Emergency Preparedness Toolkit for Primary Care Providers

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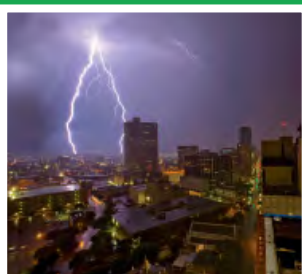
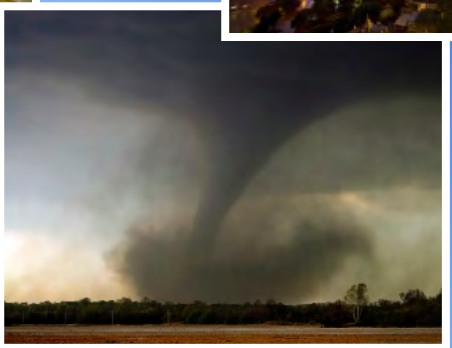
Introduction





Over the past decade, recent events have highlighted the need for communities to prepare comprehensive emergency management strategies and plans. Whether they face ice storms, hurricanes, flash floods, tornados or bridge collapses, Americans are increasingly recognizing the need to better prepare for disasters. At the same time, the Joint Commission for the Accreditation of Healthcare Organizations (JCACHO) has recognized this need in the form of Management of Environment of Care Standard EC 4.11, which states "The organization plans for managing the consequences of emergencies." Finally, experiences and research[1] support that the majority of health concerns, immediately after a disaster, are related to treatment of chronic health conditions and immunizations, both of which are normally treated in the primary care practice.

Emergency Preparedness Toolkit for Primary Care Providers (Toolkit) is one way to prepare practices for emergencies and natural disasters. This toolkit draws from a variety of sources, including government recommendations and reports, peer-reviewed research, and most importantly, the experiences and best practices of patients, providers and other local, regional and national experts in the area of emergency preparedness.

The Toolkit is meant to be scalable and usable by practices of varied sizes however not all documents will be applicable to all practice sizes. This toolkit is meant to be used as a guide for practice readiness, planning and response for emergencies and disasters as well as a document to assist communities in the aftermath of an event. Finally, the toolkit is designed to be a user-friendly resource that includes fact sheets, templates, trainings, other resources and multiple references for further information.

Background

The Toolkit is the result of a partnership between two programs at Morehouse School of Medicine (MSM): Center for Community Health and Service Learning (CCHSL) with funding provided by a sub grant of the John Hopkins University Study of Preparedness and Catastrophic Event Response (PACER), from the U.S. Department of Homeland Security, and the National Center for Primary Care, through the Regional Coordinating Center for Hurricane Response (RCC) grant from the U.S. Department of Health and Human Services, Office of Minority Health.

CCHSL was created in 2000 with the vision of becoming a connected, caring community of lifelong learners who provide valuable and meaningful service to underserved communities in Metro Atlanta. The Center has played an integral role in the development of the Nation's future public health leaders by connecting academics with service-learning, community service and civic engagement.

PACER is a program of Johns Hopkins University's Office of Critical Event Preparedness and Response (CEPAR) that seeks to improve the nation's preparedness and the ability to respond to disasters through rigorous scientific research focused on medical and public health preparedness strategies, response capabilities and surge capacity. It consists of a consortium of leading universities, premier corporations with extensive research and development infrastructure, and key government and national organizations from around the country.

The RCC provided support for mitigating the public health emergency impact of Hurricane Katrina on high disparity populations in the Southeast and South Central regions of the United States, as well as, other Centers of Excellence in states identified as Public Health Emergency States.

Based on the different resources from each program, researchers at MSM identified the need for an emergency preparedness toolkit that met the needs of primary care providers, specifically those who practice in areas that are disproportionally impacted by ongoing health disparities and areas that lack a solid community health system.

[1] *Millin, M. G., Jenkins, J.L., & Kirsch, T. (2006). A comparative analysis of two external health care disaster responses following Hurricane Katrina. Prehospital Emergency Care, 10, 451-456.*

Development of the Toolkit

Several different sources informed the contents of this toolkit. Among them were:

- Search of peer-reviewed literature
- Landscape analysis of currently existing materials, from government agencies and not-for-profit groups, that assist individuals or communities in preparing for/responding to natural disasters
- Key informant interviews with those directly impacted by natural disasters as well as local, state and national experts and healthcare providers who specialize in the areas emergency preparedness
- Focus groups with patients and providers in areas that have been impacted by natural disasters
- Survey of providers in areas that have been directly impacted by natural disasters
- The ongoing feedback, from members of the advisory board, based upon their experiences.

The contents in this toolkit provide a broad range of options for primary care emergency preparedness programs and should be adapted to fit the needs of each practice. The information presented is not meant to be comprehensive. While the materials are meant to be current and timely, new materials are continually being developed. For that reason, each section contains a listing of resources that may provide additional information to best serve the needs of a specific practice or community.

Purpose

The purpose of this toolkit is to help providers develop emergency preparedness plans that address the specific needs of primary care practices and their patients.

Acknowledgements

Emergency Preparedness Toolkit
Advisory Board Members

Since the beginning of this project, the advisory board members have met on a regular basis to provide feedback on the Toolkit. Its members include:

Leon L. Haley Jr., MD, MHSA
Grady Health System
Atlanta, GA

Lieutenant General (Ret.) Russel L. Honoré
Baton Rouge, LA

Mollie Melbourne, MPH, MEP
National Association of Community Health Centers
Washington, DC

Laveta Moody-Thomas, MPH, MSW, CHES
Mississippi State Department of Health
Jackson, MS

Romeatrius Moss, PhD, RN, MSN, APHN-BC
Mississippi Gulf Coast Black Nurses Association
Gulfport, MS

Allan Noonan, MD, MPH
Morgan State University
Baltimore, MD

Colonel (Ret.) Evan Spiceland
Baton Rouge, LA

Al Wright
Fulton County Department of Health Services,
Office of Emergency Preparedness
Atlanta, GA

Data Collection Partners

This toolkit was informed by data collected in the form of key informant interviews, focus groups with patients and providers, and provider surveys. The following organizations provided assistance in allowing the research team to collect data.

- Coastal Family Health Center, Inc, Biloxi, MS
- Franklin Primary Health Center, Inc., Mobile, AL
- Georgia State Medical Association, Atlanta, GA
- Howard University College of Medicine, Department of Community and Family Medicine, Washington, DC
- Louisiana State Primary Care Association, Baton Rouge, LA
- Meharry Medical College, Nashville, TN
- Mississippi Academy of Family Physicians, Madison, MS
- Mississippi Gulf Coast Black Nurses Association, Gulfport, MS
- Morehouse School of Medicine, Department of Family Medicine, Atlanta, GA
- Southeast Regional Clinicians Network, Atlanta, GA

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Morehouse School of Medicine Authors and Research Team

Meryl S. McNeal, PhD, MA
Elvan C. Daniels, MD, MPH
Tabia Henry Akintobi, PhD, MPH
Kendra Williams Pierson, MA
DeBran Jacobs, MPH
Toye Metoyer Williams, MSPH

