Group

As stated throughout the text, protective actions in the healthcare system can encompass multiple activities, some of which would not be directly conducted within the Security and Protection branch. Collectively, these activities are often referred to as Occupant Emergency Procedures. The major examples presented here for discussion include sheltering in place, facility evacuation, and decontamination of patients prior to entry to the facility. The latter has already been discussed above under medical surge capacity and capabilities. Some healthcare systems might choose to place the personnel positions supervising the actual reception and decontamination of the patients under a protection branch.

- Shelter in place: The collective term "shelter in place" can be misleading as it often refers to a wide range of actions, depending upon the hazard, rather than a single standardized procedure. It may be more appropriate to refer to hazard-specific and incident-specific annex titles rather than generic shelter in place when developing plans, training and specific guidance. For example, pre-planned shelter-in-place activities may be very different for staff when reacting to an imminent tornado impact versus an incoming hurricane or snow storm. Different sheltering in place may be necessary due to access restriction from a hazard impact external to the healthcare system (e.g., prolonged road disruption due to an earthquake), versus an external threat that threatens harm (e.g., an impending tornado strike versus a planned civic demonstration that may become unruly) versus a threat inside the healthcare organization (e.g., a potential active shooter within the facility[48]). Providing specifics for all types of shelter in place is beyond the scope of this text.

- Evacuation: Evacuation of any residential healthcare facility is an extremely complex undertaking. At the same time, evacuation should be addressed for projected situations identified through the HVA

[48] Active Shooter: one or more subjects who participate in a random or systematic shooting spree demonstrating their intent to continuously harm or kill others. These situations are dynamic and evolve rapidly, demanding immediate deployment of law enforcement resources to stop the shooting and limit harm or loss of life to innocent victims; definition from: J Beau. *Active Shooter: Protecting the Lives of Innocents in Shooting Situations (2006).* Regional Organized Crime Information Center Special Research Report; accessed April 30, 2010 at: http://info.publicintelligence.net/ROCICSpecialResearchReportActiveShooter.pdf

process. Though this lesson is focused upon the Operations Section of the healthcare system, some of the concepts below are more appropriately the responsibility of Command and General Staff - they are placed here due to their relevance to the topic and the direct supervision of the evacuation actions by Operations Section positions. An example construct for an incident/hazard specific annex for facility evacuation has already been provided in lesson 1.5.4. important evacuation considerations are discussed here.

- Full versus partial evacuation: Many hazard impacts will only require evacuation of one section of the physical plant. Staff and patients can often be accommodated within another section of the facility with adequate pre-planning, at least on a temporary basis; they may then be relocated to a site external to the healthcare facility under more controlled circumstances. Full facility evacuations tend to be relatively rare but also create a much more significant impact on the organization.

- Timing of evacuations: Hazard impact may necessitate immediate evacuation of the facility or allow a more staged and controlled pace. It is helpful to distinguish planned procedures according to the timing and urgency of the projected situation: emergent versus urgent versus semi-urgent. Procedures may vary between them based upon risks, costs, and other considerations.

- Recognizing the indications for evacuation: Initial recognition of the need to evacuate, across the range of incident types, can be obvious or subtle and the indicators can come from various sources. Initial information must be fed to the Baseline Situation Unit mentioned earlier in this unit. Important factors in making that decision includes a determination as to whether a safe environment can be maintained through usual or shelter-in-place procedures if a decision not to evacuate is made.

- Timing the decision to evacuate: For many hazard impacts that occur with little or no warning, the decision to evacuate factors into consideration the current impact and the projected additional issues in maintaining a safe environment. For approaching hazards such as hurricanes for coastal communities or rising rivers for flood-prone communities, both the realistically projected impact and the carefully developed assessment of the organization's ability to maintain a medically safe environment should be considered. The timing for the final decision of "go or no-go" should be determined to be the time when a safe, orderly evacuation is still possible. Preparedness for this eventuality therefore includes a full understanding of the evacuation process

and the time and resources necessary to conduct a safe and orderly evacuation.

- Evacuation decision authority: The authority to initiate evacuation must be carefully defined and clearly presented in an EOP. Personnel should be given the authority to move patients and staff from immediate harm's way, and this is a common understanding for common risks such as fire. Specific positions, however, should always be staffed and available within the facility with the authority to initiate a full scale emergency evacuation according to pre-developed criteria. Consideration should also be given to external authorities (e.g., Fire Department officers) that may have the authority to order evacuation. Executive positions that make evacuation decisions for less-than-emergent situations should also be delineated, since these may be agency executives higher in authority within the organization than the IMT.

- Evacuation notification: Initial internal notifications must be very clearly worded to avoid confusion or inappropriate staff reaction. Templates and other guidance for these may best be established within the relevant hazard-specific or incident-specific annex. Early external notifications should be rapid to facilitate assistance requests. Examples include notification to parent organizations, EMS agencies, other jurisdictional agencies, healthcare coalition member organizations, and regulatory agencies as required.

- IMT early actions: Early mobilization of pre-planned staging areas for evacuating patients, for transport vehicles, and for arriving equipment and supply resources is important. The organization's incident command post (ICP) may need to be relocated from its usual planned facility, ideally using a back-up facility with pre-planned mobilization guidance, and templated messages to notify personnel and relevant outside organizations of the new ICP location.

- Establishing a priority of patient cohorts to move from their usual location and for transport elsewhere: This can be very incident specific and depend upon immediately life-threatening danger, the availability of resources (personnel to move patients from the impacted facility, staging areas, transport vehicles and staff, available patient destinations) and other considerations. If, for example, a full scale evacuation is under way, priority may be given to more mobile patients as non-ambulatory patients may take longer to prepare for movement. Pre-planned templates for full scale evacuations can be helpful during times of crisis (e.g., listing patient care departments and which should move first).

- Planning specific evacuation routes and accountability procedures: Evacuation routes should be identified and secured early in the incident. This may necessitate certain activities such as securing elevators early (if functional) to ensure priority patient populations have access and they are not being unnecessarily diverted by staff. It may also include pre-planned guidance tool for deploying personnel and equipment to specialty floors to assist with rapid evacuation. Finally, each evacuating area should have identified rally points outside the facility to account for staff, patients and visitors. Methods for documenting this tabulation and reporting it up the protection group should be in place.

- Alternate care and patient staging areas: Personnel supervising the evacuation from the protection group should verify that planned patient staging areas and alternate treatment sites are mobilized, staffed and functional, or else identify alternate locations.

- Related activities outside the scope of the Protection and Security Branch: During evacuation or shelter in place actions, other positions within the IMT have important functional responsibilities.

  - Liaison Officer: This position has many tasks, but during evacuation the most significant may be liaison with external healthcare organizations to locate available resources to accept patients and to work with transporting agencies. These tasks may require multiple liaison officer deputies to address the expected heavy work load.

  - Safety Officer: It is important for this position to monitor the shelter in place or facility evacuation actions, which include safe patient movement during evacuation or shelter in place activities.

  - Public Information Officer: Relevant activities include providing public information regarding the evacuation and intended transfer of patients during evacuation, or alternately providing information on the shelter in place status and, if indicated, the safe conditions for patients and staff.

  - Operations, Healthcare Services Branch: A range of activities are important during these unusual situations.

    - Patient care supervision: Addresses ongoing patient care requirements whether pre or post evacuation or during shelter in place.

- Patient evacuation: Teams designated to physically move patients. The majority of these positions may be the same personnel as patient care providers.

- Patient transfer: Personnel monitoring and tracking offers of assistance, assigning appropriate transfers, and contacting assisting facilities.

- Patient transportation: Personnel working with transportation assets to affect transfers and tracking patients and transport vehicle information as they depart.

  - Security and Protection Branch: Roles include securing the facility to prevent unauthorized access, providing security to alternate care sites and staging areas, but also directing arriving resources that were requested for assistance (e.g., transport vehicles for evacuation, patient care personnel and relevant equipment for shelter in place). In addition, Protection Group personnel may manage the tactical issues associated with egress from the facility, such as managing elevator usage, sequence of ward evacuation, and directing personnel to safe egress or to safe shelter in place locations.

  - Continuity Branch: Personnel from these positions address the hazard impact that precipitated the evacuation or shelter in place. They may provide services that maintain a safe environment for shelter in place, or that preserves infrastructure continuity as much as possible as the facility is evacuated. Continuity branch personnel assigned to address business continuity may focus upon evacuating records or confirming remote access to medical records and billing information. An important infrastructure continuity function might be to establish an alternate location for the healthcare system IMT to operate during a potentially extended period of time.

- Special patient considerations during evacuation or shelter in place: Emergency Managers may wish to pre-plan guidance that addresses special situations during evacuation or shelter in place, such as non-typical movement of patients and staging procedures for special patient cohorts, including:
  - Bariatric patients
  - Critically ill patients
  - Intra-operative patients
  - Isolation patients.
  - Patients held against their will (e.g., prisoners, psychiatric cases under involuntary commitment).

- Post-evacuation facility actions: After a full facility evacuation has been completed, a judicious use of personnel may be to designate personnel to care for patients at other facilities. The activities necessary to support this are similar to those discussed below under support to external requirements. Facilities personnel will likely remain behind to address the hazard impact on the physical plant and expedite the return to operations if that is possible.

- Transition to recovery: Evacuation or shelter in place guidance should provide for a smooth transition to recovery processes which will necessarily be complex and involve a wide variety of activities. These will include careful facility evaluation, rehabilitation and recertification. Repatriation of patients and staff from the shelter in place or from the evacuation locations can then be accomplished.

Support to External Requirements

Healthcare systems may establish formal relationships with other organizations to support their needs during an emergency or disaster response. Depending upon the support provided, this can require robust or lean management procedures that should be outlined in the EOP. The types of support that may be provided can be categorized as:

- Facilities: Healthcare organizations may offer the use of facilities to external entities for use during emergency situations. One of the more likely situations is for healthcare facilities to offer patient care beds to other local healthcare organizations for patient transfer. This is now commonly accomplished through mutual aid instruments between healthcare coalition member organizations. Another example is participation in a national system for accepting patients from a disaster situation and providing definitive care, through commitment to the National Disaster Medical System (NDMS).[49]

- Personnel: Healthcare organizations may offer the use of their personnel in certain situations. This can occur through deployment of individual personnel or organized teams (alternatively called an integrated service unit). The processes and procedures for providing this type of assistance can be quite complex and are discussed later in this lesson.

