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Emergency Management Plan (EMP) Template

For use by Colorado Community Health Centers and Clinics

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VERSION 2

Developed by

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ACKNOWLEDGEMENTS

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Clinica Family Health Services, Inc.
Colorado Coalition for the Homeless
Denver Health's Family Health Services
Dove Creek Community Health Clinic
High Plains Community Health Center
Metro Community Provider Network
Mountain Family Health Centers
Northwest Colorado VNA – Community Health Center
Peak Vista Community Health Centers
Plains Medical Center, Inc.
Pueblo Community Health Center, Inc.
Salud Family Health Centers
Sunrise Community Health
Uncompahgre Medical Center
Valley-Wide Health Systems, Inc.

Portions of this emergency management plan have been adapted from excellent emergency management materials from the following organizations:

- Emergency Preparedness Project, California Primary Care Association (CPCA)
- Kaiser Permanente
- Community Health Care Association of New York State (ANYS)

TEMPLATE INTRODUCTION

The Emergency Management Plan (EMP) Template has been developed as a guide for organizations to use in writing meaningful all-hazards EMPs that satisfy The Joint Commission (TJC) and Accreditation Association for Ambulatory Health Care **(**AAAHC**)** Standards, Federal Emergency Preparedness Policy Information Notice expectations, and Colorado Board of Health Bioterrorism rules. This step-by-step guidance will provide direction for developing a comprehensive all-hazards plan as well as building upon any existing plans or policies that the organization has already developed.

Do not be intimidated by the size and detail of this Template. It contains sample wording and forms that will not be included in the final plan. Any information that does not apply to the organization will be deleted. The plan states what resources and capabilities the organization has and what resources it does not have. In some cases "none" is an acceptable answer.

All wording in this template is sample wording. Because of the diversity of the organizations in size, number of facilities, and resources, this template is all-inclusive. Delete sections that do not apply and add any information that will enhance the plan.

Components of the Template

This Template consists of the basic plan. Appendices, Annexes and references are for the organization to develop specific to the location. Templates for those mentioned within this document are available from CCHN as well.

The Basic Plan

The basic plan describes the organization and how it will function during a disaster. The leadership structure, relationships with other agencies and the legal requirements for emergency preparedness planning are included.

Appendix

The Appendices are documents that enhance or explain the basic plan. This includes organization-specific information such as contact lists, vendor lists, or the organization's Hazard Vulnerability Analysis (HVA).

The Response Procedure Annex

These attachments or references provide information for responding to specific types of disasters and incorporates the organization's current disaster operating procedures. It will include, but is not limited to, fire, tornado, pandemic flu, and lost child protocols.

References

A Document Toolkit is available from CCHN and contains forms and information that may be helpful in developing an EMP but not necessarily part of the plan. Most of these documents will be discarded after the EMP is "finished." The documents in the Toolkit that are helpful can be attached to the EMP as references.

How to Use the EMP Template

This is the EMP for your organization, so adjust the document to fit your organization's unique needs. Feel free to add or delete information.

Health Centers with more than one facility need to decide whether to do a full plan for each clinic or to write one plan for the whole organization and a separate response section for each clinic, including how the clinics will communicate with each other.

The Template is designed so that parts of it can be used word for word or modified to fit the organization. The < > symbols around information indicate information that needs to filled in, for example, <Name of organization> or <local Health Department>.

The sections in red are comments or instructions from the Template author. Comments might include options for how to approach a section or a description of what belongs in a particular section. Substitute the information that applies to your organization in place of the comments.

When the EMP is complete, delete all of the directions, comments and general information from the Template. Any documents that are to be included with the plans will be attached as appendices, annexes or references.

Keep the EMP and annexes basic. Ensure enough basic details that the employee who started work on the day of the disaster will understand.

Saving the EMP

Your plan should be in both electronic and hardcopy formats. The electronic version allows for easy access and changes. The hardcopy is a backup for power failure or a

Time Commitment

computer crash. Keep copies of the EMP offsite with all key personnel in case the facility becomes inaccessible.

Adapting the template to the organization will take time. How much time will depend on the planning that has already taken place.

If present, the current organization plan can be cut and pasted into the template.

All of the organization's current plans can be dissected and put into appropriate locations in the template. It will take about two hours to update the template with the organization's information.

Information will need to be filled into some appendices/annexes. There will be sections of the Template that were not dealt with in the old plan. Individuals with some basic history with the organization and expertise in the appendices/annex topic should be able to complete these sections in four to eight hours.

Management staff will need to develop some of the content for the appendices/annexes. There will be some sections that cannot be filled in easily. For example, if the organization has not decided what role(s) it will take during a disaster; Management Staff will need to look at the issue in depth, talk to staff, and get feedback from the local health department and county office of emergency management before committing this to paper. Identifying issues and addressing them will be an ongoing process.

Philosophies and policies may need to be discussed and developed.

Conversations about health care in disaster bring up ethics and operational issues. For example, the issue of altered standards of care is one that needs to be explored by the organization, government, and nonprofit agencies. This conversation may continue for years, with the plan reflecting the most current information.

The Board of Directors may need to approve the final plan.

The EMP Goal

The goal is to have a "completed" EMP ready to distribute to stakeholders and community partners. To be considered complete the EMP will contain:

- All current planning information for the organization
- A clear definition of the organization's disaster role(s)
- Placeholders indicating which parts of the plan are still under development
- A clear plan of how and when the EMP will be reviewed and updated

The First Steps

Take a deep breath.

Pull together all of the information that will support the EMP. This includes, but is not limited to, the current plan, operating procedures, contact lists, and information on community planning.

Look at each section of the current plan and paste it into the most logical place in the Template.

Continuation

This plan will need to be revised to meet the needs of your organization. The Appendix numbering system will change if additional documents are added. Requirements are current at date of template but it is your responsibility as an organization to maintain up-to-date requirements.

Emergency Management Plan

<Name of Community Health Center Clinic>

<Organization logo>

<Address>

Last Revised <Date>

For more information or questions about this plan contact <plan author for organization>

TABLE OF CONTENTS

INTRODUCTION

The purpose of the <Name of Community Health Center> All Hazards Emergency Management Plan (EMP) is to establish a basic emergency preparedness program to provide timely, integrated, and coordinated response to the wide range of natural and man-made disasters that may disrupt normal operations and require a preplanned response.