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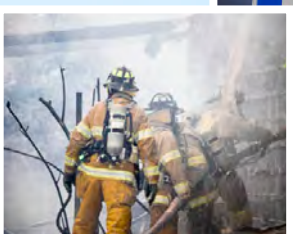
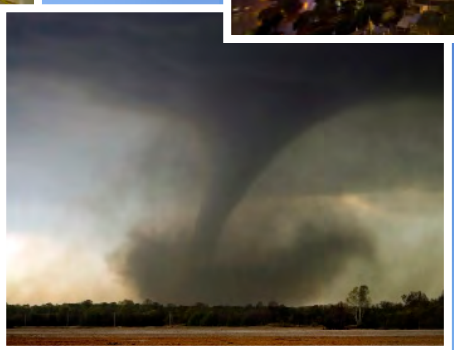
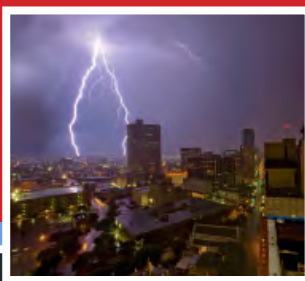
Preparing for the Unexpected







Knowing what to do during an emergency is an important part of being prepared and may make all the difference when seconds count. Several things can help prepare facilities for the unexpected. This section includes:

- Five Planning Basics
- National Planning Strategy
- The Planning Process
- Responding to an Event
- Recovery Efforts

This section will provide an overview of the key aspects of preparing for an emergency. It includes links and references to additional resources that provide more extensive details.

Five Planning Basics

Preparedness Tip #1: Know Your Local Team

- Learn about the emergency plans that have been established in your area by local government.
- Contact government agencies to see how you can become a participant in the planning or response efforts. (Click to access: Get Connected Section)

Preparedness Tip #2: Promote a Culture of Preparedness

- Create a yearly plan for trainings and exercises.
- Schedule staff meetings to share emergency preparedness efforts at your facility.
- Provide family and individual preparedness resources to your staff and patients. (Click to access: Household Information Sheets)

Preparedness Tip #3: Create a Practice Response Team

- Assemble a practice team for responding to emergencies/disasters. Include key roles such as Incident Manager, Public Information Officer, Operations Chief, Planning Chief and Logistics Chief. See the Sample Organization Chart in the Templates and Resources section.
- Create a master emergency contact list with contact information for the practice team, local government resources and key partners. Update annually.

Preparedness Tip #4: Assess Your Facility Annually

- Conduct planning with all members of the team. Contact your local emergency management agency to get local information.
- Use the Hazard Assessment worksheet to assess your facility for risk. (Click to access: Hazard Assessment Worksheet)

Preparedness Tip #5: Support the Needs of Your Staff

- Provide counseling to support the mental health needs of your staff as they respond.
- Identify areas where staff and their families can get food, shelter and other basic needs met. Consider providing resources onsite for staff and their families.

National Planning Strategy

The overall emergency management strategy for the nation is guided by the National Response Framework (NRF) and developed and managed by the Federal Emergency Management Agency (FEMA). It describes how communities, tribes, States, the Federal Government, private-sector and non-governmental partners respond to disasters and emergencies with an all-hazards approach for domestic incidents. Local and state governments base their preparedness responses upon the principles found in the NRF.

The National Incident Management System (NIMS) (Click to access: NIMS 101) is part of the NRF and provides the template for managing incidents at all levels of response. NIMS guides how communities participate in preparedness and recovery efforts. Practices that plan to coordinate their preparedness efforts with outside partners will need to become familiar with both the NRF and NIMS as all locally developed plans should include principles of NRF and NIMS.

For more information about NRF, click here http://www.fema.gov/emergency/nrf/ or click here http://www.fema.gov/nims) to learn more about NIMS.

The Planning Process

The internal planning process focuses on 5 key steps. By completing advance planning, your practice will be prepared to not only respond quickly but also recover from disasters and emergencies quickly.
(Click to access: Planning 101)

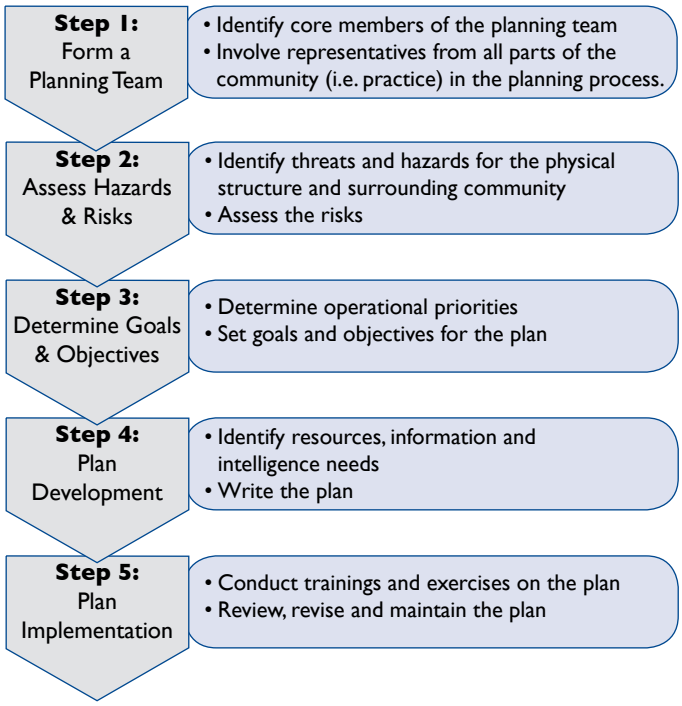


Figure 2.1 – Steps for Developing an Emergency Operations Plan

The finished product of your planning efforts is an Emergency Operations Plan (EOP). The EOP describes how people and property will be managed in emergencies and disasters; identifies the authority and actions to be taken during an event; and recognizes the personnel available during response efforts.

A completed EOP will have several parts. These are the most common parts of a plan. Depending upon the specific needs of your practice, there may be additional parts to your plan.

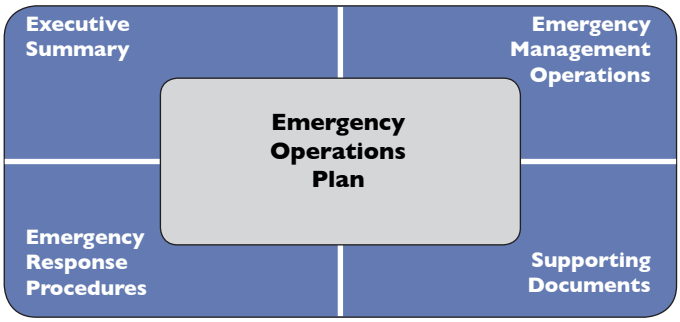


Figure 2.2 – Sections of Emergency Operations Plan

Executive Summary – Your plan's executive summary should include the purpose of the plan; the scope of the plan; the authorities and responsibilities of key personnel; the types of emergencies that the plan addresses; and where response operations will be managed.

Emergency Management Operations – This section of the plan should describe the practice's approach to the core elements of emergency management. Specific sections include:

- Internal Command Structure
- Communications
- Partnerships
- Recovery vendors

Emergency Response Procedures – This section should describe how the facility will respond to emergencies. It should detail what actions will be necessary to assess the situation and protect employees, patients, physical resources and records in the immediate response to an emergency. This section should also include checklists and templates of how to respond to specific emergencies during the preparedness, response and recovery stages.