[49] US Department of Health and Human Services/ Assistant Secretary for Preparedness and Response. *National Disaster Medical System (NDMS)*. Office of Preparedness and Emergency Response; web site accessed April 30, 2010 at http://www.hhs.gov/aspr/opeo/ndms/index.html

- Equipment/supplies: Healthcare organizations can provide external assistance through the provision of physical items such as medical supplies, durable and non-durable, as well as pharmaceuticals. This can include supporting other healthcare organizations (mutual aid or cooperative assistance) or through more limited activities such as the restocking of EMS units.

- Services: Healthcare organizations may also provide a combination of facilities, equipment and personnel that provide services or advice. Services could include priority healthcare evaluation and treatment for responders that become ill or injured, or specialized evaluation of responders after a hazard exposure. Healthcare personnel may also be tasked with provision of expert medical advice to emergency management, public health, fire services or other authorities.

The provision of assistance to external entities is most often governed by some form of pre-established instrument. A range of instruments exist for capturing the intentions of parties for desired courses of action during emergencies. These include memorandum of understanding, memorandum of agreement, contract, and other instruments, but discussion of these is beyond the scope of this text. Legal counsel should be consulted before entering into any of these relationships.

Deploying personnel to support external requirements

Because providing personnel to support external requirements of other response entities is a complicated subject area, further concepts related to this activity are provided here.[50] The relative importance of each issue may vary depending upon the personnel assignment and proximity of the deployment to the home organization.

- Preparation of personnel: Healthcare systems that deploy personnel to support external missions have an obligation to prepare those individuals to be both safe and operationally effective when deployed. Issues to be addressed include:

    - Promoting personal readiness for deployment: Individuals should be given guidance to promote their personal and family preparation for the individual to deploy to support external requirements.

        - Timing of deployment window and potential durations of expected deployments.

[50] See Unit 5, deployment competencies for personnel deployed to distant emergencies.

- Communications methods the individual may have access to contact family while deployed away.

- Guidance as to whether austere conditions can be expected while on assignment and how to adjust to them.

- Signs and symptoms of deployment and post-deployment stress and mechanisms for accessing assistance if this becomes an issue.

- Information regarding family assistance programs that may exist while the individual is deployed (for example, resources to assist deployed personnel's families with emergency home repairs).

- A list of important financial and legal affairs that the employee should have in order before deployment (e.g., wills, bill payments, power of attorney, etc.).

- Physical fitness requirements for deployment as established by the home healthcare organization. This may include attention to particular vaccinations and psychological screening of individuals who may be deployed.

- Provision of lists of supplies the individual should keep on hand for deployment as well as supplies the assisting or supported organization will supply to the employee. This can include types of clothing, sunscreen, insect-repellant as well as other various supplies depending upon expected deployment settings. A commonly missed item is for the individual to ensure that they have enough prescription medication to cover their expected duration of deployment.

- Personal documentation that may be necessary as part of a deployment (e.g., passport, driver's license).

○ Promoting professional readiness for deployment: Individuals should be given guidance that promotes their professional preparedness to deploy in support of external requirements.

- Training and other relevant professional preparations necessary to support the individual in his/her expected deployed position. Commonly cited examples are the NIMS courses.

- Licensure, certifications, and other professional documentation that may need to be kept ready and available for the individual to bring on their deployment.

- A general understanding of the response architecture under which they are expected to be operating. For example, if assigned to another hospital, providing an understanding of how they will be managed while assigned at that facility and their potential reporting requirements. This would also include the management construct at the individual's home organization that could be contacted for status updates and for problems while deployed.

- A clear description of expected professional role including expected activities and necessary associated technical skills.

- A description of how the individual's benefits will be addressed while on deployment: disability, professional liability, workers compensation, and general health insurance.

- Procedures for worker pay during deployment.

○ Clear direction on mobilization procedures to the employee: This should include the following mobilization issues.

- Method of receiving notifications regarding potential assignments.

- Method of confirming availability for potential assignments.

- Specific steps required of the individual during mobilization (initial reporting locations, receipt of initial briefings, and issuance of any related equipment by home healthcare organization).

- Any remote assessment that should be conducted by the employee prior to departure that could impact final preparations (e.g., living conditions, assignment, etc.).

- Guidance about any medical screening procedures before employee departs (for acute medical conditions that could negatively impact the employee or the response effort while deployed).

- Guidance for accessing or establishing travel arrangements to deployed mission.

- Ideally, the employee is given the opportunity to rehearse mobilization procedures through drill or exercises.

○ Expected actions while in transit (most commonly relevant during long transit times or distances).

- Points of contact for check in on travel progress or for difficulties in transit.

- Safety and security procedures for transit.

- Accountability procedures for financial reimbursement of travel costs (as appropriate).

○ Projected check in procedures for the individual when on-site.
- Points of contact and locations for check-in should be provided to the deployed personnel.

- If not provided automatically, personnel should request in initial briefing to understand the situation and other factors delineated in the relevant competencies (see Unit 5).

○ Information that can assist the employee in effectively conducting their professional duties.

- Organization structure of the assisted response organization.

- Reporting route and method for receiving assignment in the assisted organization.

- Documentation requirements associated with assigned position (e.g., electronic medical record, unit logs, etc.).

- Schedule of assigned role.

- How to ascertain cultural considerations relevant to the operating environment if relevant.

- Relevant policies the assisted organization has in place (e.g., policy for interacting with the media).

- Methods for identifying stress in responders and in patients encountered and methods for addressing it.
- Skill sets that employee is permitted to perform in their assigned role (these may differ by being more limited at the assisted organization, especially for licensed healthcare practitioners).
- Understanding of how reassignment could be made within the assisted organization.
- Emergency safety directions relevant to deployed role such as shelter in place or evacuation instructions (signal, routes, rally points). May also be applicable to billeted spaces.
- Other safety procedures related to health and hygiene in the workplace and in billeted spaces, including personal protective equipment.
- Procedures for reporting injury or illness.
- ID requirements at work location.
- How to recognize and report safety or security threats at work location.
- Personal health issues that should be maintained such as nutrition, hydration, rest.

○ Necessary demobilization and out-processing procedures.

- Reporting requirements to both assisted and supporting organizations upon completion of task assignments.
- Participating in any evaluation activities of employee's actions in supporting role or exit interviews.
- Return of assigned equipment to either home or supported organization.
- Transit home procedures that should mirror tasks in transit to the deployed location.

○ Post mission recovery activities.

- Records and paperwork necessary for completion.
- How to indicate return to work status.
- How to deal with post-deployment family and work re-unification issues.
- Participation in any indicated post-deployment physical or mental health screening.
- Participation in any indicated post-deployment after action processes.

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Lesson 3.2.7 Concept of Operations for Healthcare Emergency Response and Recovery: Incident Operations Stage – Planning Section Actions

Lesson Objectives

- *List the major responsibilities of the Planning Section during incident operations.*
- *List and describe the key elements contained in a Healthcare System Incident Action Plan.*
- *List the types of meetings to be held under the supervision of the Planning Section and describe the characteristics of each meeting type.*
- *List and describe other types of planning activities related to comprehensive incident action planning that are the responsibility of the Planning Section.*

Incident Action Planning

As previously stated, the ICS Planning Section has two major responsibilities: incident action planning and information management. For smaller incidents in which formal incident action planning is not necessary, the requirement remains for effective information management including the development of regular healthcare facility situation assessments. The Planning Section, therefore, should always be staffed with at least a minimum number of personnel to accomplish the indicated incident planning and information processing tasks.

- Management by objective: As described in Lesson 2.1.3, one of the most efficient methods of managing a complex organization during incident response is through "management by objective," a process where organizational objectives are established and subsequently strategies and tactics (i.e., parameters within which the objectives are to be accomplished) are developed to achieve these objectives. This essentially describes the incident action planning process contained in NIMS/ICS. By establishing incident objectives, healthcare facilities are in a sense developing measures of effectiveness for their response: if at the end of a defined time interval, objectives are being achieved, then the response efforts in that area can be considered successful. The development and internal dissemination of a written incident action plan can facilitate incident information response direction across the organization, as well as providing a basis for conveying information external to the organization. The Planning Section provides the workforce for incident action plan review, revision, and

acceptance by the healthcare organization's IC, followed by appropriate dissemination for each operational period.

Healthcare System Incident Action Plans should contain specific organizational objectives.

- Incident action plan content: For healthcare facilities, incident action planning crosses a range of activities, with the information developed from these activities captured in an appropriate format on ICS forms. It includes:
  - Organizational objectives for the incident response: Explained in detail in Textbox 3.2.4.4 and summarized here.
    - Incident objectives: Essentially the organization's goals statement, these are expected to change little during Incident Operations (ICS 202).
    - Operational period objectives: These are developed or revised for each specific operational period. They should be measurable and achievable within the operational period (ICS 202).
  - Other mission-critical information:
    - Structure of the organization's response: The incident command structure that the healthcare response organization is using should be documented, including the names of personnel assigned to key positions. An accompanying organizational chart with names placed in boxes can be helpful (ICS 203 and 207).
    - Assignments, strategy, and general tactics: Resources assigned at the strategic or management levels (i.e., functional areas activated and units assigned to key tasks, but not those in charge of component tactical actions or the names of individual responders) should be listed and described (ICS 204). The defined strategy and general tactics for them to achieve the objectives should be included. An example is providing information on what group is assigned to initiate personnel prophylaxis, the medications to be used, and where/when/how this will happen in general terms. The specific tactics are then established by the individuals responsible for achieving the assignment.
    - Safety message: In most incidents, a brief safety message is included with the incident action plan, highlighting relevant incident-specific hazards for healthcare facility personnel. For example, Command and General Staff may wish to highlight

the importance of appropriate PPE during response to a communicable disease outbreak. Documenting this type of information emphasizes its importance to response personnel, and provides a mechanism (when incident action plans are shared external to the facility) to promote consistent protective tactics in managing responder safety issues across the participating healthcare facilities (ICS 202 and then 208 as needed).

- Communications plan: Key personnel (Command and General Staff and leaders/supervisors of key operating units) are listed, with preferred and alternate contact methods (ICS 205). The communications plan may also list other pertinent positions, such as branch directors and unit leaders. Functional areas contact information is also listed, so that telephone, e-mail, and any other preferred contact information is current and immediately available.

- "Medical" plan: Even though healthcare facilities are in the "business" of caring for people, they ironically tend to focus less than public safety agencies on responder well-being and treating injured or ill responders, even when hazardous conditions are possible. The incident action plan should provide guidance for supporting responder health (some of this may be included in the safety message), and the strategy and tactics for caring for injured or ill healthcare system responders (ICS 206). It is advisable that a capability be established to "care for your own" separate and distinct from that for general victim care. In very high-risk areas, such as the decontamination (DECON) facility, the set-up should support rapid DECON and doffing of PPE and immediate medical intervention for compromised DECON staff.