The reason for this approach is to:

- Provide maximum safety and protection from injury and illness for patients, visitors, and staff.
- Provide care promptly and efficiently to all individuals requiring medical attention in an emergency.
- Provide a logical and flexible chain of command to enable maximum use of resources.
- Maintain and restore essential services as quickly as possible following an emergency incident or disaster.
- Protect clinic property, facilities, and equipment.
- Satisfy all applicable regulatory and accreditation requirements.

POLICY

It is the intent for <Name of Community Health Center> to adequately prepare, mitigate, respond, and recover from a natural or man-made disaster or other emergency. This will be done in a manner that protects the health and safety of patients, visitors, and staff, and that is coordinated with the local community-wide response to a large-scale disaster.

Executive management recognizes that the families of our employees are their primary concern during a disaster and we will support employees to ensure their own families are safe. We support and encourage each employee to create a personal preparedness plan for their families. It is expected that all employees will be prepared and ready to fulfill their duties and responsibilities as part of the team to provide the best possible emergency care to patients and the community. Each supervisor will ensure that employees are aware of their responsibilities.

<Name of Community Health Center> will work in close coordination with the local health department and other local emergency officials, agencies and health care providers to ensure a coordinated community-wide response to disasters.

SCOPE

Within the context of this EMP, a disaster is any emergency event which exceeds or threatens to exceed the routine capabilities of the clinic.

This EMP describes the policies and procedures <Name of Community Health Center> will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.

This plan applies to <all> clinic locations, annexes and administrative areas and covers <all> employees, contractors and volunteers.

Development and implementation of this plan complies with relevant sections of The Joint Commission Standards <list sections here if applicable> and Accreditation Association for Ambulatory Health Care (AAAHC) Standards. <Use this wording if you are TJC or AAAHC certified and be sure to update plan as certification requirements change.>

<NAME OF COMMUNITY HEALTH CENTER>

<Describe the organization. What is unique about the organization in terms of population, services, geography…? How many facilities does the organization have? What is unique about those facilities? What about those facilities presents a challenge during a disaster?>

MITIGATION

Mitigation is the pre-event planning and action steps that aim to lessen the effects of potential disaster. Mitigation activities may occur both before and following a disaster.

<Name of Community Health Center> will undertake risk assessment and hazard mitigation activities to lessen the severity and impact of a potential emergency by identifying potential emergencies (or hazards) that may affect the organization's operations or the demand for its services.

Identification of Hazards and Vulnerabilities

During the mitigation phase, <Name of Community Health Center>'s <insert title of person or committee responsible for hazard identification> will identify internal and external hazards.

The <Insert title of person or committee responsible for hazard identification> will conduct a Hazard Vulnerability Analysis (HVA) annually to identify hazards to the clinic. Within the HVA, the direct and indirect effect these hazards may have on the clinic will be quantified and prioritized (refer to Appendix A1 for completed HVA). <Refer to Appendix A1, Hazard Vulnerability Analysis (HVA) for template. If you used a different HVA form, attach it as Appendix A1.>

The <Insert title of person or committee responsible for hazard identification> will conduct a Management of Environment Safety Survey of its facilities at least quarterly to rank problems and set priorities for remediation. Refer to Appendix A2, Environment Safety Survey.

<Name of Community Health Center> will use the HVA and the Management of

Hazard and Vulnerability Mitigation

Environment Safety Survey to regularly take steps towards reducing the potential impact hazards have on the clinic. Ongoing policy development, plan revision, repairing and retrofitting contributes to reducing the overall vulnerability of the clinic to various hazards. <Refer to Toolkit #4, Structural, and Non-Structural Hazard Mitigation Checklists for mitigation recommendations for specific hazards.>

Insurance Coverage

The Chief Financial Officer (CFO) of <Name of Community Health Center> will meet with insurance carriers to review all insurance policies and assess the facility's coverage

for relocation to another site, loss of supplies and equipment, and structural and nonstructural damage to the facility.

The CFO will assess clinic coverage for floods as this is an additional policy beyond general coverage and flood needs can change. If coverage is absent or inadequate, the clinic will evaluate if it is financially sound to acquire it. Clinics located in special flood hazard areas must have flood insurance to be eligible for disaster assistance. Refer to Appendix C1, Vendor Contact List, for insurance plan information.

<An option to the previous wording is to list the types of insurance that the organization has and any additional information that is needed.>

PREPAREDNESS

Preparedness activities build organization capacity to manage the effects of emergencies.

The <Name of Community Health Center> <Executive Director, Emergency Preparedness Committee (EPC) (use whatever titles apply)> will develop plans and operational procedures to improve the effectiveness of the clinic's response to emergencies. Annually, by this date <00/0000> the organization will:

- Review and update the EMP and other related documents.
- Review the organization's Emergency Response Role.
- Develop and update agreements with other community health care providers and with civil authorities.
- Train personnel on emergency response procedures.
- Conduct drills and exercises and revise the EMP and related documents if needed.
- Present any of the changes that need approval to the Board of Directors.

Emergency Response Role

Clinics are not equipped to respond definitively to all disasters. However, the organization may play a variety of roles in responding to a disaster including, but not limited to:

- Providing emergency medical care
- Providing temporary shelter
- Expanding primary care services to meet increased community needs created by damage to/evacuation of other health facilities
- Providing mental health services to disaster victims and serve as a conduit for information dissemination to affected communities
- Assisting with victim management by acting as a medical liaison to victim's family members
- Closing clinics in order to move staff to other organization facilities or to the local hospital

Clinic roles may be constrained by limited resources, technical capability, and by the impact of the disaster on the clinic facility. (Refer to Toolkit #5- Clinic Response Roles

and Requirements, for a list of potential roles and the planning and preparedness requirements for meeting those roles.)

The organization, not the emergency management community, needs to decide on the response roles it will perform following a disaster and describe those roles in this section. This decision will involve input from clinic management and staff, the clinic board of directors, the community, and government emergency management officials. Be sure to share this information with the emergency management community (e.g. local health department and county office of emergency management) so that they will know what to expect from the organization.