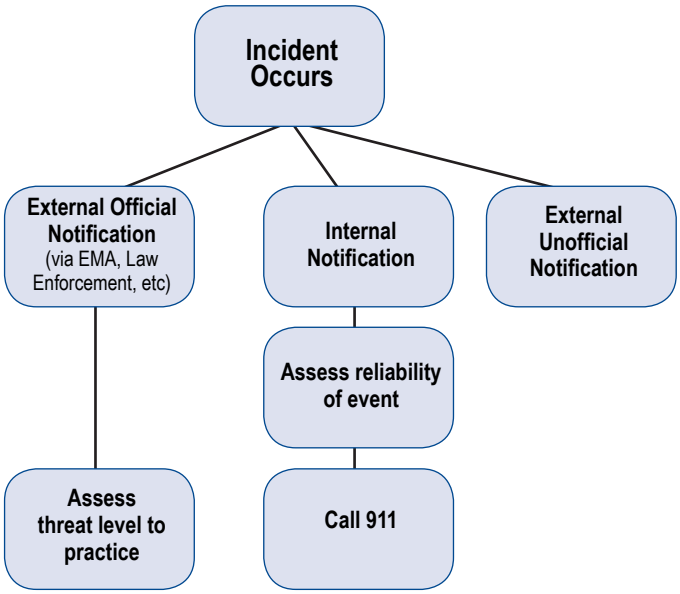
Supporting Documents – This section should list the documents that will help most immediately during a response, including:

- Emergency Contact Lists for Employees, Local Partners & Vendors
- Facility Inventory Lists
- Building Maps
- Memorandums of Agreement
- Communications Templates
- Patient Information Sheets

A template to complete your own plan is available in the Templates and Resources section.
(Click to access: EOP Template).

Responding To An Event

After the planning process is completed, responding to an event will be much easier. The flowchart below provides a sample sequence for responding to an incident.



The process for activating the EOP will depend upon the incident threat level and the response level needed. For Level 1 threats, the situation will require ongoing monitoring while a Level 3 threat will require the immediate activation of the EOP. The EOP should include a policy on what incidents will require the activation of an EOP.

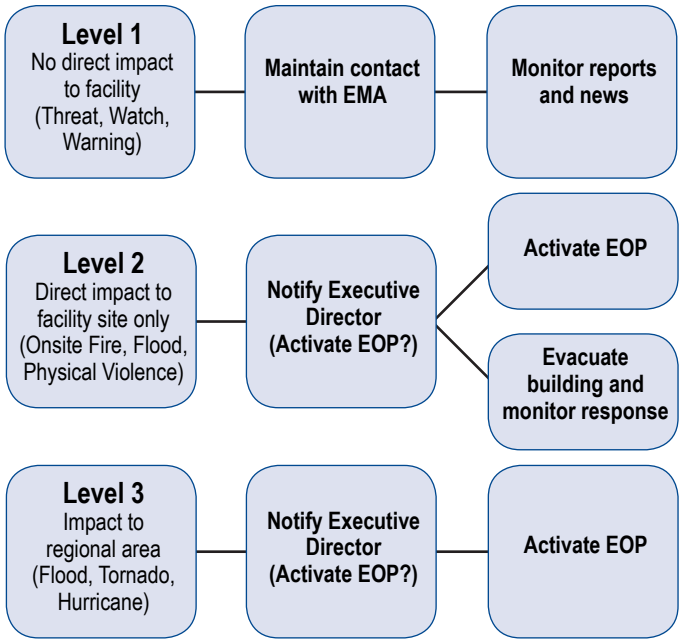


Figure 2.3 - Responding to an Incident

Recovery Efforts

After an event, the recovery phase can be divided into three time periods.

- **Immediate: 1 – 7 days after an event.** Debris clean-up begins. Emergency, short-term repair of utilities and transportation occurs; buildings are inspected for damage and essential services are reoccupied or relocated. Government agencies and businesses activate their continuity of operations plans (COOP) with limited services. Shelters open to provide housing.

COOP (Continuity of Operations) **is the effort of businesses and government agencies to ensure that essential functions continue to be performed during emergency or disaster events. For more information, visit** http://www.fema.gov/about/org/ncp/coop/index.shtm.

- **Mid-term: 7 – 90 days after an event.** Full restoration of utilities, social and health services. Government agencies begin to resume normal operations and non-essential businesses begin operations. Temporary housing is found.
- **Long-term: 90 days – several years.** Rebuilding efforts begin. Reconstruction of permanent business sites and housing. Full services return to pre-event levels or better.

For most practices, the most critical times are the immediate and mid-term periods. COOPs, similarly to EOPs, provide a plan for how to operate during these times. Past experiences have shown that after an event, patients will not have a great need for emergency services but will need the practice to meet their basic needs for chronic health conditions.

The planning process for developing a COOP is similar to developing an EOP and will evaluate resources in the same way. For these reasons, it may be helpful to develop the EOP and COOP at the same time.

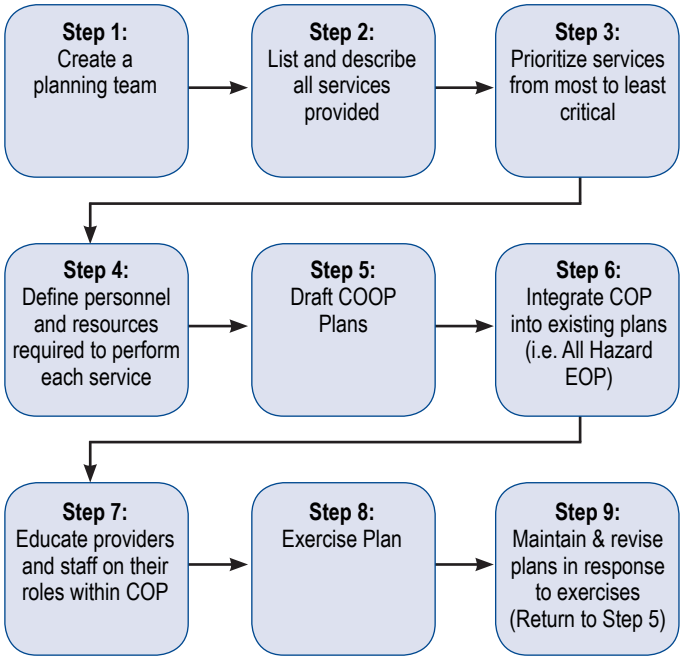


Figure 2.4 – Process of Developing a Continuity of Operations Plan (COOP)

A template to complete your own plan is available in the Templates and Resources section. (Click to access: COOP Template).

Evaluation & Long-Term Rebuilding

While the plans contained in the EOP and COOP will carry a practice through the immediate and mid-term recovery periods, there should be an evaluation of the response through an after action report to determine how effective the plans were in meeting the needs of the community as well as any areas of improvement. The goal of recovery efforts is to both restore and improve communities. The outcomes of the evaluation, when incorporated into rebuilding efforts and the development of future plans, will help meet this goal.