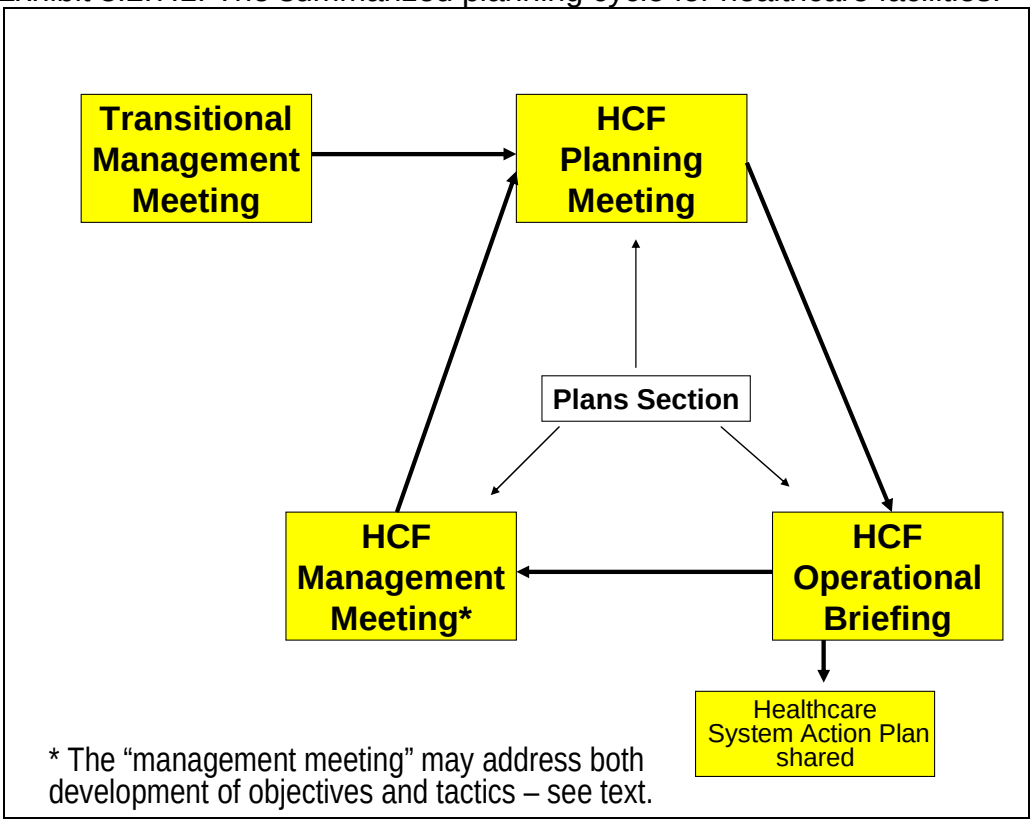
- Supporting information: Other details as deemed relevant are included (e.g., maps of buildings that demonstrate the high-risk areas where an infectious agent was detected).

- ICS forms for information capture and processing: The critical information from these planning activities, therefore, is captured in the aggregate of ICS forms 202, 203, 204, 205, and 206.

- Organized and sequential planning steps: Defined steps are essential to the development of an incident action plan, and the Planning Section is responsible for conducting meetings and assuring that planning actions are accomplished within the defined schedule.

- Transitional Management Meeting: The Transitional Management Meeting, after delineating the incident objectives, defines the IMT structure, the command and general staff assignments, and establishes the timing of the operational periods and planning cycle. This is discussed in detail in Lesson 3.2.4 and below. Objectives for the upcoming operational period are established. Strategy and major tactics to achieve the operational period objectives may also be determined here, in a separate "tactics meeting" for very complex incidents (see the "Planning P" in Exhibit 2.1.3.3 in the preceding unit), or in the Planning Meeting while assigning resources. The follow-on sequential steps as displayed in Exhibit 3.2.7.1 should then be accomplished under the supervision of the Planning Section.

Exhibit 3.2.7.1: The summarized planning cycle for healthcare facilities.



- Planning Meeting:

Strategies are established and resources assigned during Planning Meetings.

  - Who attends: Command and General Staff, with others as indicated and approved by the healthcare organization's incident commander. The list of attendees usually includes:
    - Healthcare System Commander
    - Command staff members
    - General staff members

- Resource Unit Leader
- Situation Unit Leader
- Operations Branch Directors and possibly key Operations Unit Leaders
- Communications Unit Leader
- Technical/Specialists (as indicated)
- Outside Agency Representatives (as indicated)
- Information specialists to record meeting findings.

○ What occurs: Exhibit 3.2.7.2 provides an example of a Planning Meeting general agenda. **During the meeting general tactics and resource and task assignments are established to achieve the response objectives developed in the preceding Transitional or regular Management Meeting**. These are developed by the Operations Section Chief and the Healthcare System Commander, and the Planning Meeting is facilitated by the Planning Section Chief. Each Section Chief is given a brief interval to comment on major issues related to the development of the Healthcare System Incident Action Plan. **During each Planning Meeting, Section Chiefs confirm assignments and sign off that the assigned resources are adequate to meet response needs for the upcoming operational period**. In some ICS practices, "tactics" and/or "pre-planning meetings" are held to define most of the tactics and assignments, and the planning meeting is used to bring this work together and assure all IAP development tasks have been completed.

○ Meeting outputs: Information is formally captured and processed by the Planning Section into the written incident action plan for the upcoming operational period.

Exhibit 3.2.7.2: Planning meeting general agenda.

Planning Meeting

Traditional ICS*	Hospital ICS
• Brief on situation and resource status (Planning) • Set/review incident objectives (IC) • Plot control lines and geographic boundaries (Operations) • Specify tactics for each Division/Group (Operations) • Specify safety measures for identified hazards • Specify resources needed (Operations/Planning) • Specify facilities and reporting locations (Operations, Planning, Logistics) • Place resource and personnel orders (Logistics) • Consider communication, medical, and traffic plan requirements (Planning, Logistics) • Finalize, approve, and implement IAP (IC, Plans, Operations)	• Brief on situation and resource status (Planning) • Review/set incident objectives and operational period objectives (Hospital IC) • Specify tactics for each Operations element: Branch/Division/Group (Operations) • Specify resources needed (Operations) • Review facilities and reporting locations (Operations, Planning, Logistics) • Place resource and personnel orders (Logistics) • Consider communication, medical, and other supporting plans (Planning, Logistics) • Finalize, approve, and implement IAP (Hospital IC, Planning, Operations)

*National Wildfire Coordinating Group, available at: http://www.nwcg.gov/pms/pubs/410-1/chapter11.pdf

- Operations Briefing:
  - Who attends: Command, General Staff, specific branch directors, and unit leaders (per Healthcare System IC). For some incidents requiring close coordination with external agencies, the healthcare facility may wish to invite a liaison (an "Agency Representative") from that entity. For example, if an unusual outbreak has been confined to one hospital, local or Federal health officials may be invited to attend the Operations Briefing (or listen in via teleconference).
  - What occurs: **The next IAP is presented to key leaders within IMT and to liaisons from agencies that aren't within the IC structure.** The Planning Section Chief establishes the agenda,

with IC approval and facilitates the meeting. A brief situation update is presented, usually by the Planning Section Chief, followed by a briefing (i.e., summary) of the incident action plan to attendees. Exhibit 3.2.7.3 provides an example template for the briefing. Command staff (e.g., Safety, PIO), section chiefs and pre-designated leaders of key functions are given the opportunity to provide comments relative to their responsibilities. Liaisons from external agencies ("Agency Representative") are also provided a short interval to succinctly describe activities relevant to their agency. A well-run Operations Briefing should be concluded within 30 minutes.

Relevant personnel are given a situation update and briefed on the incident action plan during Operations Briefings.

- Meeting output: Hardcopies of the incident action plan should be available for dissemination to operations briefing participants prior to the briefing. The information conveyed in the meeting, and in the incident action plan itself, should then be disseminated by the Section Chiefs to personnel within their respective sections.

Exhibit 3.2.7.3: Template for Operations Briefing.

Operations Briefing

Traditional ICS*	Hospital ICS
• Review objectives and changes to IAP (Planning) • Discuss current response actions and last shifts achievements (Operations) • Review weather forecast (Situation) • Division/Group assignments (Operations) • Trajectory analysis (Situation) • Transport, communication, supply updates (Logistics) • Safety Message (Safety) • IAP approval and motivational comments (IC)	• Brief on situation and resource status (Planning) • Review incident and operational period objectives and changes to IAP (Planning) • Trajectory analysis – include weather forecast if appropriate (Planning) • Discuss current response actions and last shifts achievements (Operations) • Operations elements (Branches, Divisions, Groups) assignments (Operations) • Transport, communication, supply, care for personnel updates (Logistics) • Safety message (Safety) • IAP approval and motivational comments (Hospital IC)

* Adapted from: US Coast Guard Field Operations Guide (FOG). 2000 Edition
No longer available on line

- Management meeting:[51]

  - Who attends: Command Staff and Planning Section Chief, with additional staff (e.g. Operations Section Chief) attending at the direction of the Healthcare System Incident Commander.

  - What occurs: **During each management meeting, Incident response objectives for the upcoming operations period are established. Command confirms, often in consultation with General Staff, that the current IMT organizational structure is adequate to meet response needs.** If a change in structure is indicated, this is agreed upon and documented for the next incident action plan. For example, patient tracking may take on such complexity and management attention that it is re-defined as a separate and distinct branch within the Operations Section, with

Management Meetings start the operations cycle all over again with the review and revision (as necessary) of organizational objectives.

[51] NIMS now refers to this step as the "IC/UC develop/update objectives meeting." Healthcare systems are encouraged to dedicate time during response to this important activity.

its own Branch Director focused solely on patient tracking.

- Meeting outputs: Overall incident objectives are confirmed and specific operational period objectives are established. The current response structure is confirmed or revised. If General Staff is included in the meeting membership, the major tactics for the upcoming operational period may also be established in this meeting. Alternatively, a follow-on "tactics meeting" may be conducted for this purpose.

- Conduct of all meetings: It is important that all meetings be conducted in the most efficient manner possible. Textbox 3.2.7.1 presents standard practices to accomplish this.