The following wording based on language from the High Plains EMP:

During an emergency the <Chief Executive Officer or Executive Director> will determine if <Name of Community Health Center> facilities will:

1) Continue normal operation and see regular patients. This decision will be made internally with consideration of the following:
    - Orders from authorities
    - Integrity of the facilities
    - Ability to access facilities
    - Security
    - Availability of support staff
    - Availability of medical staff
    - Ability to provide uncompromised care
    - Availability of medications/vaccines
    - Adequate supplies for staff, e.g. water, food
    - Availability of power and other utilities
2) Provide care to only those affected by the emergency or close.
    a. If the emergency is community-wide <Name of Community Health Center> will consider becoming a triage center, family gathering area, or other solution in support of the medical community.
    b. If the <Chief Executive Officer or Executive Director> or designee approves the decision to continue to see patients, staff will then consider the need to:
        - Cancel non-urgent appointments
        - Schedule changes to increase available patient hours
        - Increase the number of staff by using the dental staff or qualified volunteers

When <Name of Community Health Center> decides to take any of the actions described above, <Name of Community Health Center> will notify the <insert county name> County Public Health Department and the <insert county name> County Office of Emergency Management. (Refer to Appendix C2- Disaster Contacts).

For more information regarding decision making, refer to the organization's Surge Capacity Annex and Crisis Communications/ Public Information Plan Annex.

Incident Command System/National Incident Management System

<Name of Community Health Center> has adopted the principles of Incident Command System/National Incident Management System (ICS/NIMS) for this plan to ensure compatibility with local government response plans and procedures.

<Name of Community Health Center>'s CEO/ED, Vice Presidents, and Communications Manager have a certificate on file for the following courses provided by the Federal Emergency Management Agency (FEMA):

- *Introduction to Incident Command System* (IS-100),
- *Applying ICS to Healthcare Organizations* (IS-200 HCa), and
- *National Incident Management System (NIMS) An Introduction* (IS-700)

<Name of Community Health Center>'s directors and managers have all been trained in the concepts of ICS and NIMS so that they can integrate with Executive Management and response agencies during an emergency.

Incident Command Center

<Name of Community Health Center> has selected <describe the location> this could be someone's office, a conference room or another building as the Incident Command Center. The Incident Command Center is the location which the on-scene Incident Command Team will gather to assess and manage the situation.

The alternate Incident Command Center will be <describe the location>.

During an area-wide disaster, fire, EMS and law enforcement may not be able to respond to emergencies at the clinic. This is why it is critical that staff at each clinic be capable of assessing the damage and immediately respond to the situation.

When the community is involved with an event, the <insert county name> County Public Health Department and the <insert county name> County Office of Emergency Management will set up a community Emergency Operation Center (EOC). The EOC is where non-tactical teams from multiple agencies will join together to manage the strategic scope and disseminate information to partner agencies and individuals. The phone number for the county EOC is in Appendix C2, Disaster Contacts.

Integration with Community-wide Response

<Name of Community Health Center> will, to the extent possible, ensure that its response is coordinated with the decisions and actions of the <insert county name> County Public Health Department and other health care agencies involved in the response.

Coordination with Government Response Agencies

<Name of Community Health Center> will notify <Who is responsible for community wide emergencies in your community?> of any emergency impacting clinic operations and will coordinate its response to community-wide disasters with the overall medical and health response of the Operational Area. Refer to Appendix C2- Disaster Contacts.

To ensure coordination with government response agencies, clinic staff will:

- Participate in planning, training and exercises involving government response agencies and medical health agencies in the community.

- Develop reporting and communications procedures with government response agencies and medical health agencies in the community.
- Define procedures for requesting and obtaining medical resources and for evacuating/transporting patients.
- During an emergency response, report the status and resource needs of the clinic and obtain or provide assistance in support of the community-wide response.
- Cooperate with Emergency Responders, such as EMS and law enforcement personnel when they respond to emergencies at the clinic. This may include providing information about the location of hazardous materials or following instructions to evacuate and close the clinic.

Coordination with other Medical Facilities

<Name of Community Health Center> recognizes that it may need to rely on other health care facilities, especially those nearby, in responding to a disaster to increase its capacity to meet patient care needs.

At least annually, <Name of Community Health Center> will discuss plans with other health facilities to explore the expansion of provisions to cover disaster response conditions.

<Name of Community Health Center> will seek to establish written agreements with relevant facilities where no written agreement currently exists.

These agreements are reciprocal and <Name of Community Health Center> will provide support to these facilities <u>if conditions and resources allow</u>. Refer to Appendix C3, List of Memorandums of Understanding.

Acquisition of Resources

<Name of Community Health Center> has developed written Memorandums of Understanding (MOU) for acquisition of supplies through other clinics, hospitals, and health care providers if their resources are available. Refer to Appendix C3, List of Memorandums of Understanding.

Procedures to work with <insert county name> County Public Health Department to acquire supplies through the Strategic National Stockpile (SNS) during a disaster have also been developed, see County Emergency Operation Plan Annex.

<The applicable ideas/processes of the County Emergency Operation Plan can be inserted here with reference to the page and date of the County Plan for easy updating.>

<u>Roles and Responsibilities</u>

<This section needs to fit the titles and assignments of the organization and clinic(s). Read through and adjust the lists to fit. Use the information below for examples of titles, roles, and responsibilities. Staff who qualify should be listed on Appendix D1, Emergency Management Organizational Chart. The finalized Job Action Sheets for the organization will be attached to the plan as Appendix D3, Job Action Sheets. Job descriptions for key staff members should be reviewed to include their disaster role.>

Executive Director (ED)/Chief Executive Officer (CEO)

The ED/CEO is directly or through delegation responsible for:

- Development and implementation of this Emergency Management Plan (EMP).
- Appointing an Emergency Preparedness Committee (EPC) that is responsible for coordinating the development and maintenance of the <Name of Community Health Center> EMP and, provide for ongoing training for clinic staff. Refer to Appendix C4, Emergency Preparedness Committee.
- Appointing the Incident Management Team (IMT) that is the leadership team that is activated during a disaster in compliance with ICS/NIMS. <Beware of the term Emergency Response and requiring employees to respond as this will increase required training per Occupational Safety and Health Administration standards 1910.38 or 1910.120(q).>
- Supporting staff training to ensure preparation for performing emergency roles.
- Ensuring that drills and exercises are conducted semi-annually and records are maintained.
- Determining how, when and who will perform the annual disaster program evaluations and updates.
- Activating <Name of Community Health Center>*'s* emergency response and the IMT.
- Developing the criteria for and direct the evacuation of staff, patients, and visitors when indicated.
- Ensuring <Name of Community Health Center> takes necessary steps to avoid interruption of essential functions and services or to restore them as rapidly as possible. (See Business Continuity Plan annex).