Additional Resources

Ready.gov Business - Ready Business assists businesses in developing a preparedness program by providing tools to create comprehensive emergency plans. http://www.ready.gov/business

FEMA Continuity of Operations (COOP) Division – FEMA COOP provides the development of guidance, education and training, and coordination between the Federal, state, local, territorial, tribal and private sectors. http://www.fema.gov/about/org/ncp/coop/index.shtm

Continuity of Operations (COOP) Planning Workbook Developed by Harford County Health Department Harford County, MD – A workbook, complete with worksheets and guided directions, to develop a COOP. http://www.harfordcountyhealth.com/wp-content/uploads/2011/12/COOP-Workbook1.pdf

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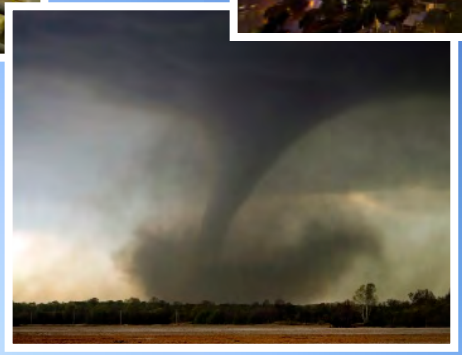
Getting and Staying Connected



One of the most critical parts of your Emergency Operations Plan (EOP) is how you will communicate with your staff, patients and internal and external partners during an event. Connecting with these partners will allow your practice to make the most of your emergency preparedness efforts.

This section will discuss how to get and stay connected with your staff, patients and community as well as build external partnerships and successfully manage these partnerships. This section will also explore the specific roles for individuals who want to serve as volunteers during and after disasters.

Getting Connected

- **Create procedures for communicating with patients, staff and other key partners during an event.** Maintain a listing of all staff, vendors, and partners to keep in the office and an electronic copy that's accessible offsite. Print patient appointment schedules, with contact information, one week in advance. Leave print copies onsite and an electronic copy that's accessible offsite. (Click to access: Staff Contact List or click to access: Practice Support Services)
- **Communicate with patients in advance about emergency procedures.** Use practice communications (telephone hold messages, newsletters, appointment reminder cards, and social media pages) to tell patients about alternate care sites and procedures in advance of an emergency. Ensure your patients know what your preferred media sources are for practice updates in case of an emergency.
- **Develop message templates for communicating with the community through the media and community partners.** Designate an individual in the practice (preferably the communications lead from the command structure) to create a list of media contacts where you will send messages regarding closing, reopening and locations for alternate service. (Click to access: Communications 101) Make sure to send the information to your community partners for local emergencies.
- **Contact and connect with local organizations who you can partner with.** Make sure to contact your local emergency planning agency, public health agency, and medical association but also consider non-traditional area partners such as schools, churches, community groups, businesses and others that might be able to help you prepare and reopen your practice. (Click to access: Partnerships & MOU 101)

Staying Connected

Government Agencies

All emergency events are local, so begin your planning by contacting your local emergency management agency and public health agency. Your local emergency management agency can provide a wide range of emergency preparedness information to not only help prepare your practice but to also help you recover after an event. The local public health agency can incorporate your practice in the community's plans for treating health emergencies and make sure you have the most complete information. By participating in training exercises, your practice will become a resource in your community.

Community Partners

There are organizations (i.e. hospitals, emergency management agencies, American Red Cross) with clearly identified roles as partners for emergency and disaster planning. When planning for an emergency, it is important to consider non-traditional partners who can provide assistance such as community groups, faith-based organizations, schools, colleges, and local businesses. The roles of these groups will vary based on the needs of your practice but they may be able to offer locations to see patients, temporary storage, and possibly, materials for the rebuilding or powering of your practice. In some instances, they may be able to immediately serve as an evacuation site during an event. As you move forward in developing your EOP and identifying areas of need, you will be better able to determine potential partners and how you can assist each other in preparing your community.

Volunteers

When accepting volunteers, one of the first decisions you must make is whether to create a volunteer program or choose to work with a volunteer agency. For most practices, it will be more practical to work with a volunteer agency because of the requirements needed to establish a volunteer program.

Your practice should have a designated volunteer coordinator during the period after an emergency. This person should be the primary contact for any volunteers sent by the agency. Even though volunteers will be sent, your practice should still create an on-site volunteer check-in area and a skills survey for screening volunteers to find the most appropriate location for their assistance.

When using volunteers, please consider risk management and liability issues. The Volunteer Protection Act of 1997 provides legal immunity for volunteers who are working in disaster-related functions and organizations hosting volunteers . Additional protections are available for healthcare professionals who choose to register with the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) program.

Note: Consult your practice's legal advisor for specific questions regarding the management of liability.

Providers & Staff during an Event

If your practice is not operational, providers and staff who are willing to serve the community have several volunteer options. The following programs are places where your practice can build skills for emergency preparedness and serve your community in the event of a disaster.

Medical Reserve Corps

The mission of the Medical Reserve Corps (MRC) is to engage volunteers to strengthen public health, emergency response and community resiliency. Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.
http://www.medicalreservecorps.gov

Citizen Corps

Citizen Corps is an easy way for communities across America to engage every individual in preparing the homeland for any type of emergency or threat. Citizen Corps trains citizens to prepare their communities. The program offers emergency preparedness training opportunities to citizens and community opportunities to engage in volunteer activities that support first responders, disaster relief groups, and community safety organizations.
http://www.citizencorps.gov/

Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

ESAR-VHP is a federal program created to support states and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. The program, administered on the state level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance, saving valuable time in emergency situations.
http://www.phe.gov/esarvhp/pages/default.aspx

[1] *The Nonprofit Risk Management Center has developed a state by-state overview of the state liability laws in the handbook "State Liability Laws for Charitable Organizations and Volunteers—4th Edition" available for review at http://www.nonprofitrisk.org/downloads/state-liability.pdf.*

Additional Resources

National Voluntary Organizations Active in Disaster (VOAD) – National VOAD is the primary point of contact for voluntary organization in the National Response Coordination Center and is a signatory to the National Response Plan. http://www.nvoad.org

Federal Emergency Management Agency publication A Whole Community Approach to Emergency Management: Principles, Themes and Pathways for Action – Published by FEMA, this document presents a foundation for increasing individual preparedness and engaging with members of the community to enhance the resiliency and security of our nation through a whole community approach.
http://www.fema.gov/library/viewRecord.do?id=4941

Community Preparedness Tools and Resources Catalogue – A collection of federal, state and local community preparedness tools assembled by Citizen Corps. http://www.citizencorps.gov/library/index.shtm

FEMA Emergency Management Institute Training Course IS-244.a Developing and Managing Volunteers – This course is for emergency managers and related professionals working with all types of volunteers and coordinating with voluntary agencies.
http://training.fema.gov/EMIWeb/IS/is244a.asp

FEMA Emergency Management Institute Training Course IS-660 Introduction to Public-Private Partnerships – This course provides an introduction to the role of public-private partnerships in emergency preparedness and planning.
http://training.fema.gov/EMIWeb/IS/is660.asp

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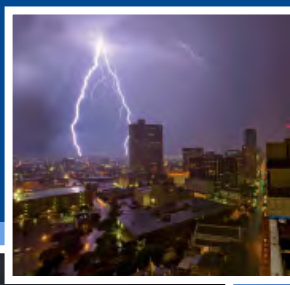
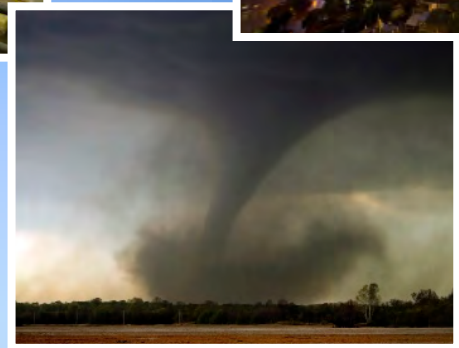
Training and Exercises





There are a variety of organizations that provide training in emergency preparedness, both in-person and online. The following is a sample of training sources found at the national level. Additional organizations that provide trainings include non-governmental agencies such as American Red Cross and professional organizations such as medical societies. Finally, consider consulting local emergency management agencies and public health departments as they will have knowledge of local trainings.