Textbox 3.2.7.1

Management of Meetings/Teleconferences

It has been a perennial challenge for public health and medical personnel to conduct efficient meetings and teleconferences during Incident Operations. Observations during major exercises (TOPOFF 1-3[52] and others) and actual incidents (anthrax 2001) demonstrated health and medical meetings without clear purpose (i.e., objectives), firm facilitation, or formal agenda. This resulted in prolonged discussions, difficult decision processes, and no clear process for disseminating the results of these meetings. The following factors, validated through extensive incident command system experiences, maximize the efficiency of the meeting process:

- Establish a clear purpose for the meeting: No meeting is called without a clear goal (usually indicated by the meeting name) and so the meeting output is automatically understood by all. For example, Planning Meeting participants understand that strategy, major tactics, and resource assignments will be established by the meeting conclusion.
- Firm meeting facilitation: One pre-designated individual, trained on incident meeting rules, facilitates the meeting. This person is usually responsible for establishing the agenda and so is familiar with the meeting agenda and objectives. For the primary incident planning meetings, the Planning Section Chief assumes the facilitation role.

[52] Author observations and: Inglesby, T.V.; Grossman, R.; O'Toole, T. A Plague on Your City: Observations from TOPOFF. *Clinical Infectious Disease* (February 1, 2001); 32(3): pages.436-45.

- Meeting discipline is enforced: Meeting "rules" are established and disseminated before the meeting (it may be helpful for the facilitator to briefly review the rules with participants at the beginning of the meeting):
  - Meetings start and end on time.
  - Participants (except the IC) speak only when recognized by the facilitator.
  - Strict time limits are enforced for oral reporting.
  - Prolonged discussion or controversy is generally discouraged (the planning process should identify and resolve most of these prior to large meetings); contentious issues are assigned to specific parties to resolve "offline;" the resolution is reported at the next meeting.
  - Outside distractions are limited (e.g., cell phones and pagers must be silenced or on "vibrate").
  - The meeting/teleconference is not the appropriate forum for sharing contact information between individual participants (this is not only inefficient but rude to delay proceedings while information is exchanged. The activity should only occur outside the meeting context).
  - For teleconferences, all participants' phones should be muted except when speaking.
- Establish and disseminate meeting agenda: A brief agenda outlining discussion topics should be developed (a standard template for each common type of meeting should be used). Persons responsible for presenting specific topics should be listed and notified of this task so they can prepare. The facilitator assures tight adherence to the agenda.
- Select individual to capture proceedings: For most major meetings, one Planning Section position should capture information exchanged and major decisions reached. This documentation may serve as an important reference for the development of the incident action plan or for other Incident Response activities.

Completion of the Incident Action Plan

The Healthcare System Incident Action Plan (IAP) must then be completed:

- IAP document: The series of meetings and other planning activities allow completion of the appropriate ICS forms that make up the IAP. These are then collated, approved by the incident commander (IC) and any members of a unified command, and prepared for dissemination. The collated forms represent the core of the IAP.

- Supporting plans: These planning documents (see Terminology Textbox) are completed by the designated position for each plan within the ICS. It is the responsibility of the Planning Section to assure they are completed, approved by the IC, and incorporated into the IAP.

Terminology alert!

Supporting plans: Supplemental sections of the incident action plan that provide additional information related to action planning. These generally are documents that address the response-generated demands during an incident. Standard supporting plans include the Safety Plan, Medical Plan, Communications Plan, and Transportation Plan.

Other planning activities related to comprehensive incident action planning are also the responsibility of the Planning Section, and the outputs from these activities should be included in the IAP as supporting plans. Depending on the nature of the incident, these may include:

- Alternate plans: In some situations, providing alternatives to the currently selected strategies and tactics can be valuable to Command. In particularly complex events, careful development of alternatives can be essential, allowing the exceptionally focused managers to "step back" and consider a change in operations that could be beneficial. Experienced personnel within the Planning Section should be assigned specifically to this task. For example, the Planning Section may wish to develop several alternative strategies to the implementation of an employee prophylaxis program and provide the alternatives (with pros and cons) to Command during the Planning Meeting.

The Healthcare System Planning Section provides other important considerations for Command decision-making.

- Long-term planning: For any lengthy incident, establishing a long-term planning capability is essential. This assures that complex decisions, scarce resources, personnel relief, and other issues that will arise in later operational periods have been considered in time for organized planning to address the needs. Planning Section personnel should therefore perform a projection analysis and delineate issues, needs, and questions that could present as the incident evolves through multiple operational periods. As with alternative planning, long-term focus rarely occurs within the cadre with responsibility for "managing the moment." It is important, therefore, for the Planning

Section to assign personnel to this that have no other immediately urgent responsibilities. An example that highlights the importance of long- term planning was experienced during the anthrax 2001 dissemination event in the National Capitol Region: Exposed victims were started on six-week antibiotic prophylaxis regimens, but planning for how to address the prescription refills and what the advice to patients would be at the end of the prophylactic period was not comprehensively addressed in a timely fashion.[53]

- Demobilization planning: Early consideration and development of procedures for deliberate, efficient disengagement from incident response should be accomplished. This guidance material should be ready for the earliest demobilization actions, promoting rapid return to readiness and resumption of regular healthcare system functions.

- Contingency planning: Many incidents may have sudden changes in their parameters that, while unexpected, are not entirely unpredictable. Examples include severe aftershock following an earthquake; during a contagious disease outbreak (e.g., SARS), emergence of the disease in the healthcare worker population; or after a local terrorist attack, sequential device is aimed at the healthcare facility. Effective incident management requires the system to be prepared to rapidly respond to reasonably predictable sequential impacts if they transpire. Contingency planning develops action plans in case the potential circumstance occurs. Though many of these plans are never utilized, pre-planning initial actions may be critical to successful response.

Planning Section – Other Information Management Duties

The remaining responsibilities of the Planning Section during Incident Operations stage relate to information management, establishing reporting requirements, and obtaining expert information as it is needed (from Technical Specialists).

- Maintaining a common operating picture through situation assessment: As described in Lesson 3.1.2, the Situation Unit captures information in relation to the hazard and its impact as well as community response information (to include patient tracking information). For example, during public health emergencies, the Situation Unit should be the repository for information regarding public health recommendations (from liaisons), which then should be

[53] Authors' observations

incorporated into the appropriate incident action planning considerations.

- Tracking incident resources: The Resources Unit captures information on personnel, supplies, and facilities related to the healthcare system's response, as well as other response entities working closely with the IMT assets. The use of ICS forms, adapted to the specific environment of the healthcare facility, can provide adjuncts in collecting and processing this information.

- Developing incident summaries: The Planning Section may also be responsible for developing summaries of the incident and the healthcare organization's response. The frequency and timing of these reports should be determined by the Planning Section Chief in conjunction with the organization's Incident Commander. Traditional ICS utilizes an ICS 209 form (Incident Status Summary) as a template for conveying this information. This information can be shared (as appropriate) within the facility, as well as with external agencies and healthcare organizations. The information contained in this report differs from the incident action plan in that it contains summarized information on the hazard impact (e.g., patients presenting to the hospital for care) and the organizational response (e.g., numbers of patients treated, discharged, and admitted).

- Accessing expert information: If additional expertise is needed to address incident issues, the Planning Section is tasked with obtaining this outside expertise and providing a conduit for the technical experts to provide their input. This may occur within the Planning Section, or the technical expert may be assigned to operations, management (as a senior advisor), or other appropriate area within ICS.

The Planning Section Chief in conjunction with the IC should determine appropriate timing, dissemination, and recipients of Situation Updates (ICS 209).

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Lesson 3.2.8 Concept of Operations for Healthcare Emergency Response and Recovery: Incident Operations Stage – Logistics Section & Finance/Administration Section Actions

Lesson Objectives

- *Describe the basic functions of the Logistics Section during incident operations.*
- *Describe convergence issues for volunteers (external and internal) and basic management concerns for each.*
- *Describe the major functions of the Finance and Administration section during incident operations.*
- *Describe obstacles to healthcare systems related to financial reimbursement during response and list potential Federal reimbursement mechanisms for healthcare systems providing emergency response.*

Logistics Section

The Logistics Section supports the ICS organization with resources and support services. Traditionally, the healthcare industry has viewed all facilities personnel, security personnel, and others as exclusively belonging in the Logistics Section of the organization under ICS. This concept is not always accurate, since incident parameters and organizational objectives may dictate that these positions belong in the Operations Section of the incident management team (IMT). Alternatively, hospital day-to-day operations conducted by some of these personnel may remain completely intact and so outside the purview of the IMT. For example, during loss of a mission critical system, such as occurs with a power failure, incident objectives focus response on restoring power to critical areas, as well as augmenting patient care services to address issues created by loss of electrical power. Consequently, facilities personnel (engineering and others) are appropriately situated in the Operations Section as addressed in Lesson 3.2.5. Facilities personnel continuing with day-to-day operations during this power outage remain in everyday positions outside the supervision of the activated IMT. The following Logistics functions and activities may be important during the healthcare organization's Incident Operations:

A defined methodology is necessary for the Logistics Section to adequately manage resource requests.

- Supplies Unit
    - Management of requests: For efficient resource supply or re-supply in the hectic atmosphere of incident response, a structured methodology for managing requests should be followed, whether for personnel, equipment/supplies, facilities or services. Requests

should ideally be made on paper or through electronic media, particularly for unusual items where the acquisition process is prolonged or includes seeking outside assistance. Having only one form for requesting a resource (e.g., a modified ICS 213) can make the process more uniform, and would be described in a resource support annex to the EOP (see Lesson 1.5.4). Submission of the requests should also follow a standardized process, and a method for tracking requests for accountability and assuring expedient answers should be established. A Logistics Support Annex, used by all elements of the IMT when requesting resources, would complement the Supplies Unit guidance.

- Resource assistance from outside the ICS organization: Strategies for where to seek outside resources should also be well worked out ahead of time. When a particular resource is not available internal to the organization, the Logistics Section should (in conjunction with Command) seek the most appropriate solution external to the facility, utilizing Mutual Aid, initiating emergency contracts, seeking governmental assistance, or obtaining help from a parent organization. For requests from within the IMT for assets that are unusual, expensive, or difficult-to-support, approval from the Incident Commander may be required before seeking outside assistance. In requesting outside resources, careful attention must be paid to the way in which the requests are developed and submitted. Federal assistance rules, and some State and local assistance procedures, expect the request to be shaped in terms of the "need" as opposed to requesting a specific asset. For example, rather than requesting a Disaster Medical Assistance Team (DMAT) or other specific resource to assist with patient care activities, the request should accurately define the need for which assistance is requested. The assisting government agency will then offer the most appropriate available assets that can address the defined need.

- Accountability for resource acquisition: Methods for requesting, tracking, approving, transporting, and taking receipt of resources should be clearly defined. This standardized request process should be briefly described in a Logistics Support Annex to the EOP, so it is understood by all relevant personnel.