Medical Director

The Medical Director, directly or through delegation, will:

- Serve on the Emergency Preparedness Committee (EPC).
- Identify alternates and successors if unavailable or if response requires 24-hour operation.
- Contact local health department to determine how to receive medical updates.
- Provide clinicians with updates from the Center for Disease Control and <insert county name> County Health Department on standards for the detection, diagnosis, and treatment of novel diseases and agents.
- Ensure the continuity of care and maintenance of medical management of all patients in the care of the clinic during a disaster.
- Assign clinical staff to medical response roles such as triage and treatment.
- Determine disaster response clinical staffing needs in cooperation with the Nursing Director.

Nursing Director

The Nursing Director may fill the following roles:

- Serve on the Emergency Preparedness Committee (EPC).

- Communicate with <insert county name> County Public Health Department for public health threats and guidance.
- Provide clinicians with updates on standards or the detection, diagnosis, and treatment of public health threats.
- Determine the disaster response clinical staffing needs in cooperation with the Medical Director.
- Perform other duties delegated by <Name of Community Health Center> Medical Director, Executive Director, or Incident Commander consistent with training and scope of practice.

Safety Officer

The Safety Officer is responsible for the following roles:

- Chair the Emergency Preparedness Committee (EPC).
- The Safety Officer will appoint teams and develop procedures for the following response tasks:
    - Light search and rescue - appoint and train a light search and rescue team to ensure all rooms are empty and all staff, patients, and visitors leave the premises when the clinic is evacuated.
    - Appoint and train a damage assessment team on each shift to evaluate damage.

Clinic Staff

All clinic staff have emergency and disaster response responsibilities. Details are outlined in each job description when applicable. All staff are required to:

- Familiarize themselves with evacuation procedures and routes for their areas.
- Become familiar with basic emergency response procedures for fire, HAZMAT, and other emergencies.
- Understand their roles and responsibilities in <Name of Community Health Center>'s plans for response to and recovery from disasters. Refer to Appendix D3, Job Action Sheets.
- Participate in Clinic training and exercises. Refer to Appendix E1, Training and Exercises.

All staff will also be encouraged to:

- Make suggestions to their supervisor or the Emergency Preparedness Committee (EPC) on how to improve clinic emergency preparedness.
- Prepare family and home for consequences of disasters. Refer to Appendix F1 – Home Preparedness Guidelines for Disasters. <Examples of information is available through the Red Cross. Decide what information should be made available to staff. This information does not have to be included as an attachment to your plan, but could be listed in Appendix E1 Training and Exercises.>

<u>Notifications</u>

Primary emergency notification to staff and partners off-site will be the local telephone system. Staff within the facility will be notified of emergencies affecting the facility by alarms, strobe lights and an overhead paging system. Refer to Appendix G1 Communications Equipment Inventory and Communications Annexes for other methods and procedures.

Internal Contacts

The<insert title of responsible person> will update Appendix B1, Staff Call List, at least quarterly or when information changes. The Staff Call List includes 24/7 contact information for all staff members.

The Staff Call List is available on the <Health Center shared drive/Intranet> and hard copies are to be kept with each Director. Managers are responsible for keeping a hard copy of numbers for those who report to them. Refer to Appendix B1, Staff Call List.

External Contacts

The <title of person responsible> will compile and maintain lists of external contact phone numbers such as emergency response agencies, key vendors, stakeholders, and resources at least twice a year in Appendix C1, Vendor Contact List. Additionally, government response entities, nearby hospitals and clinics, media, and others will be updated in Appendix C2, Disaster Contact List once every 6 months.

Emergency Resources

Personnel

<Name of Community Health Center> will rely primarily on its existing staff for response to emergencies and will take the following measures to estimate staff capability and availability for emergency response:

- Identify clinical staff with conflicting practice commitments.
- Identify clinical staff and support staff.
- Identify staff with distance and other barriers that limit their ability to report to the clinic.
- Identify staff that is likely to be able to respond rapidly to the clinic.
- Identify bi-lingual staff by language.

<Name of Community Health Center> will take the following steps to facilitate response to clinic emergencies by its staff when their homes and families may be impacted:

- Promote staff home emergency preparedness. Refer to Appendix F1, Home Preparedness Guidelines for Disasters.
- Identify childcare resources that are likely to remain open following a disaster.
- Coordinate with other entities to establish an emergency relief fund for affected staff.

Pharmaceuticals / Medical Supplies / Medical Equipment

Community Health Centers are required to prepare a plan that the organization would implement as a result of an occurrence or imminent threat of an emergency epidemic. The plan shall be reviewed and updated annually thereafter and if applicable, the revised plan should be submitted to the Colorado Board of Health, local board of health, and

local county commissioners (CDPHE, Regulation 3). (See Annex, Pandemic Flu Plan.) The plan must be tested annually.

<Name of Community Health Center>'s Pharmacy Director will determine the level of medical supplies and pharmaceuticals it is prudent and possible to stockpile. Given limited resources, the clinic will stockpile only those items it is highly likely to need immediately in a response or in its day-to-day operations. All stored items will be rotated to the extent possible.

The Pharmacy Director will identify primary and secondary sources of essential medical supplies and pharmaceuticals and develop estimates of the expected time required for re-supply in a disaster environment.

If the Governor of Colorado declares a disaster, mass quantities of pharmaceuticals, equipment, or supplies will be distributed through the Strategic National Stockpile (SNS). Each local public health department will distribute the supplies as requested throughout their territory.

<Name of Community Health Center> will alert <insert local public health department name> of supply needs and make appropriate requests as outlined in the local SNS distribution plan.

Personal Protective Equipment (PPE)

<Describe the organization policy for determining what PPE is used in which situations. List who, by title, will make the decision and how it will be carried out.