Trainings

FEMA Center for Domestic Preparedness

The Center for Domestic Preparedness (CDP), located in Anniston, Alabama, is the United States Department of Homeland Security (DHS)'s only federally chartered Weapons of Mass Destruction (WMD) training center. Training and travel is provided at no cost to state, local, or tribal government emergency responders. Federal, civilian and international requests are considered upon inquiry. https://cdp.dhs.gov/

FEMA Emergency Management Institute

The Emergency Management Institute (EMI), located in Emmitsburg, Maryland, is the emergency management community's flagship training institution, and provides training to Federal, State, local, tribal, volunteer, public, and private sector officials. EMI directly supports the implementation of the National Incident Management System (NIMS), the National Response Framework (NRF), the National Disaster Recovery Framework (NDRF), and the National Preparedness Goal (NPG). http://training.fema.gov/EMI/

The Emergency Management Institute (EMI) also offers self-paced online courses that support the nine mission areas identified by the NPG designed for people who have emergency management responsibilities and the general public. All courses are offered free-of-charge to those who qualify for enrollment. http://training.fema.gov/IS/

Johns Hopkins Preparedness and Emergency Response Learning Center

The Johns Hopkins Preparedness and Emergency Response Learning Center (JH~PERLC) has developed a variety of training opportunities that include over 50 free online just-in-time training modules, RAPID – Psycholocial First Aid Workshop, Incident Command for Public Health Agencies and Core Competency-based preparedness trainings for mid-level public health workers. http://www.jhsph.edu/preparedness/training/

Nova Southeastern University

The Nova Southeastern University Institute for Disaster and Emergency Preparedness (IDEP) provides a variety of interdisciplinary trainings related to all-hazards preparedness in a global society. Courses are offered at no cost and are available live, online or by CD. Courses also offer CME/CE credits for selected health professions. http://www.nova.edu/idep/index.html

Exercises

Exercises offer the opportunity for practices to test their plans as part of their ongoing preparedness efforts. There are two basic categories of exercises, discussions-based and operations-based, as defined by FEMA's Homeland Security Exercise and Evaluation Program (HSEEP).

Discussions-based exercises include seminars, workshops, tabletop exercises and games. They are used to familiarize participants with current plans, policies, agreements and procedures, or may be used to develop new plans, policies, agreements and procedures. They are generally require fewer participants, fewer resources and are more cost effective than operations-based exercises.

Operations-based exercises include drills, functional exercises and full-scale exercises. They are used to validate plans, policies, agreements and procedures, clarify roles and responsibilities, and identify resource gaps in an operational environment. Operations-based exercises provide opportunities for testing partnerships and multi-agency or multi-jurisdictional coordination.

Additional resources that are available for the development of exercises can be found at the HSEEP website at https://hseep.dhs.gov.

Two sample tabletop exercises are available for practice use in the following pages.

Hurricane Disaster Scenario Tabletop Exercise

A tabletop exercise provides practices with an opportunity to consider key preparedness issues in advance of a disaster or emergency incident. Tabletop exercises are based on fictitious scenarios of an emergency situation. They provide the practice with the framework for discussing 1) how can we respond with our current resources and 2) what do we need to modify our existing response?

Preparing for the Exercise

- Invite key staff responsible for the practice's administration and services. Invite members of the emergency response team and consider extending an invitation to all members of the staff, which might help you gain new emergency response team members. The maximum suggested size of the group is 20 people.
- The exercise consists of a scenario overview and three news reports that give a status for the community. Structured questions after each news report are provided to guide the discussion among the group.
- The facilitator is responsible for leading the discussions and keeping the group focused on the exercise scenarios provided. The facilitator should be well prepared, able to engage all members of the group and adjust the pace of the exercise as needed.
- One person should be designated as the note taker for the meeting. The note taker should document all responses, comments and any issues that arise during the meeting.
- The most effective presentation to use is PowerPoint. The facilitator will use the slides to guide the group.
- Provide all invitees with copies of the existing emergency response plan for advanced reading. The PowerPoint, scenario and news report should not be shared with other participants in advance.
- Contact the local emergency management agency to determine any current local emergency management concerns that may impact the practice's planning.
- Consider inviting local emergency managers and community partners to join in the scenario as well.
- All participants should be asked to turn off their telephones and pagers before beginning.
- The room should be large enough to accommodate the full group comfortably.
- The facilitator should review the agenda with the group and ask if they have any questions or concerns before the exercise begins.

Introduction to Exercise (to be read by Facilitator):

During the exercise today, we will work through this scenario as if it's a real incident. We will identify specific areas of concern that need to be answered and respond with the answers as they currently stand. If there's no answer or an outdated answer, we will write that down as an area for improvement. We will end by conducting a debriefing where we will review the entire exercise. Ultimately, we will use the responses from today to strengthen our emergency plans.

The ground rules for today are:

- *There are no right or wrong answers. If someone has a different opinion, it's important to share that opinion because we want to ensure that everyone has the same information to work with.*
- *Respond on what you know is true.*
- *Feel free to add additional information to support your responses.*
- *(Insert housekeeping regarding breaks, bathroom locations, etc.)*
- *Relax. This is a no-fault, low stress exercise. Again, there are no right or wrong answers.*

Scenario Overview:

The scenario we will examine is a Category 5 Hurricane with winds reaching 160 mph with a storm surge of 20 feet above normal. As the storm moves across inland states, it will stall and impact communities with tropical wind and rain, inland flooding and tornados. Here are some other impacts to expect:

Causalities: 1,000 fatalities, 5,000 hospitalizations

Infrastructure Damage: Buildings destroyed, large amounts of debris on streets and limited public transportation

Evacuations/Displaced: 150,000 seek shelters in safe areas; 200,000 homes destroyed

Contamination: In some areas, from hazardous materials in some areas

Economic Impact: Billions of dollars

Recovery Timeline: Months to years

Here is the first local news report:

The National Hurricane Center is warning this morning that Hurricane Hanna has strengthened into a dangerous Category 4 storm and it's tracking toward our greater metropolitan area. Models indicate possible landfall over the region as early as three days from now, but forecasters are not sure if the storm will strengthen or weaken over the next few days. The Governor is not taking any chances. She has ordered the evacuation of all citizens and tourists within 10 miles of the coast, that means more than 1 million people are evacuating from the metro area and coastal regions.

The Hurricane Center is warning that if Hanna strengthens to Category 5, many homes and buildings will be damaged or destroyed. Mobile homes are especially vulnerable as they could be completely destroyed. Any building that is unsound could collapse. With the storm surge and rains, there could be major damage to the lower floors of all buildings located up to 15 feet above sea level and within 500 yards of the shoreline. Again, the Governor has ordered a mandatory evacuation for everyone within 10 miles of the coast.