- Tracking of resources: Critical supplies within the response system should be tracked during response to assure adequate amounts at all times. The ability to anticipate shortages and re-supply ahead of time is a critical focus of Logistics during their incident planning activities. Some hazards produce very predictable resource shortages, and anticipating this can avoid severe impact on the

organization's response. For example, a very frequent problem noted after hurricanes is shortage of fuel for generators that must run throughout the prolonged interruption of the electrical power grid. Acquiring a large fuel cell during the pre-impact period may avoid this occurrence. Alternatively, confirming that the suppliers obligated by emergency contracts can deliver as promised may be prompted by an operational checklist.

Some requested resources (e.g., personnel) require specific types of support that the Logistics Section is responsible for establishing.

- Supporting requested resources: If outside personnel are requested, the Supply Unit may have additional responsibilities for processing and supporting these assets. Processes for receiving them, confirming identities and credentials, and connecting them with their assigned supervisors should be established. Providing sleeping quarters, food, and other support may also be necessary.

- Volunteers: As previously discussed in module 3.1, specific attention must be paid to the management of volunteers.

  - External volunteers: Volunteers commonly present with good intentions to assist a healthcare facility during its response. Security personnel should control the influx and direct them to a secured volunteer reception area for processing (see Textbox 3.2.8.1 and 3.2.8.2). Alternatively, if instructed by Command and the Supply Unit, security officers may inform them that assistance is not requested and decline their offer. If this alternative is selected, a printed declination (developed during preparedness) should ideally be provided to the volunteers, thanking them for their offer, and declining it in a gracious manner. In this example, security falls under the Operations Section, while those staffing the volunteer reception and processing area are within the Logistics Section. Potential volunteers are under the supervision of Logistics until processed, accepted, and assigned.

Textbox 3.2.8.1

Unsolicited Volunteers at the Healthcare Facility[54]

Volunteers must be processed through an organized volunteer management center, so that healthcare system administrators can meet their ethical and legal responsibility of assuring qualified service providers. Volunteer registration includes the collection of name, address, contact information, qualifications and certifications, and professed professional abilities. Verification of identity and credentials should be accomplished through a pre-determined process, commensurate with the trust level in each volunteer's potential assignment.[55]

Credentialed volunteers are either released (if no actual or anticipated need for their services exists at that time), sent to staging (if there is a potential need for their services), or provided an assignment. Those given assignments should receive just-in-time training about their supervised role, their responsibilities, and any general safety measures. Volunteers should then receive a second, more job-related briefing when they report to their assigned supervisor.

All volunteers who register should be given a written briefing that includes:

- "Thank you for coming and volunteering your services."
- Brief explanation of current incident status.
- Explanation that an incident management system is in place, volunteers work within this system under supervision, and that freelancing can be disruptive and possibly dangerous to both the freelancers and/or the accepted responders.
- If there is no current or anticipated need for assistance from the volunteers, an explanation is provided that states they are released and will be called if needed, through the contact method they provided. It describes the need for unequivocal credentials of professional capacity if called. In clear terms, it

[54] Adapted from: Barbera J.A., Macintyre A.G. *Medical and Health Incident Management (MaHIM) System: A Comprehensive Functional System Description for Mass Casualty Medical and Health Incident Management* (October 2002). Institute for Crisis, Disaster, and Risk Management, The George Washington University, accessed February 16, 2010 at: www.seas.gwu.edu/~icdrm/

[55] Adapted from: ICDRM/GWU. *The Standardized Volunteer Management System for Public Health & Medical Emergency Response & Recovery* (October 2006). Institute for Crisis, Disaster, and Risk Management, The George Washington University); accessed February 12, 2010 at: http://www.gwu.edu/~icdrm/projects/eVMS/index.htm

states they should not re-attempt to access patient care areas, as unauthorized entry is considered criminal trespass subject to prosecution.

A common motivation that moves unsolicited volunteers to converge on hospitals is the desire to donate blood. A plan should therefore be pre-established that diverts these well-intentioned individuals to an appropriate blood bank resource, preferably one that is physically distant from the healthcare facility. Hospitals should work with blood banks to assure they have effective plans in place for large surge donation offers. The plan should include written public information and a system for staging donor volunteers to provide blood at a designated time in the future rather than immediately. This will avoid the glut of blood products that occurred in the U.S. after the September 11, 2001, terrorist attacks and maintain the goodwill of the donor population.

Additional volunteer processing and management details are available through the above referenced documents.

Textbox 3.2.8.2

Credentialing of External Volunteers – Licensed Practitioners

Regular verification of credentials in healthcare systems (primary source verification) for licensed practitioners is appropriately a time consuming process. This approach is precluded during incident operations where time is an issue and sources of information may be compromised. Because of this and other factors, healthcare systems predicting the need for potential volunteer use should proactively establish a credentialing process pre-incident. For licensed practitioners, The Joint Commission has addressed this in its new standards and provides the following minimum standards for credentialing:

- Before a volunteer is considered eligible to function as a licensed independent practitioner, the [organization] obtains his or her valid government issued photo identification (for example, driver's license or passport) and at least 1 of the following:
  - A current picture identification card from a healthcare organization that clearly identifies professional designation.
  - A current license to practice.
  - Primary source verification of licensure.
  - Identification indicating that the individual is a member of a

Disaster Medial Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR VHP), or other recognized State or Federal response organization or group.
- Identification indicating that the individual has been granted authority by a government entity to provide [patient] [care, treatment, or services] in disaster circumstances.
- Identification by [organization] with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

- Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the [organization], whichever comes first. Note: Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided [care, treatment, or services] under the disaster privileges.

- If primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, it is performed as soon as possible.

- If primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the [organization] documents all of the following:

  - Reason(s) why it could not be performed within 72 hours of the practitioner's arrival.
  - Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate [care, treatment, or services].
  - Evidence of the organization's attempt to perform primary source verification as soon as possible.

Source: The Joint Commission standard, EM.02.02.13 [56]

- Internal volunteers: This is essentially the role that the personnel/labor pool plays during the mobilization and incident

[56] Information about The Joint Commission and its programs accessed January 29, 2010 at: http://www.jointcommission.org/AccreditationPrograms/

operations stages of incident response: regular personnel who are released by their supervisors to volunteer for new roles within the organization's IMT. Issues may arise, however, with internal "volunteers" who do not follow the defined labor pool methods: It is common for healthcare facility personnel to gravitate toward "the action" during times of Incident Operations, even if they have no specified role or it is not their assigned area. This can be particularly problematic in hectic, critical areas, such as the Emergency Department where organization and assignment of resources must be tightly managed (see Textbox 3.2.8.3). Assignment of security to screen personnel before admittance to these areas may ensure that only those with assigned roles are admitted.

Textbox 3.2.8.3

Convergence of Internal Volunteers: A Hospital Example

During mobilization for the Pentagon terrorist attack on 9/11/01, multiple personnel were appropriately requested and arrived in the Emergency Department of a local hospital. Unfortunately, healthcare facility staff that did not have a direct role self-dispatched to this area as well. Self-dispatched personnel included pulmonologists with bronchoscopes, Critical Care Nursing staff, and an administrator with multiple medical students in tow. These personnel were cleared from the ED as they posed the potential to disrupt operations in that area. They were instructed to remain available through the Labor Pool, so that they might be dispatched as indicated.

- Facilities Unit: This logistics unit is responsible for providing and directly supporting incident facilities during response and recovery, such as the Healthcare System Command Post and Emergency Operations Center, decontamination area, staging areas, discharge areas, and patient family assistance area.

- Communications Unit: In addition to supporting the communication needs of the hospital, an important consideration for the Healthcare System Communications Unit during Incident Operations would be the development and submission of a Communications Plan (modeled on an ICS Form 205/205T). In its simplest form, this would entail a list of names, response positions, and telephone/cellular numbers. This form should be submitted to the Planning Section for further dissemination, either independently or with the incident action plan,

and updated regularly. It should be noted that if a healthcare system is disseminating its IAP outside of the organization, a truncated or shortened ICS Form 205 might be more appropriate to avoid the dissemination of sensitive information.

- Medical Unit: Activities undertaken to support the health and welfare of staff may require external coordination with other agencies or organizations. This can become critical in an effort to provide a consistent approach in the community towards protection of healthcare staff. For example, working with public health on recommendations for staff prophylaxis can be important to prevent the perception of inadequate attention to staff needs.

- Transportation and Food Units: These units should be staffed based upon incident needs. The Food Unit may simply be the facility's usual meal service, with Logistics Section oversight to meet incident support needs.

Finance/Administration Section

Healthcare Systems have very different reimbursement mechanisms for emergency response than most other response entities.

A distinction for many healthcare facilities from traditional public safety agencies is the financial payment methods for services rendered. Though there are, in many situations, opportunities to recuperate some costs through traditional third party payer coverage, many incident-generated activities will not be adequately covered through these means. In other cases, the necessary documentation and other regulatory requirements for compensation may not be possible to accomplish during Incident Operations. As an example, the costly activity of decontaminating a patient is not billable as a pass-through cost via traditional healthcare reimbursement mechanisms. Accounting for incident related expenditures is vital for the continued viability of the healthcare system.

- Cost-recovery issues: The cost for many incident activities may be reimbursable through other mechanisms (see below), particularly during officially declared incidents. For this to occur, however, these expenditures must be tracked closely and carefully documented by the Finance/Administration Section during Incident Operations. Otherwise, expenditure accounting must be reconstructed from scattered data after a response, and this may be problematic both in timeliness and accuracy. Some of these potentially reimbursable costs include:

    - Extra staffing or holdover staffing (overtime pay) that is committed to assist with "surge," whether or not an actual surge of patients

materializes.

- Postponement or cancellation of elective procedures (diagnostic and therapeutic), which traditionally are significant revenue generators for healthcare facilities.
- Use of disposable supplies that are not covered under traditional reimbursement mechanisms, such as PPE for decontamination.
- Prophylaxis or vaccination of staff that is only for the purpose of safety during incident response.
- Supplies and personnel time devoted to pre-hospital or community issues, such as re-supply of EMS units.
- Supplies and equipment that cost more to acquire than normal due to the incident-generated urgency and scarcity.
- Volunteer staffing costs associated with Mutual Aid or processing and supervising solicited volunteers.

- Out-processing and return to readiness costs: In addition, Finance/Administration personnel should be capable of projecting the costs associated with post-incident issues, such as the out-processing of the response staff (e.g., health monitoring, debriefing sessions, and other costs) and return to readiness of healthcare facilities and equipment.