Refer to Toolkit #14, OSHA Pandemic Recommendations and Toolkit #15, PPE.

<Name of Community Health Center> will take measures to protect its staff from exposure to infectious agents and hazardous materials. Clinic health care workers will have access to and be trained on the use of PPE.

The Nursing Director and designee will receive training annually to provide just-in-time training in the event use of PPE is required. Training records will reflect the nature of training each employee receives in the proper use of PPE.

Protective equipment is located <location in clinic>.

Public Information / Risk Communications

<If the organization doesn't have a Public Information Officer (PIO), CCHN can be contacted for assistance.>

Refer to Appendix G2, Communications Methods and Crisis Communications/Public Information Annex.

Training, Exercises and Plan Maintenance Drills and Exercises

<Name of Community Health Center> will incorporate disaster preparedness information into its normal communications and education programs for staff and patients including:

- Home and family preparedness. Refer to Appendix F1, Home Preparedness Guidelines for Disasters.
- Information on clinic emergency preparedness activities and staff responsibilities.
- Procedures for emergency evacuation, including alarm systems, exit routes and meeting areas.

- Responsibilities for predetermined staff to perform critical duties prior to evacuation (i.e. fire wardens, critical equipment shut down).
- Rescue and medical duties for those employees who are to perform them.
- Information dissemination channels for these activities include newsletters, pamphlets, health education and in-service education classes, internet postings and specific personnel who can be contacted with questions.

Community Health Centers are required to maintain an up-to-date notification list for emergency epidemics that includes clinics, physicians and providers working as contractors or staff. Health Centers must participate in testing notification methods for those on the list by a broadcast fax or another communications method for rapid notification at least twice per year (CDPHE, Regulation 3).

According to the Occupational Safety and Health Administration (OSHA) parts of this plan necessary for self protection must be reviewed with each employee upon hire, when employee responsibilities change, and when the plan is changed.

Refer to Appendix E1, Training and Exercises for general guidelines.

RESPONSE

Response Priorities

<Name of Community Health Center> has established the following disaster response priorities:

- Life safety: Provide for the safety of patients, staff, and visitors
- Contain hazards that could pose a threat to people in the facility
- Provide care for injured patients, staff, and visitors
- Protect critical infrastructure, facilities, vital records, and other data
- Restore essential services/utilities
- Support the overall community response
- Provide crisis public information
- Resume the normal delivery of patient care

Alert, Warning and Notification

Disasters can occur both with and without warning. Upon receipt of an alert from credible sources the <Name of Community Health Center> Executive Director will:

- Notify key managers,
- Implement Incident Command System,
- Activate the Incident Command Center, and
- Review plans and consider possible actions.

Depending upon the nature of the warning and the potential impact of the emergency on <Name of Community Health Center>, the Incident Commander may decide to:

- Evacuate the facility;

- Suspend or curtail clinic operations;
- Ensure essential equipment is secured, computer files backed-up and essential records stored offsite;
- Implement other measures the Incident Commander may find appropriate to reduce clinic, staff and patient risk.
- Notify the <local health department>, <county name> Office of Emergency Management, community members, and staff.
- Communicate status to CCHN.

Response Activation and Initial Actions

This plan may be activated in response to events occurring within the clinic or external to it.

Any employee or staff member who observes an incident or condition which could result in an emergency condition should report it immediately to the <insert title of responsible person> or his/her supervisor.

Staff will report fires, serious injuries, threats of violence and other serious emergencies to fire or police by calling 9-1-1.

All staff should initiate emergency response actions consistent with the emergency response procedures.

If the emergency significantly impacts clinic patient care capacity or the community served by the clinic, the Executive Director or Incident Commander will notify <local health department> and CCHN.

Refer to Appendix G3, Emergency Codes for response to adverse situations.

Incident Management Team

<Name of Community Health Center> will organize its emergency response structure to mobilize appropriate resources and take actions required to manage its response to disasters utilizing the Incident Command System (ICS) and National Incident Management System (NIMS). ICS is flexible and can be increased or decreased in size, as needed. The specific functions that are activated and their relationship to one another will depend upon the size and nature of the incident. ICS is also a standardized management system used by government agencies and hospitals in emergencies. Refer to Appendix D1, Emergency Management Organizational Chart.

ICS employs four functional sections (operations, planning, logistics, and finance) who report to the Incident Commander in its organizational structure. Each activated section will have a person in charge of it, but a supervisor may be in charge of more than one functional element. Each supervisor will have three to seven (preferably five) people to supervise. Below are brief descriptions of the ICS structure that create the Incident Management Team (IMT).

As a whole, the IMT is responsible for the strategic, or "big picture" thinking of the disaster response. The IMT collects, gathers and analyzes data; makes decisions that protect life and property, and maintains continuity of the organization. The IMT disseminates decisions to all impacted agencies and individuals.

Incident Commander:

- Is the first person on scene, until the duties are transferred if necessary
- Oversees the command/management function
- Provides overall emergency response policy direction
- Oversees emergency response planning and operations
- Coordinates the responding clinic staff and organizational units

The staff supporting the Incident Commander consists of the:

- Public information officer (PIO)
- Safety/Security Officer
- Liaison Officer

The Incident Commander may be Executive Director, Chief Operating Officer, Medical Director, or the Nursing Director.

Operations Section

- Coordinates all operations in support of the emergency response and implements the incident action plan for a defined operational period.
- Operations Section manages medical and mental health care.

The Operations Section Chief may be the Medical Director or Nursing Director.

Planning and Intelligence Section

- Collects, evaluates, and disseminates information.
- Develops the incident action plan in coordination with other functions
- Performs advanced planning; and, documents the status of the clinic and its response to the disaster. Refer to Appendix D4, Response Checklists for Action Plan for guidance on gathering and managing information.

The Planning and Intelligence Section Chief may be the Chief Operating Officer.

Logistics Section

- Logistics provides facilities, services, personnel, equipment, and materials to support response operations. <Refer to Toolkit #21, Volunteer Policies and Procedures, and Toolkit #22, Volunteer Roster.>
- Logistics manages volunteers and the receipt of donations. Refer to Appendix D4, Response Checklists.