Prepare & Protect Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Prepare & Protect

- What are the hazards?
- Who is our team? Internally and externally?
- How will we communicate? What if systems fail?
- What are our needs in general and needs for supplies, etc.?
- What are the needs of employees and their families, customers, members? How do we protect them?
- What are the needs for protecting the organization?
- Who do we contact and inform, internally and externally?
- What can we do now to recover more quickly later?
- Is our organization typically involved in the response to a significant incident in the community?
- Do we have resources that could be useful to the community (facilities, supplies, personnel) should an incident occur? If so, have we engaged with our local emergency management partners to let them know about our resources? If not, what is keeping us from engaging with them? How could we overcome those obstacles?
- Do we have alternate locations established where we can relocate and maintain operations if our current location is disrupted?
- Do we know what it would take to reestablish operations in our current location (resources needed, length of interruption before it became less desirable to reestablish in current location versus relocating, other factors impacting our ability to reestablish business)?
- Do we train our employees/community so they know what our emergency plans are for the organization/community?
- Does our organization have a written emergency plan available to employees/customers/community?

Here is the second local news report:

Hurricane Hanna made landfall this morning as a Category 5 storm, making a direct hit on the metropolitan area. The city has been hit hard by sustained 160 mph winds and more than 20 inches of rain have fallen in the past 24 hours. Hanna's storm surge was more than 18 feet and broke through seawalls and flooded neighborhoods. The storm has moved north of us now, and search and rescue operations are underway. We've heard reports of victims trapped in collapsed buildings, and others stranded by floodwaters. Utility companies meanwhile are reporting that more than 1 million customers are without power and utility crews are fighting to restore at least temporary power to critical facilities. The state is also working with federal officials and private companies on restoring communications, transportation, water, and other critical infrastructure.

The Governor reported from the Emergency Operations Center a few minutes ago that the state is struggling to clear roads and bypasses so residents can get to shelters and safe areas. The region's mass transit system is calling on private transportation companies for backup. Meanwhile, with so many homes and buildings destroyed, the Governor is identifying additional temporary shelter and housing while the state is working with FEMA, the Red Cross and other federal agencies to create temporary shelters. Since the evacuation was ordered three days ago, many residents have been staying in hotels and motels. The area's hospitals are overwhelmed. They're taking in large numbers of survivors, but they're also trying to shore up their own facilities which in many cases have been damaged and flooded. The hospitals say they need more critical medical supplies, they need help evacuating patients from damaged facilities and, as a grim sign of the scope of this disaster, they even need help with mortuary services and victim identification.

Respond Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Respond

- What equipment do we need and who's in charge?
- What's our evacuation plan?
- What tasks must be completed immediately, and by whom?
- How will we notify employees, responders, neighbors, government, community, media, and others of any emergency conditions at our facilities?
- How will we restore damaged services and systems?
- If looting affects our organization or neighborhood, what do we do?
- How will we communicate if certain communications systems are down?
- What common tools do we have in place in case of a power outage, i.e. portable AM/FM radio, extra batteries, portable TV, mobile phones, portable battery chargers?
- Is the community counting on our organization to deliver medical care to the public?
- Do we have a buddy system in place for individuals who need assistance?
- What mechanisms do we have in place to consistently collect/disseminate reliable updated information?
- What supplies do we have on hand if we need to stay onsite? Does our determined food, refrigeration, sleeping, and water requirements account for employees only or visitors also? What is the protocol for employees who want to leave to join family?
- What additional information, resources, or other requirements would we look for from Federal, State and Local partners? What additional information, resources, or other requirements could we provide to Federal, State and Local partners?

Here is a final local news report:

Since Hurricane Hanna made landfall last week, communities across the region, from the coast to hundreds of miles inland, are struggling to recover. The slow-moving storm brought severe winds and rains and tornadoes, causing catastrophic flooding throughout the region. At least four states reported record rainfall, and most of the fatalities were due to flooding. Utility companies are saying they need another week or more to restore power in some neighborhoods. Responders are also working hard to provide temporary roofing to homes and businesses with damaged roofs and to provide temporary housing to the thousands who have lost their homes.

The states and FEMA have established locations where residents can get emergency supplies and water. There are distribution points in many communities where supermarkets and other food stores are still closed or damaged.

The state is warning citizens that the public water supply has been breached by toxic chemicals and sewage from treatment plants. Residents should not use public water for drinking, washing hands or bathing. But some neighborhoods are still flooded and unreachable, so residents are fending for themselves.

Local emergency managers are taking a number of steps to inform and protect residents, including reverse 911 calls and even sending officers into the streets with bullhorns.

Hurricane Hanna has devastated communities across the region. We have reports of more than 1,000 fatalities, and 5,000 critical or serious injuries.

Recovery Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Recovery

- How could this affect our operations?
- Do we have generators and other back-up utilities?
- Will our employees miss work, e.g. to attend to family if schools are closed?
- How will we repair structural and physical damage?
- How will we restore disrupted services?
- How will we clean the facility and remove all health and safety hazards?
- How will we resume operations, toward returning to normal ? (Especially important if a portion of the building is damaged to such a degree that operations must be relocated temporarily.)
- How will we document any damaged facilities or equipment on video or photographs?
- How will we track staff and volunteer time and labor involved in the cleanup?
- Do we have policies to allow flexibility to displaced employees, such as policies for working half-days, alternate sites, mobile sites, and teleworking?
- What is our plan for identifying and allowing essential employees to gain access to impacted buildings or properties? Have we coordinated access issues with local officials?
- What are some other critical factors that would determine our ability to resume normal operations (employee availability, customer access, community services, and government services)?
- Do our customers/community/employees know where to go to obtain information after a crisis has disrupted normal operations, including when to report back to work and how to get paid in the interim?
- Do we have a recovery plan developed for our organization/customers/community? If so, what are the key processes most critical to reestablish in order to begin our recovery?

Summary of the Exercise

- What gaps in our plans were revealed by this exercise?
- What obstacles must we overcome or conflicts must we resolve?
- What strengths in our plans were proven by this exercise?
- Who within our organization do we need to meet with to develop and improve our emergency plans? And what information do we need from them?
- Who outside our organization do we need to meet with to develop and improve our emergency plans? What information do we need from them? And what information do they need from us?
- What can we do to be better prepared for earthquakes, as well as other catastrophic events?
- How would our organization/facility assist in the overall response?
- How would our organization/facility re-initiate production/services? How would the organization/facility ensure business continuity and community resiliency?

Exercise contents adapted based upon the 2010 National Planning Scenario for a major hurricane developed by the U.S. Department of Homeland Security and FEMA's Office of External Affairs together with FEMA's National Exercise Division.

Ice Storm Scenario Tabletop Exercise

A tabletop exercise provides practices with an opportunity to consider key preparedness issues in advance of a disaster or emergency incident. Tabletop exercises are based on fictitious scenarios of an emergency situation. They provide the practice with the framework for discussing 1) how can we respond with our current resources and 2) what do we need to modify our existing response?

Preparing for the Exercise

- Invite key staff responsible for the practice's administration and services. Invite members of the emergency response team and consider extending an invitation to all members of the staff, which might help you gain new emergency response team members. The maximum suggested size of the group is 20 people.
- The exercise consists of a scenario overview and three news reports that give a status for the community. Structured questions after each news report are provided to guide the discussion among the group.
- The facilitator is responsible for leading the discussions and keeping the group focused on the exercise scenarios provided. The facilitator should be well prepared, able to engage all members of the group and adjust the pace of the exercise as needed.
- One person should be designated as the note taker for the meeting. The note taker should document all responses, comments and any issues that arise during the meeting.
- The most effective presentation to use is PowerPoint. The facilitator will use the slides to guide the group.
- Provide all invitees with copies of the existing emergency response plan for advanced reading. The PowerPoint, scenario and news report should not be shared with other participants in advance.
- Contact the local emergency management agency to determine any current local emergency management concerns that may impact the practice's planning.
- Consider inviting local emergency managers and community partners to join in the scenario as well.
- All participants should be asked to turn off their telephones and pagers before beginning.
- The room should be large enough to accommodate the full group comfortably.
- The facilitator should review the agenda with the group and ask if they have any questions or concerns before the exercise begins.