- Potential cost-recovery sources: The Finance/Administration Section should understand the mechanisms available to the healthcare system for cost reimbursement, even though the actual submission of compensation requests for these unusual activities and expenditures may not occur until the recovery phase. This may impact the types of data collected during Incident Operations and how it is formatted.

  For other private sector facilities, a summary of potential reimbursement mechanisms is provided in Textbox 3.2.8.4.[57]

[57] Though private sector healthcare resources are considered part of the nation's "key resources," no clear mechanisms have been pre-established to support emergency response fiscal requirements, particularly regarding for-profit organizations.

A range of options may be available for emergency response reimbursement, but all require meticulous planning and attention to detailed cost accounting.

Textbox 3.2.8.4

Potential Reimbursement Mechanisms for Hospitals

Disaster Recovery Assistance for Healthcare Facilities from FEMA and SBA

If your healthcare facility is located in a declared disaster area and has suffered disaster-related damage, the facility may well be eligible for Federal disaster assistance. The two main entities offering disaster assistance to government, non-profit, and private businesses are the Federal Emergency Management Agency (FEMA) and the United States Small Business Administration (SBA).

How to Apply for SBA Disaster Loan Assistance after a Declared Disaster

Any business or nonprofit - regardless of size - that is located in a declared disaster area can apply for SBA disaster assistance. The agency has two types of loans: physical disaster loans and economic injury disaster loans. Physical disaster loans cover all types of physical loss, including uninsured or underinsured damage to structures, equipment, and inventory. Economic injury disaster loans typically cover unmet financial obligations and are only available to small businesses (small business size standards vary according to NAICS code and are available at www.sba.gov). SBA may loan a maximum of $1.5 million to businesses with rates starting as low as 4 percent at terms of up to 30 years. If a healthcare facility qualifies as a major source of employment in a disaster struck zone, the SBA can waive this statutory lending limit.

Applications are available online, by calling, or at any Disaster Recovery Center (DRC) or Business Recovery Center in the disaster impacted area. It is not necessary to wait for insurance settlements before applying for an SBA loan. However, any eventual insurance proceeds that duplicate SBA coverage must go toward repaying the loan. Information about SBA's Disaster Loan Program is available by calling 1-800-659-2955 or at: http://www.sba.gov/services/disasterassistance/index.html .

FEMA's Public Assistance Grant Program[58]

The Public Assistance Grant Program provides supplemental Federal disaster grant assistance to help State and local governments and certain Private Non-Profit (PNP) organizations

[58] US Department of Homeland Security. *Public Assistance Grant Program.* Federal Emergency Management Agency, accessed February 15, 2010 at: http://www.fema.gov/government/grant/pa/index.shtm

rebuild after a disaster. The program provides for the repair, replacement, or restoration of disaster-damaged, publicly owned facilities and the facilities of certain Private Non-Profit (PNP) that are considered a critical part of a community's infrastructure. While these grants are aimed at governments and organizations, their final goal is to help a community and all its citizens recover from devastating natural disasters. Eligible PNP facilities must be open to the public and perform essential services of a governmental nature. Emergency medical facilities and other healthcare facilities, such as non-profit hospitals, outpatient, and rehabilitation facilities, qualify to be considered as critical PNP facilities.

To be eligible, the repair and recovery work to be done must be a direct result of the disaster, be located within the designated disaster area, and be the legal responsibility of an eligible applicant. Work that is eligible for supplemental Federal disaster grant assistance is classified as either emergency work or permanent work. Emergency work includes debris removal and emergency protective measures, while permanent work addresses buildings and equipment. The Federal share of assistance is not less than 75% of the eligible cost for emergency measures and permanent restoration. The State determines how the non-Federal share (up to 25%) is split with the applicants.

Note: *It may be useful for healthcare facility officials to investigate legal agreements with local government partners that stipulate that emergency services are critical services performed on behalf of State/local government. This should be done* ***before*** *a disaster during emergency preparedness planning and may facilitate reimbursement.*

- Difficulties in re-capturing incident expenses: Though these formal mechanisms exist as potential avenues for healthcare systems, it should be noted that none are guaranteed.
    - Past experience: In many past incidents, challenges were regularly encountered in obtaining financial assistance or reimbursement for healthcare systems in a timely and equitable fashion. This experience spans the time period before and during 9-11[59] and continued during the Hurricane Katrina experience.
    - Future considerations: For non-governmental healthcare systems

[59] *Proceedings for the National Symposium on Hospital Disaster Readiness*. American Hospital Association, February 15, 2002; accessed November 22 2009 at: http://www.hospitalconnect.com/aha/key_issues/disaster_readiness/

that are working closely with their local and State jurisdictions on emergency preparedness, exploring reimbursement mechanisms that provide real-time payment during the response may be beneficial. In declared incidents, well-documented expenses that are paid through local and State governments are eligible for Federal reimbursement to those governments through Stafford Act[60] and other mechanisms.

- Additional financial issues during mass effect and mass casualty incidents: During large-scale incidents that significantly impact the local community, additional financial considerations may be important for the healthcare organization and must be addressed by this IMT section. These include:

  - Payroll: If the hazard impact is extensive, the payroll mechanism may be affected (contractors enlisted for payroll may no longer be functional, the postal system may be non-operational, as well as other issues). In order to optimally support staff during prolonged Incident Operations, it may become necessary to seek novel solutions to maintain payroll delivery, such as partial cash payments or handwritten corporate checks.

Local infrastructure impact can affect the financial operations of the Healthcare System.

  - Local banking systems: Even if payroll can be sustained, additional consideration should be given to the financial infrastructure impact. If the banking system is disrupted, employees may not be able to deposit or cash checks, and so personal financial tasks could contribute to work absenteeism. Additional employee assistance may be required to sustain the workforce, such as assistance with food or shelter for family members.

  - Purchasing: Given the nation's reliance on fiber-optic transmissions for the transfer of funds, there could be physical impediments to paying for goods and services vital to Incident Operations. Contingency contracts that allow delayed payments (with interest if necessary) and other mechanisms should be in place for these types of issues encountered during large-scale incidents.

Pre-existing emergency ('contingency') contracts can be invaluable to sustaining Healthcare System operations.

- Contingency contracts: During the Incident Operations stage, the Finance/Administration Section is responsible for execution of contingency contracts as required by the Logistics Section to obtain

[60] The Robert T. Stafford Act, as amended, provides the primary method for federal financial support to State and local jurisdictions during presidentially declared disasters and emergencies.

critical resources. Contracts should ideally be in place pre-incident for some of the following:

- ○ Potable water: To be used not only for patient and staff hydration but also for important medical activities such as hemodialysis.
- ○ Food: In the event that hazard impact delays the usual mechanisms for food delivery to the healthcare facility.
- ○ Fuel: For generators or for staff vehicles in severe events in which the local infrastructure is impacted.
- ○ Additional staffing: These may be acquired through commercial staffing resources.
- ○ Materials to support the facility infrastructure: For example, fans and portable air conditioning units, portable generators, and others.
- ○ Materials to support the medical mission: pharmaceuticals, ventilators, private ambulance services, medical gases, sterile supplies, and others.
- ○ Specific expertise: Such as building engineers, hazardous materials contractors, or structural specialists who can rapidly certify a facility's structural integrity, clean-up, or other after-hazard impact.

- Accounting for donated assistance: In addition to the above resource costs, the Finance/Administration Section should maintain records of all Mutual Aid/Cooperative Assistance/intergovernmental assistance to support reimbursement requests.

Healthcare regulatory relief may be necessary during Incident Operations.

- Regulatory compliance: As noted in the Systems Description, the Finance/Administration Section may also carry the responsibility for monitoring regulatory compliance. As a component of "managed degradation" strategy, situations may arise in which the Finance/Administration Section could alert the Operations Section to request regulatory relief from appropriate agencies (ideally, through pre-arranged processes and pre-determined options) so that surge capacity and capability can be achieved. Some examples include:
  - ○ Licensed bed limitations: Total admitted patient number may exceed the maximum number of licensed beds, and temporary relief from the licensing agency may be indicated.

- Decontamination wash water: Disposition of wash water from decontaminating patients may be regulated by local, State, and Federal agencies. Though the U.S. Environmental Protection Agency has released statements that exclude organizations from everyday hazardous materials containment regulations for the purpose of "life saving" interventions[61], local and State regulatory agencies may have specific notification requirements or other procedures requiring variance from regular hazardous material wash water disposal.

- Privacy of medical information: Federal restrictions such as HIPAA[62] severely restrict the everyday sharing of patient information. Currently, variances for emergencies are defined but still may limit the ability to share patient information.[63] Healthcare organizations should work with their legal experts and with local and State public health authorities to define the "public health emergency powers" that will clearly cover release of pertinent information, at the request or direction of public health authorities, to appropriately manage a healthcare-related incident.

[61] Office of Solid Wastes and Emergency Response. *Chemical Safety Alert: First Responders' Environmental Liability Due To Mass Decontamination Runoff* (July 2000). US Environmental Protection Agency; accessed February 15, 2010 at: http://www.nacwa.org/images/stories/public/2006dwlepaceppfr.pdf

[62] Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Congress.

[63] US Office for Civil Rights *Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations* (September 2, 2005). US Department of Health and Human Services; accessed November 25, 2009 at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/katrinanhipaa.pdf

Lesson 3.2.9 Concept of Operations for Healthcare Emergency Response and Recovery: Demobilization and Transition to Recovery Stages

Lesson Objectives

- *Describe critical factors related to demobilization of the healthcare incident management team (IMT).*
- *Describe the purpose of the Incident Review and explain how it differs from the After Action Report process.*
- *Describe the importance of the management structure during the transition to and during the recovery stage.*
- *Describe the major classes of recovery activities.*
- *Explain the purpose of recovery in relation to the continuity of patient care and the other phases of comprehensive emergency management (mitigation, preparedness and response).*

Demobilization Stage of Response

Demobilization is the response stage that out-processes personnel and other resources from incident operations, so they may be returned (through Recovery) to their day-to-day functions or undergo rehabilitation and readiness for the next incident. Demobilization for the healthcare facility begins as incident response objectives are met and follow-on objectives change or become more focused upon recovery. Given the current financial constraints and full caseloads within the healthcare industry, it is advantageous for the healthcare functions to return to regular operations at the earliest possible time. The demobilization of resources no longer needed for Incident Operations should occur rapidly and efficiently, and many healthcare assets may be demobilized while Incident Operations are still underway. For example, the additional staff and other resources assigned to the Emergency Department may be demobilized earlier than other assets that address in-patient surge capacity. The common demobilization activities across all resources could be conveyed as an EOP Support Annex, with the supervisory activities presented as checklists within appropriate Functional and Hazard Specific or Incident Specific Annexes.