The Logistic Section Chief may be the Facilities manager, Purchasing manager, or Human Resources manager.

Finance and Administration Section

- Tracks personnel and other resource costs associated with response and recovery.
- Finance and Administration provides administrative support to response operations.

The Finance and Administration Section Chief may be the Chief Financial Officer or Finance Director.

<Name of Community Health Center> Incident Command Center

The Incident Command Center (ICC) is a central command and control area for where the Incident Management Team meets to carry out the functions at a strategic level in an emergency, and ensuring the continuity of operation of the organization.

The primary ICC is located at <insert location>. A backup location is <insert location>. Both locations are capable of communicating with outside agencies such as police, fire, and the local health department by means of <insert available communication equipment>. Each ICC has copies of this EMP, forms for recording and managing information, and facility floor plans. Refer to Appendix D2, Command and Control and Appendix H2, Clinic Floor Plans.

If the both ICC locations are unavailable or unsafe, the Incident Commander will select a new location based on environmental conditions.

The Incident Commander will deactivate the ICC when the response phase ends and recovery activities can be performed at normal workstations. Refer to Appendix D2, Command and Control.

Action Plans

The Action Plan is developed by the Incident Management Team and establishes the priorities and objectives of the response.

Action plans are developed for a specified time period which may range from a few hours to several days.

The action plans should be sufficiently detailed to guide the response. Refer to Appendix D4, Response Checklists.

If possible, operational period work shifts will be no more than 12 hours long and will overlap by at least 30 minutes to allow for briefings.

All actions, decisions, and expenses will be documented. This will protect against stress memory loss and provides needed documentation for disaster reimbursement after the emergency.

Medical Care

The confidentiality of patient information remains important even during emergency conditions. Clinic staff will take feasible and appropriate steps to protect confidential information.

Triage/First Aid

The Operations Section Chief will establish a site for triage and first aid. Qualified staff and volunteers will be assigned to triage incoming patients.

Triage decisions will be based on the patient condition, clinic status, availability of staff and supplies and the availability of community resources.

<There are two ways to complete this section. Either write down a full description for your Triage unit or put the detailed triage information into a Response annex document and cite its location here. The advantage of having the detail in the response annex is

that it can be taken out, copied, and handed to key people in an emergency. The following wording is an example for how to put the detail into the plan itself.>

<Name of Community Health Center> will establish a triage area in the <location of triage area>. When possible, the triage area will be clearly delineated and secured with controlled access and exit.

Triage staff will wear appropriate personal protective equipment and use universal precautions when interacting with patients. Appropriate personal protective equipment will be used when the involvement of chemicals or hazardous materials is suspected or a contagious illness is of concern.

All patients entering the triage area will be tagged and registered.

The medical care team will provide medical services within the clinic's capabilities and resources.

Patient Release/Discharge

Patients will be permitted to leave with family or friends ONLY after they have signed a release form.

Children will be allowed to leave ONLY with parents, family members or other adults who accompanied them to the clinic and who provide confirming identification (e.g., driver's license or other government identification). If no appropriate adult is available, clinic staff will:

- Provide a safe supervised site for children away from unrelated adults.
- Attempt to contact each child's family.
- If contact is not possible, contact Child Protective Services to provide temporary custodial supervision until a parent or family member is located.

To the extent possible, patients injured during an internal disaster will be given first aid by the clinic staff.

If the circumstances do not permit treating patients at the clinic, they will be referred to the local emergency room at <Name of Hospital> unless their injuries require immediate attention. Appendix H1, Health Care Alternate and Referral Facility Locations lists the alternate clinic site and hospital and clinic referral facilities.

If immediate medical attention is required and it is not safe or appropriate to refer the patient to the emergency room, 911 will be called and the patient will be sent by ambulance to the nearest emergency room. Due to legal liabilities, staff will not transport patients in their private vehicles.

If 911 services are not available, a request for medical transport will be conveyed to <name of the local agency in charge. It could be the local health department or the county emergency operations center.> In a widespread emergency, the county will determine how and where to transport victims through already established channels selected by the county.

Visitors or volunteers who require medical evaluation or minor treatment will be treated and referred to their physician or the hospital.

Employees who need medical evaluation or minor treatment will be treated and referred to their physician or the hospital.

Acquiring Response Resources

The Logistics Section will monitor medical supplies and pharmaceuticals and request augmentation of resources from <what agency would take this role for the area the clinic serves, public health?> at the earliest sign that stocks become depleted.

The clinic will maximize use of available hospitals, other clinics, and other external resource suppliers as is feasible.

If resources cannot be found and the request is high priority, it will be submitted to Regional, State, and Federal response levels until the requested resource can be obtained.

Vendors

As information develops about current and future resource needs, clinics should consider contacting vendors of critical supplies and equipment to alert them of pending needs and to ascertain vendor capacity to meet those needs.

<Name of Community Health Center> recognizes that in a major disaster, medical supply vendors may face competing demands that exceed their capacity. In that case, request for assistance will be submitted to the <what agency would take this role for the area, local EOC/ OEM/Public health?>, who will set resource allocation priorities.

Coordination with Clinics

<This section is for organizations with more than one facility. What is the chain of command? Will the organization administration contact the clinics or will the clinics contact the administration? The following wording is from the High Plains (EMP).>

At the onset of an emergency, each clinic affected will contact the Chief Executive Officer (CEO)/Executive Director (ED).

The CEO/ED or designee will contact the affected clinics if:

1. The CEO/ED is aware of a possible emergency and has not heard from the clinic.
2. The CEO/ED knows of a potential emergency.
3. The primary facility <address/name> has been impacted and support is needed from the other clinics.

During the emergency, the clinics will report changing status and needs at regular prearranged intervals or as needed.

Coordination with <Name of local health department>

<Describe relationship and methods of communication.>

Coordination with Colorado Community Health Network (CCHN)

<Name of Community Health Center> will contact CCHN to inform them of an emergency/disaster. CCHN can assist the Health Center with the following:

- Communication and coordination of support from:
    - Other Colorado organizations
    - Organizations outside of Colorado

  - Colorado Department of Public Health and Environment (CDPHE)
  - FEMA and other Federal agencies
  - Colorado Division of Emergency Management
- Support in dealing with the media
- Technical support

Communications

Logistics Section Chief will be responsible for appointing a Communications Officer, if necessary to use the clinic's communications resources to communicate with:

- Other clinics
- The <name of local health department>
- The <name the county> Emergency Operations Center (EOC)
- CCHN
- Emergency response agencies
- Outside relief agencies
- <Name of Community Health Center>'s Board of Directors

Staff telephone numbers are listed in Appendix B1, Staff Call List.