Introduction to Exercise (to be read by Facilitator):

During the exercise today, we will work through this scenario as if it's a real incident. We will identify specific areas of concern that need to be answered and respond with the answers as they currently stand. If there's no answer or an outdated answer, we will write that down as an area for improvement. We will end by conducting a debriefing where we will review the entire exercise. Ultimately, we will use the responses from today to strengthen our emergency plans.

The ground rules for today are:

- *There are no right or wrong answers. If someone has a different opinion, it's important to share that opinion because we want to ensure that everyone has the same information to work with.*
- *Respond on what you know is true.*
- *Feel free to add additional information to support your responses.*
- *(Insert housekeeping regarding breaks, bathroom locations, etc.)*
- *Relax. This is a no-fault, low stress exercise. Again, there are no right or wrong answers.*

Scenario Overview: *(Show Scenario Slide)*

The scenario we will examine is an Ice Storm. Forecasters are expecting freezing rain and light snow to move into the area and produce an ice accumulation of more than 1 inch. It will stall communities and block roads. Here are some other impacts to expect:

Causalities: 150 fatalities; 1,000 hospitalizations – mostly due to house fires, car accidents and hypothermia among the homeless

Infrastructure Damage: Trees destroyed; power lines, telephone cables, utility poles and transmission towers damaged; limited public transportation

Evacuations/Displaced: 150,000 residents seeking shelters because of no power

Economic Impact: Millions of dollars

Recovery Timeline: Weeks to months

Here is the first local news report:

The National Weather Service is warning this morning that a winter storm is tracking toward our greater metropolitan area. If the current patterns continue, models indicate possible snow accumulations but if the pattern shifts, we could experience freezing rain with ice accumulations in the overnight hours as early as two days from now. Forecasters are not sure if the storm will strengthen or weaken over the next few days.

Prepare & Protect Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Prepare & Protect

- What are the hazards?
- How will this storm impact our practice operations?
- How will we communicate to our staff? To our patients?
- Who do we contact and inform, internally and externally?
- What is the practice's activation procedure and staffing plan for emergency situations?
- What information do we have available for patients to assist them in storm preparation?
- What can we do now to recover more quickly later?
- Do we have alternate locations established where we can relocate and maintain operations if our current location is disrupted?

Here is the second local news report:

A winter storm arrived this morning, bringing with it freezing rain and some snow.

The city has had more than 2 inches of rain fall in the past 24 hours. There is an even coating of ice over the entire region, which is not prepared with appropriate snowplows or sanding trucks. There are reports of downed trees and utility lines. Roadways are sheets of ice and many are closed. Meanwhile, utility companies are reporting that more than 1 million customers are without power and utility crews are fighting to restore temporary power to critical facilities. The state is also working with federal officials and private companies on restoring communications, getting public transportation operational, clearing roads and restoring other critical infrastructure.

The Governor reported from the emergency operations center a few minutes ago that the state is struggling to clear roads and bypasses so residents can get to shelters and safe areas. Still, they are asking that people remain off the roads until they can be better cleared. The region's mass transit system is calling on private transportation companies for backup.

Respond Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Respond

- What equipment do we need and who's in charge?
- What tasks must be completed immediately and by whom?
- How will we notify employees, responders, neighbors, government, community, media, and others of any emergency conditions at our facilities?
- How will we communicate if certain communications systems are down?
- What common tools do we have in place in case of a power outage, i.e. portable AM/FM radio, extra batteries, portable TV, mobile phones, portable battery chargers?
- Is the community counting on our organization to deliver medical care to the public?
- Do we have a buddy system in place for individuals who need assistance?
- What mechanisms do we have in place to consistently collect/disseminate reliable updated information?
- What supplies do we have on hand if we need to stay onsite? Does our determined food, refrigeration, sleeping, and water requirements account for employees only or visitors also? What is the protocol for employees who want to leave to join family?
- Who should you communicate with about getting "essential workers" into the practice?
- What additional information, resources, or other requirements would we expect from Federal, State and Local partners? What additional information, resources, or other requirements could we provide to Federal, State and Local partners?

Here is a final local news report:

Since the winter storm hit our area last week, communities all across the region are struggling to recover. The storm brought freezing ice, snow and rain. The melting ice and snow has caused significant flooding throughout the region. Utility companies are saying they need another week to restore power in some neighborhoods. Several dozen families who lost their homes in house fires are still living in shelters. Schools have just reopened this week but there are still some delays in food shipments because of the damaged roadways.

The state is warning citizens that the public water supply has been breached by toxic chemicals and sewage from treatment plants due to power outages. Local emergency managers are taking a number of steps to inform and protect residents, including reverse 911 calls and updating local public information websites.

There is a sharp increase in local hospitals reporting hypothermia and frostbite, carbon monoxide poisoning, and broken bones, so they are asking people to take caution in moving around and using portable heaters. Patients can expect long delays at emergency rooms because of staff shortages.

Recovery Discussion

At this point, the facilitator should begin leading the discussion by asking the following questions. The designated note taker should capture the comments on butcher paper or a laptop. Not all questions have to be answered. In some instances, you may not be able to answer the questions with the information provided.

Recovery

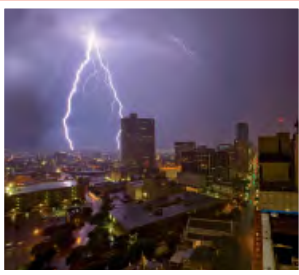
- How could this affect our operations?
- Do we have generators and other back-up utilities?
- Will our employees miss work, e.g. to attend to family if schools are closed?
- How will we repair structural and physical damage?
- How will we restore disrupted services?
- How will we resume operations, begin returning to normal operations?
- Do we have policies to allow flexibility to displaced employees, such as policies for working half-days, alternate sites, mobile sites, and teleworking?
- Do our customers/community/employees know where to go to obtain information after a crisis has disrupted normal operations, including when to report back to work and how to get paid in the interim?
- Do we have a recovery plan developed for our organization/customers/community? If so, what are the key processes we focused on as most critical to reestablish in order to begin our recovery process?

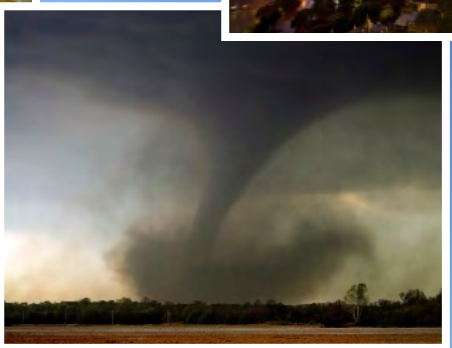
Summary of the Exercise

- What gaps in our plans were revealed by this exercise?
- What obstacles must we overcome or conflicts must we resolve?
- What strengths in our plans were proven by this exercise?
- Who, within our organization, do we need to meet with to develop and improve our emergency plans? And what information do we need from them?
- Who outside our organization do we need to meet with to develop and improve our emergency plans? What information do we need from them? And what information do they need from us?
- What can we do to be better prepared for earthquakes as well as other catastrophic events?
- How would our organization/facility assist in the overall response?
- How would our organization/facility re-initiate production/services? How would the organization/facility ensure business continuity and community resiliency?