Demobilization of the healthcare facility incident management team has traditionally received little preparedness attention. Several factors are critical and so should be addressed during EOP development:

- The decision to demobilize - defining the end of Incident Operations: In many situations, the decision to demobilize the partially or fully activated healthcare response is relatively straightforward (e.g., the

Demobilization management includes specific considerations such as appropriate notifications to outside agencies and authorities.

jurisdiction announces that no more incident victims are expected, and the current load can be handled through normal procedures). In other situations, the decision is more complex (for example, if no official incident-site information is available). Healthcare facilities may wish to maintain some emergency response capability at a reduced level (such as maintaining a partially staffed Healthcare System Command Post) while awaiting confirmation of incident resolution from authorities. During incidents with ongoing, formal incident action planning, the demobilization decision is incorporated into the planning process.

- Management of demobilization: The incident management structure and process established during response are maintained through the demobilization process, as response resources are out-processed, and continued well into the recovery phase. The objectives of the organization may change from response objectives to those focused on recovery (see below). Position assignments may also change to reflect the recovery focus, but the ICS-based planning and management structure and process should continue. When remaining tasks can be adequately managed through usual management methods and normal positions in the organization (as determined through the incident planning process), the incident command transitions the tasks to their new supervisory resources and then demobilizes. The final ICS functions to demobilize are the Command and Planning Section. This allows efficient response wrap-up, including document collection and archiving for the After-Action Report process (see Unit 4).

- Announcement of demobilization: Relevant parties (the jurisdictional authorities, response personnel, and non-response personnel in the facility) should receive notice prior to healthcare facility demobilization. In some situations, this notification should also be extended to the public. The healthcare organization should also expect to receive notification before the "standing down" or demobilization of any major jurisdictional incident response effort.

- Managing the public perception of demobilization and recovery: In some incidents, appropriate healthcare system demobilization, while the jurisdiction continues with an ongoing incident response, may be perceived unfavorably by the public. It may be important to make the public demobilization announcement jointly with jurisdictional authorities, where the healthcare organization is thanked for its services. It may also be very important to avoid business loss by publicizing that the healthcare organization has fully recovered and returned to its normal business, that scheduled appointments and services will be honored, and that hazard contamination has been

removed or safely contained. Measures taken to resolve backlogs, changes in usual service locations, or other variances should be clearly explained to the public.

- Equipment rehabilitation and restocking: Early restoration of equipment (both regular and incident-specific equipment) should be addressed during demobilization and completed as early as possible in the recovery phase.

- Financial accounting: As presented in the preceding lesson, the Finance/Administration Section should complete tallies of incident expenditures and recovery actions related to reimbursement, and financial restoration should commence.

- Staff rehabilitation and health concerns: Addressing staffing requirements during demobilization can be challenging. Providing for continuity of operations can also be challenging during this stage. Rehabilitation and health concerns should be expeditiously addressed during demobilization. For example, after response to a contaminated patient event, it is important to have personnel performing decontamination in PPE undergo a medical evaluation and record findings in an incident log. This may assist in recognizing delayed complications and may serve to address concerns about potential exposure.

- Documentation: Incident-related paperwork should be completed and secured according to established mechanisms. In the healthcare business, attention is usually focused on patient charting. Other important incident documentation, such as ICS forms (e.g., 214s or unit logs), should also be high priority. The Planning Section is responsible for ensuring that appropriate documentation is completed, submitted, and secured.

- Release/return of outside resources: It may be important to rehabilitate or return outside resources, whether Mutual Aid, commercial, or loaned assets. Used mutual aid or loaned equipment should be replaced or rehabilitated in a timely fashion. For personnel who have assisted the healthcare facility during Incident Operations, individual or organizational expressions of gratitude are important to the individual responders and to maintaining good will for future assistance. Financial reimbursement may be necessary for some of these resources.

- Rescheduling of regular activities: Healthcare facilities must address the complexities of rescheduling regular activities, such as operating suite appointments and outpatient procedures.

- Rescheduling of regular staffing: Staffing patterns are commonly disrupted by incident response, and attention may be required to confirm adequate staffing during the immediate post-incident period. Providing funded time off after a lengthy incident to allow responders to address personal business or to allow rest and rehabilitation may also be important (this has become a standard expectation in many public safety agencies). Overtime and other excessive costs incurred to accomplish this should be documented as legitimate incident-related expense.

- The Incident Review: Early in the demobilization stage, response personnel should be brought together to conduct a review and explanation of the incident and response actions. This is referred to as an "Incident Review" (IR), and it is useful to conduct after every major response by the healthcare facility. This activity differs significantly in purpose from the After Action Report meetings (see Unit 4), which are primarily intended for evaluation. It is also distinct from stress debriefing sessions, which are intended to address personnel feelings and concerns. In an IR (see Textbox 3.2.9.1), personnel are brought together to review the timeline of the incident not for purposes of discovering potential improvements to the systems response but **for the purpose of clarifying the incident details for all involved organizational responders**. This should resolve any confusion that can result over what occurred and why certain decisions were made during Incident Operations. Even a brief review of the timeline can resolve many misunderstandings. The Incident Review is usually managed by the personnel who were assigned to the Planning Section, whereas After Action Report meetings are managed through EM program mechanisms. The best timing for an Incident Review is at the completion of other Demobilization activities but before releasing responders or returning them to their regular work assignments. Though this may appear to be a challenging timeframe, the early timing is critical to avoiding misperceptions becoming "perceived realities" within the organization. For a large-scale incident, IRs may be conducted within response areas or units if bringing all organizational responders together is not feasible. A suggested template for an Incident Review is presented below:

The Incident Review does not provide evaluation of response or identify corrective actions, but instead is designed to convey a comprehensive situational awareness for all organizational responders.

Textbox 3.2.9.1

Suggested Template for an Incident Review (IR)

- Welcoming remarks and appreciation expressed for the response efforts by staff (Planning Section Chief)
- Describing the IR purpose (Planning Section Chief)
- Describe ground rules, including that comments are "not for attribution," remarks should not be personal, and this is not a critique (Planning Section Chief)
- Review of timeline according to stages of response:
  - Incident Recognition: specific personnel as appropriate (Command)
  - Activation/Notifications: specific personnel as appropriate (Command)
  - Mobilization: specific personnel as appropriate (Section Chiefs)
  - Incident Operations: specific personnel as indicated (Section Chiefs)
  - Demobilization: specific personnel indicated (Section Chiefs)
- Closing remarks (Command)
- Announcements regarding After Action Report meetings and other planned activities (Planning Section Chief)
- Documentation of all of the above (Situation Unit Leader).

- Performance evaluations: Traditional ICS provides mechanisms for staff to receive performance evaluations based upon the work performed in the incident response position. The evaluation is usually conducted by immediate supervisors, such as Section Chiefs, Branch Directors, or Group Leaders. This type of evaluation can be critical to improving overall EM program success, since aggregation of evaluation reports can be used in evaluating training and other preparedness activities (see Unit 4). In more sophisticated systems, performance evaluations can be developed by comparing performance against the defined **competencies** for the relevant response position (see Lesson 1.5.6). To keep the process objective, evaluation forms should be developed during preparedness and be immediately available during response. These forms should promote documentation of objective measures of job performance and adherence to EOP processes and procedures. At a minimum, all major assigned positions should receive formal evaluations after every major response.

Incident response performance evaluations are a vital part of maintaining overall EM program effectiveness.

Incident-related evaluation activities by the healthcare organization subsequent to response demobilization are considered part of evaluation and organizational learning (see Unit 4) or incident recovery.

Transition to Recovery

This stage, Transition to Recovery, can be defined as a separate task interval where the primary focus is on transitioning the Incident Management Team from demobilization of response to a focus on managing recovery and conducting return to readiness and other recovery activities. While the tasks in this stage are relatively limited, their importance to overall response and recovery success prompted their delineation as a distinct stage.

The transition to recovery stage contains several important considerations for the healthcare system's IMT and executive leadership:

- Transition of the IMT structure: A range of management constructs may be available to address recovery activities going forward. A range of options may be acceptable, but it is critical that the selected management structure be defined and publicized within the organization. The IMT may continue to function in its usual role, but the transition evolves the IMT structure and position staffing. It is very likely that the operations section in particular will be revised, with section structure and specific resources replaced by recovery-oriented configuration and resource assignments. The IMT may then continue functioning well into recovery.

- Transition of the IMT position staffing: It is very likely that during this transition, key positions such as the IMT's Incident Commander and Operations Section Chief will undergo staffing change. Personnel with subject matter expertise in the specific recovery issues (and the requisite position competencies) may be assigned as the IMT evolves into a recovery organization with a very different focus from emergency response.

  The IMT is phased out only upon the deliberate determination that it is no longer needed. Two illustrating examples are provided below:

  - Response IMT demobilized all at once: Depending on the incident needs and timing, the specific IMT used for response and recovery may be fully demobilized. For example, in low intensity incidents (e.g., partial activation of the EOP in response to a threatened hazard impact that never materializes), the remaining responsibilities of returning to readiness any activated resources

can be reasonably transferred to non-response positions. The emergency program manager, for example, may be designated as the point person for this responsibility. Another example might be the response to a limited incident with a few contaminated patients. If demobilization of the decontamination facility and decontamination team has been accomplished, all normal healthcare system activities could resume and final decontamination area cleanup can be conducted using everyday, non-response positions in facilities management.

- Transition to ICS-based recovery structure: Some incidents require long-term, complex recovery effort, such as clearing debris and re-building. An ICS-based management entity could be maintained, separate from the day-to-day administrative functions of the organization, to manage the short term issues as this process is undertaken. This IMT would have the more specific focus of recovering the healthcare system. The objectives should delineate the state when recovery can be judged complete or the condition when management responsibilities transition to construction management or another defined management entity. The day-to-day administration of the organization continues focusing on normal healthcare system operations, with the recovery IMT reporting its progress at regular intervals. This is addressed in greater detail in the next lesson.

- Clearly defining roles and responsibilities: Both of the above examples require formal decisions by the organization's executive leadership about the management of recovery. The decisions must be followed by a clear delineation of the responsibilities to be transferred to regular day-to-day administrative positions and the responsibilities retained by ICS management.

Recovery phase

The focus of recovery is to return organizations to their baseline levels of function.

The **recovery phase** of Comprehensive Emergency Management (CEM) for healthcare systems follows response. It focuses specifically upon returning the organization and community to baseline their functional state. Recovery can be viewed as both the time interval and the functional activity period that extends from demobilization until return to either the pre-incident function/capacity or to a defined "new normal."