Disaster response agency contact telephone numbers are listed in Appendix C2, Disaster Contacts.

Refer to Crisis Communications/ Public Information Plan Annexes.

Security

The purpose of security will be to ensure unimpeded patient care, staff safety, and continued operations.

The Incident Commander will appoint a Security Officer (Refer to Appendix D3, Job Action Sheets) who will be responsible for ensuring security measures are implemented.

<If security becomes an issue, the organization may be able to get assistance from law enforcement through the county EOC.>

Security will be provided initially by existing security services or by personnel under the direction of the Security Officer. Security may be augmented by contract security personnel, law enforcement, clinic staff or, if necessary, by volunteers.

Checkpoints at building and parking lot entrances will be established as needed to control traffic flow and ensure unimpeded patient care, staff safety, and continued operations.

All clinic staff are required to wear their ID badges at all times. Security will issue temporary badges if needed.

The Security Officer will ensure that the clinic site is and remains secure following an evacuation.

Mental Health Response

The Operations Section Chief will ensure that Mental Health support has been established in a disaster. Refer to Annex, Mental Health Plan.

Volunteer Management

<In a widespread emergency, physicians and nurses may seek to volunteer at the clinic. In this section describe if and how the organization will accept volunteers. Keep in mind insurance and credentialing issues.>

Donation Management

<In a disaster, individuals and corporations try to gain a sense of control. One way that they can do that is to donate items or money to those they perceive need it. Not all of these donations are practical.

Describe how the organization will deal with donations of "stuff". Include instructions for documentation of the donations, and disposal or use of the items.

It is not always possible to turn down the donation (people will leave "stuff" on your doorstep) of items that you do not need, so include agencies in your plan that can pick up the items and put them to good use.>

Refer to Appendix D4, Response Checklists for a Donation Tracking form.

Damage Assessment

<Name of Community Health Center> will assess damage caused by the disaster to determine if an area, room, or building can continue to be used safely or is safe to re-enter following an evacuation.

Systematic damage assessments are indicated following an earthquake, flood, explosion, hazardous material spill, fire or utility failure.

Refer to Appendix D4, Response a damage assessment form that may be used if the clinic facility is completely safe.

Hazardous Materials Management

Refer to Annex, Hazardous Materials Management Plan.

Evacuation Procedures

The clinic may be evacuated due to a fire or other occurrence, threat, or order of the clinic Executive Director or designee. Refer to Appendix D4 Response Checklists and Evacuation Plan Annex for complete information.

Where and how to shut-off the utilities, including emergency equipment, gas, electrical timers, water, computers, heating, AC, compressor, and telephones are listed in Annex, Utility Shutoff.

Decision on Clinic Operational Status

Following the occurrence of an internal or external disaster or the receipt of a credible warning the Incident Commander will decide the operating status for <Name of Community Health Center>. Refer to Appendix D4, Response Checklists.

The decision will be based on the results of the damage assessment, the nature, and severity of the disaster and other information supplied by staff, emergency responders, or inspectors.

The decision to evacuate the clinic, return to the facility, and/or re-open the facility for partial or full operation depends on an assessment of the following:

- Staff availability
- Extent of facility damage / operational status
- Status of utilities (e.g. water, sewer lines, gas and electricity)
- Presence and status of hazardous materials
- Condition of equipment and other resources
- Availability of supplies
- Environmental hazards near the clinic
- Recommendation of local authorities
- Extended Clinic Closure

If the <Name of Community Health Center> experiences major damage, loss of staffing, a dangerous response environment, or other problems that severely limit its ability to meet patient needs, the Incident Commander, in consultation with the Executive Director, may suspend clinic operations until conditions change.

If <Name of Community Health Center> remains fully or partially operational following a disaster, the Executive Director, Medical Director, and other members of the IMT will define the response role the clinic will play.

The appropriate response role for <Name of Community Health Center> will depend on the following factors:

- The impact of the disaster on <Name of Community Health Center>
- The level of personnel and other resources available for response
- The pre-event medical care and other service capacity of <Name of Community Health Center>
- The medical care environment of the community both before and after a disaster occurs
- The needs and response actions of residents of the community served by <Name of Community Health Center> (e.g., convergence to the clinic following disasters)
- The priorities established by <Name of Community Health Center>'s Executive Director and Board of Directors (e.g., to remain open if possible following a disaster)
- The degree of planning and preparedness of <Name of Community Health Center> and its staff

<u>Weapons of Mass Destruction (WMD)</u>

Preparations for an event involving weapons of mass destruction - chemical, biological, radiological, nuclear, or explosives (CBRNE) - should be based on existing programs for handling hazardous materials.

- If staff suspects an event involving CBRNE weapons has occurred, they should:
    - Remain calm and isolate the victims to prevent further contamination within the facility.
    - Contact the Medical Director, Nursing Director, or other appropriate clinician.
    - Secure personal protective equipment and wait for instructions.
    - Comfort the victims.
    - Contact appropriate Operational Area authorities.

Refer to Appendix C2, Disaster Contacts and Annex, Pandemic Plan.

Shelter-In-Place

When there is a chance that there has been a release of radiation, hazardous materials, or biological agents in proximity to the organization the safest response may be to shelter-in-place. Refer to Appendix D4, Response Checklists and Shelter in Place Annex.

Mass prophylaxis

<Name of Community Health Center> encourages its clinicians to participate in a mass prophylaxis program if the disruption to clinic operations would not negatively affect the health of the community the clinic serves.

Health care providers from clinics throughout the county could be called to volunteer to distribute medication or provide vaccines in response to a large-scale attack.

<Name of County> would establish mass prophylaxis sites throughout the county.

These sites would be large facilities such as school gymnasiums or warehouses that can accommodate large groups of people.

These sites would require a large number of healthcare providers to administer medications.

Since the county does not employ enough practitioners to staff public sites, they will look to the private sector, including clinics, to provide mass prophylaxis to existing patients or assist with a public clinic.

RECOVERY

Recovery actions begin almost concurrently with response activities and are directed at restoring essential services and resuming normal operations.

Depending on the emergency's impact on the organization, this phase may require a large amount of resources and time to complete.

This phase includes activities taken to assess, manage, and coordinate the recovery from an event as the situation returns to normal. These activities include:

- Deactivation of emergency response: The <Name of Community Health Center> Executive Director or designee will call for deactivation of the emergency when the clinic can return to normal or near normal services, procedures, and staffing. Refer to Appendix D2, Command and Control.
- After Action Report: Post-event assessment of the emergency response will be conducted to determine the need for improvements. Refer to Appendix D5, After Action Reports.
- Establishment of an employee support system: Human resources will coordinate referrals to employee assistance programs as needed.

Accounting for disaster-related expenses

The Finance Section Chief will account for disaster-related expenses.

Documentation will include:

- Direct operating cost
- Costs from increased use
- All damaged or destroyed equipment
- Replacement of capital equipment
- Construction related expenses
- Return to normal clinic operations as rapidly as possible

Inventory Damage and Loss

<Name of Community Health Center> will document damage and losses of equipment using a current and complete list of equipment serial numbers, costs, and dates of inventory.

One copy will be filed with the Chief Financial Officer and another copy in a secure offsite location.

Lost Revenue through Disruption of Services

The Chief Financial Officer will work with the Finance Section to document all expenses incurred from the disaster.

An audit trail will be developed to assist with qualifying for any Federal reimbursement or assistance available for costs and losses incurred by the clinic because of the disaster.

Cost / Loss Recovery Sources

The eligibility of clinics for federal reimbursement for response costs and losses remains ambiguous. It may be possible to gain reimbursement through county channels under certain (largely untested) circumstances.

Depending on the conditions and the scale of the incident, <Name of Community Health Center> will seek the following financial recovery resources:

Public Assistance

After a disaster occurs assistance may be available to applicants through:

- The Federal Emergency Management Agency (FEMA)

- The Colorado Department of Emergency Management (CDEM)
- The Small Business Administration (SBA) provides physical disaster loans to businesses and non-profit organizations.
- Request assistance in determining available resources from Colorado Community Health Network (CCHN).
- Federal Grant - Following a presidential disaster declaration, the Hazard Mitigation Grant Program (HMGP) is activated.
- A private non-profit facility is eligible for emergency protective measures including, but not limited to:
    - Emergency access such as provision of shelters
    - Emergency care
    - Provision of food, water, medicine, and other essential needs and may be eligible for permanent repair work such as repair or replacement of damaged elements restoring the damaged facilities:
        - Pre-disaster design
        - Pre-disaster function
        - Pre-disaster capacity

Insurance Carriers

<Name of Community Health Center> will file claims with its insurance companies for damage to the clinic.

The clinic will not receive federal reimbursement for costs or losses that are reimbursed by the insurance carrier.

Eligible costs not covered by the insurance carrier such as the insurance deductible may be reimbursable.

<u>Psychological Needs of Staff and Patients</u>

Mental health needs of patients and staff are likely to continue during the recovery phase.

The organization recognizes that clinic staff and their families are impacted by community-wide disasters. The clinic will assist staff in their recovery efforts to the extent possible.

The Mental Health Coordinator will continue to monitor for and respond to the mental health needs of clinic staff and patients. The clinic will partner with local mental health professionals to coordinate staff support if necessary.

<u>Restoration of Services</u>

<Name of Community Health Center> will take the following steps to restore services as rapidly as possible:

- If necessary, repair clinic facility or relocate services to a new or temporary facility.
- Replace or repair damaged medical equipment.

- Expedite structural and licensing inspections required to re-open.
- Facilitate the return of medical care and other clinic staff to work.
- Replenish expended supplies and pharmaceuticals.
- Decontaminate equipment and facilities.
- Attend to the psychological needs of staff and community.
- Follow-up on rescheduled appointments.

After-Action Report

<Name of Community Health Center> will conduct after-action debriefings with staff and participate in <county name> debriefings.

The clinic will also produce an after-action report describing its activities and corrective action plans including recommendations for modifying the surge capacity expansion procedures, additional training, and improved coordination. Refer to Appendix D5, After-Action Report.

<Name of Community Health Center> will review this plan using the After Action Report and will revise the plan as needed.

REFERENCES

Appendix A1, Completed Hazard Vulnerability Analysis

Appendix A2, Completed Environment of Safety Survey

Appendix B1, Staff Call List

Appendix C1, Vendor Contact List

Appendix C2, Disaster Contacts

Appendix C3, List of Memorandums of Understanding

Appendix C4, Emergency Preparedness Committee

Appendix D1, Emergency Management Organizational Chart

Appendix D2, Command and Control

Appendix D3, Job Action Sheets

Appendix D4, Response Checklists

Appendix D5, After Action Reports

Appendix E1, Training and Exercises

Appendix F1, Home Preparedness Guidelines for Disasters

Appendix G1, Communications Equipment Inventory

Appendix G2, Communications Methods

Appendix G3, Emergency Codes

Appendix H1, Health Care Alternate and Referral Facility Locations

Appendix H2, Clinic Floor Plan

Annex - County Emergency Operation Plan

Annex - Pandemic Flu Plan

Annex – Business Continuity Plan

Annex - Patient Surge Capacity Plan

Annex - Hazardous Materials Management Plan

Annex – Crisis Communications/Public Information Plan

Annex - Utility Shutoff Procedures

Annex - Shelter in Place Guidelines

Annex – Evacuation Plan

RESOURCES

Reference 1, Colorado Department of Public Health and Environment, Disease Control and Environmental Epidemiology Division. (2007). *Rules and Regulations Pertaining to Preparations for a Bioterrorist Event, Pandemic Influenza, or an outbreak by a novel and*

highly fatal infectious agent or Biological Toxin (CCR Number 6 CCR1009-5), Regulation 3.

Reference 2, HRSA Emergency Preparedness PIN 2007-15

Reference 3, United States Department of Labor, Occupational Safety & Health Administration. *Means of Egress, Emergency Action Plans (29 CFR1910.38)*