Well-executed recovery activities can significantly improve the function of the recovering organization or its system compared with its pre-incident condition. Improvements may be related to hazard/risk reduction or elimination (through concomitant mitigation actions). Improvements may

also be made to every-day operations of the recovered organization, incorporating positive changes discovered during the emergency response activities. Recovery may also establish a base for long-term growth. In some cases, recovery must accomplish new building construction, geographic re-location, sweeping change in methods for conducting business, more stringent security arrangements or other sweeping measures. These may create such a change from the "pre-incident state" that it is referred to as "the new normal."

Recovery Phase concepts include:

- Starting point for recovery: The planning for incident recovery begins early in response, ideally as soon as the IMT is organized and functioning. The demarcation between the response phase and recovery phase is rarely obvious; Recovery activities may begin well before most response assets are demobilized and grow in importance as response objectives are accomplished. A transition period is therefore recognized as described in the preceding section. The onset of the formal recovery phase, as determined by the IMT in consultation with executive leadership, should be at the start of new operational period and the distinction should be conveyed through public pronouncement as part of the transition.

The formal start and the projected endpoint of recovery should be delineated during recovery action planning.

- End point for recovery: The point when the recovery phase is complete can be similarly difficult to recognize, so it must be addressed through a formal process. The recovery phase can extend for very prolonged periods of time, even years in some cases. As an example, a community impacted by a large earthquake may require years to recover to its pre-event status. Though the organization may have reverted to its day-to-day organizational structure, components of the EOP can be continued to manage specific residual recovery activities and to objectively define the endpoint of recovery.

- Organizing recovery tasks: Recovery activities commonly require even more organized planning than response tasks, which are more likely to have parameters partly established by incident circumstances (life safety, obvious needs, time urgency, specific functional location, etc.). It is therefore important that these factors be clearly defined by the recovery management process. The ICS-based action planning process (perhaps called "recovery action planning") and procedures delineated in the EOP are used for many recovery activities to ensure efficiency and effectiveness in planning and supervision. The EOP guidance related to IMT operations, as well as any EOP recovery annexes or appendices, may therefore be utilized well into the recovery phase as noted below.

- Return to readiness: As noted earlier, for organizations with emergency response roles, the completion of "return to readiness" tasks must be expeditiously completed during recovery.

- Recovery as part of a larger effort: Recovery for an organization is rarely conducted in isolation. Frequently, recovery is also undertaken by the larger community at the local, State, and Federal levels. The healthcare system's recovery should be coordinated with this larger system where feasible. In particular, the healthcare organization's commitment of support to external requirements may include recovery tasks, so these must be managed in coordination with outside entities.

  Community authorities should be notified when the healthcare system is recovered. This may be simple (e.g., an organization officially notifying the jurisdiction that it has achieved baseline operating status) or complex (e.g., extensive interaction required for allocation of Federal recovery resources, expeditious building and operating permits and other issues in a post-disaster environment).

  It is therefore helpful to consider the Recovery phase in terms of **required management functions and organized recovery activities, adequately supported by planning, logistics, finance and administration, to return to a pre-incident status with achievable improvements**.

Recovery Planning and the EOP

Recovery planning guidance, established during preparedness, is an extension of the EOP. It provides priorities for recovery of mission-critical systems and guidance for actions related to physical and financial restoration that extends beyond the response phase. A stand-alone recovery plan that is separate from the EOP may therefore not be helpful, given the overlap of the response and recovery phases. Important considerations for recovery planning are presented here:

- Recovery planning and ICS: Recovery planning, as noted above, should acknowledge the use of ICS structure and process, and assume this is a continuation from effective IMT structure and process in place for response. Adapted ICS forms may therefore have continued utility in the recovery action planning process.

- Recovery management by objective: The implementation of recovery planning should be guided by documenting and using 'management by (recovery) objective.' These objectives will necessarily require periodic evaluation and adjustment (and so operational periods and a

The methodology of management by objective should be extended through recovery.

planning cycle should be established for recovery). The recovery objectives should be achievable and measurable, and provide metrics that indicate when recovery is complete.

- This transition of objectives may be the prompt for change in command and general staff personnel, and other position assignments for the incident management team to reflect the change in primary objectives. It is important to recognize, however, that the new leaders are still operating within ICS and not simply within their key operating unit or other day-to-day management position. For example:
  - If recovery is primarily a financial objective, the healthcare system's finance personnel may assume the manager or operations sections chief role.
  - If recovery is focused upon deconstruction of impacted buildings and rapid reconstruction, administrators in charge of facility engineering and construction may assume the manager or operations chief role.
- Throughout recovery, the need for continued IMT structure and processes is reassessed during the management and planning meetings in the recovery action planning cycle. The determination should be clearly described in any formal recovery action plan.

ICS consistent organizational structures may be utilized to manage an organization's recovery.

  - For recovery from some complex incidents, the IMT may remain for extended periods in a more compact form with a smaller cadre. For clarity, it may become known as the "recovery management team."
  - IMT responsibilities will transition, as the complexity of recovery management and the number of recovery tasks recedes, to regular day-to-day key operating unit managers or other management positions within the recovering organization. At some point, the regular administrative structure will reassume management of the healthcare system, but components of the recovery management structure may remain in place to continue managing specific issues.
- The strategic recovery objectives, delineated in recovery action plans, provide an "endpoint" at which recovery is considered complete.

- Recovery guidance: Recovery planning should provide documented processes that guide restoration of services (see activities below for

examples of activities to address). Some of these may take the form of 'tools,' such as checklists, that are contained within EOP recovery or other annexes.

- Recovery and mitigation: The motivation (and therefore the ability) to perform large-scale mitigation such as structural improvements is often greatest immediately after an incident and recovery planning should capitalize on this. Considerations include:

  - Revision of the latest HVA as indicated. Identification of unexpected or underestimated hazards and vulnerabilities encountered during the incident may be described and ranked for priority action.

  - Review and possible revision of the mitigation plan. Identified mitigation actions that had originally been considered too cost-prohibitive or too disruptive to implement may now be considered feasible (e.g., new motivation and/ or availability of funds provided for recovery/reconstruction funds that allow design change to achieves hazard/risk reduction).

- Recovery and organizational learning: The link between recovery and organizational learning (or systems improvement) should be well delineated so that important data elements are captured during recovery and used to drive, in a documented fashion, the organizational learning process (see Unit 4).

- Short- and long-term recovery planning: Recovery is both a short-term and potentially a long-term process and the plan should reflect this.

  - Short-term Recovery is necessarily focused on vital services in the organization and return-to-readiness of emergency response capability and capacity. Suggested activities (listed below) to accomplish these key tasks may require prioritization according to the organization's recovery objectives.

  - Long-term recovery focuses on restoring the organization and the community to their normal or pre-disaster condition, or to the 'new normal' state as described above.

An organization should consider specific recovery issues in the Support and Incident Specific Annexes.

Recovery planning actions: a synopsis

Recovery actions may be facilitated by Support Annexes or Incident Specific Annexes (recovery guidance similar to response guidance). Activities that recovery planning should address include:

- Personnel recovery:
  - Completion of activities initiated during demobilization such as out-processing of personnel:
    - Accountability of personnel.
    - Incident review meeting.
    - Individual and group debriefings as necessary.
    - Ensuring adequate rehabilitation time and actions for those participating in the response.
    - Rescheduling as necessary for shift workers.
    - Documentation of potential exposures (as appropriate).
  - Attending to acute and long-term physical and psychological health effects incurred by healthcare system personnel during response (e.g., conducting long-term health surveillance for exposed staff, or providing counseling services).
- Non-personnel resources: Recovery of mission critical systems and return to readiness of response resources.
  - Physical structure recovery:
    - Evaluating, cleaning, repairing damage to the facilities or reconstruction as indicated by assessment findings.
    - Rehabilitation of incident facilities, such as cleaning the DECON areas, or returning to normal function the area used to support the Healthcare System Command Post.
    - Recertification of facilities that have received hazard impact (e.g., professional evaluation of a facility in a post-earthquake environment to certify structural integrity for occupation and use, certification that a contaminated area is clean, and others).
  - Equipment and Supply Cache recovery:
    - Replacing or servicing equipment used during response.

- Inventory of supplies and replacement of expended materials.

- Financial recovery:

  - Accounting accurately for all costs incurred as a result of a hazard impact and incident response and recovery. For healthcare systems, this may include:
    - Loss of normal business revenue due to the voluntary suspension of certain services in order to provide incident services (e.g., cancellation of elective surgical and diagnostic procedures).
    - Overtime staff costs.
    - Loss of durable equipment.
    - Structural impact.
    - Loss of revenue due to patients avoiding an 'impacted facility.'
    - Others.

  - Application for reimbursement of costs from appropriate resources.

  - Tracking of costs and reimbursements and impact on regularly budgeted operations.

- Business systems recovery:

  - Re-establishing normal operations
    - Recovery of infrastructure necessary to resume normal operations
    - Notification to community authorities and the public that normal healthcare e system operations are resuming, and any relevant changes (location, contact information for re-scheduling, security procedures, and others)
    - Rescheduling of canceled or postponed activities
    - Addressing the backlog of urgent and elective cases in an expedited manner
    - Evaluation of the public's perception of the system's response, with public information interventions as indicated.

- Coordination with external systems: Recovery activities should be coordinated with other healthcare facilities and the community response system. This might include:

  - Notification when baseline operations have been restored.

- Sharing particular hazard or vulnerability information that was developed during response and recovery and that may impact other healthcare facilities or the community.

- Coordinating the application for and allocation of financial assistance in an objective and fair manner, as well as receipt of other resources (e.g. re-supply of medications from an arriving shipment, or resumption of the normal blood supply for the region).

○ Organizational learning/Systems improvement: As noted earlier, the Recovery plan should address the critical activities that initiate the organizational learning process.

- Recovery efforts should include a thorough evaluation of how the response system performed under stress (see Unit 4 for descriptions of Incident Review and After Action report meetings).

- Specific strengths, weaknesses, and strategies to both lessen vulnerability and improve the system's ability to respond to future emergencies and disasters should be captured and tracked.

- This information is analyzed, formatted and entered into the EM program process for organizational learning (See Unit 5) and should also be noted and considered during the HVA revision process.

• Community recovery activities:

○ Follow-through on pre-existing commitments for support to external requirements. This may include continued participation in a local healthcare coalition's information and resource sharing activities. It may also include continued actions for contracted or otherwise obligated services to outside organizations.

○ Active participation in planning and implementing initiatives to assist the community itself in returning to normal or a defined "new normal." Some of this may be done urgently through the community-wide incident management team structure, and some may be accomplished through more normal business administration routes as the community undertakes reconstruction.

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