Exercise contents adapted based upon National Planning Scenario developed by the U.S. Department of Homeland Security and FEMA's Office of External Affairs together with FEMA's National Exercise Division.

Fact Sheets





Emergency Resource Materials

The information contained in this section is provided as reference materials to help you plan, prepare and respond to immediate threats from several different types of disasters and emergencies.

It is recommended that several copies be made available for each location and placed in several areas (i.e. main reception, patient treatment rooms, and pharmacy) for reference in the event of an emergency.

The information contained in these pages comes from the Federal Emergency Management Agency U.S. Department of Homeland Security's Ready.gov website, Centers for Disease Control and Prevention Emergency Preparedness and Response website, and other sources as cited.

Blackouts

The biggest blackout in U.S. history occurred on August 14, 2003, leaving roughly 50 million people without power. Blackouts can happen anywhere, and to anyone, so being prepared is important.

Step 1: Get a Kit

- *Make sure you have an emergency supply kit on hand.* The kit should include non-perishable food, flashlights, battery-powered radios and extra batteries.

Step 2: Make a Plan

- *Consider the specific needs of your practice and contact your local power company before rolling blackouts happen.*
  A rolling blackout occurs when a power company turns off electricity to selected areas to save power. The blackouts are typically for one hour, then the power is restored and another area is turned off. Hospitals, police stations, and fire departments are often exempt from these rolling blackouts.

Step 3: Be Informed

- *Know if your practice is located in an area that has rolling blackouts.*
- *Back up computer files and operating systems. Consider buying extra batteries and a power converter if you use a laptop computer.*
- *Get a high-quality surge protector for your electronic equipment.*
- *If you use store medication that requires refrigeration, most can be kept in a closed refrigerator for several hours without a problem.* Do not open units to check temperatures during the power outage.
- *Contact the CDC National Immunization Program or contact your state or local health department for guidance about vaccine storage during a power outage.*

For more information:

Centers for Disease Control and Prevention
What You Need to Know When the Power Goes Out Unexpectedly
http://www.bt.cdc.gov/disasters/poweroutage/needtoknow.asp

Chemical Attack

Chemical attacks are the deliberate release of a toxic gas, liquid or solid that can poison people and the environment. The possible signs of the attack are many people, in a certain area, suffering from watery eyes, twitching, choking, difficulty breathing or losing coordination. Many dead or sick birds, fish or small animals are also cause for suspicion.

If You See Signs of Chemical Attack:

- *Quickly try to define the area where the chemical originated.*
- *Take immediate action to leave the area.*
- *If you can't find clean air without passing through the contaminated area, move as far away as possible and shelter-in-place*. (see Shelter-in-Place next page)*

If You Think You May Have Been Exposed to a Chemical Attack:

- *Strip your clothes immediately and wash. Removed clothing should be bagged and sealed.*
- *Look for a hose, fountain, or any source of water, and wash with soap if possible, being sure not to scrub the chemical into your skin.*

***To Shelter in Place:**

- Bring everyone indoors.
- Close and lock doors, close windows, air vents and fireplace dampers.
- Turn off fans, air conditioning and forced air heating systems.
- Take your emergency supply kit, unless you have reason to believe it has been contaminated.
- Go into an interior room with few windows, if possible.
- Seal all windows, doors and air vents with plastic sheeting and duct tape
- Local authorities may not immediately be able to provide information about what is happening and what you should do. Watch TV, listen to the radio or check the Internet often for official news and instructions as they become available.

For more information:

Centers for Disease Control and Prevention
Go to FAQs: http://www.atsdr.cdc.gov/toxfaqs/index.asp

Earthquakes

An earthquake is the sudden, rapid shaking of the earth, caused by the breaking and shifting of subterranean rock. Forty-five states and territories throughout the United States are at moderate to high risk for earthquakes, including the New Madrid fault line in Central U.S.

During an Earthquake:

- *DROP to the ground, Take COVER by getting under a sturdy table or other piece of furniture and HOLD ON until the shaking stops.*
- *Stay away from glass, windows, outside doors and walls, and anything that could fall, such as lighting fixtures or furniture.*
- *DO NOT use the elevators.*

What to Do After an Earthquake:

- *Expect aftershocks.*
- *Stay away from damaged areas.*
- *Listen to a battery-operated radio or television for the latest emergency information.*
- *Help injured or trapped persons.*
- *Clean up spilled medicines, bleaches, gasoline or other flammable liquids immediately.*
- *Check gas leaks. If you smell gas or hear a blowing or hissing noise, open a window and quickly leave the building.*

For more information:

Earthquake Country Alliance (ECA) Education and Public Information Center – http://www.earthquakecountry.info/

Fires

When there is a fire, do not waste time gathering valuables or making a phone call. Fires can spread quickly, becoming life threatening in two minutes and engulfing a location in as little as five minutes. The leading cause of fire-related deaths is asphyxiation, which outnumbered burns by a three-to-one ratio.

Prepare in Advance

- *Install smoke alarms.*
- *Plan escape routes from all areas of the practice.*
- *Clean out storage areas to remove trash and extra materials that may ignite accidentally.*

During a Fire:

- *Determine the location of the fire.*
- *Remind staff members to stay low to the floor when escaping.*
- *Close all doors and clear hallways as you exit the building.*
- *Attempt to extinguish the fire, if properly trained.*

What to Do After a Fire:

- *Check with the fire department to make sure your practice is safe to enter.*
- *Conduct an inventory of damaged property and items.*
- *Consider replacing any medications stored onsite, if there's a possibility that your supply was exposed to excessive heat.*
- *Ensure that patient records are secured in place or moved to a secure location.*

For more information:

FEMA Fire Resource Center – FEMA resources for recovery after a fire. http://www.fema.gov/hazard/fire/index.shtm

Floods

Flooding is the nation's most common natural disaster. Flooding can happen in every U.S. state and territory. It's important to be prepared for flooding no matter where you live, but particularly if you are in a low-lying area or near water.

Familiarize yourself with these terms to help identify a flood hazard:

- *Flood Watch:* Flooding is possible. Tune in to NOAA Weather Radio, commercial radio, or television for information.
- *Flash Flood Watch:* Flash flooding is possible. Be prepared to move to higher ground; listen to NOAA Weather Radio, commercial radio, or television for information.
- *Flood Warning:* Flooding is occurring or will occur soon. If advised to evacuate, do so immediately.
- *Flash Flood Warning:* A flash flood is occurring. Seek higher ground on foot immediately.

Prepare Your Practice:

- *Consider installing "check valves" to prevent flood water from backing up into the drains of your practice.*
- *Carefully assess how your company functions, both internally and externally, to determine which staff, materials, procedures and equipment are absolutely necessary to keep the practice operating.*
- *Identify operations critical to survival and recovery.*

After the Flood:

- *Wear gloves and boots when cleaning up.*
- *Ensure that all staff members visiting the building or participating in cleanup have received their appropriate vaccinations (Tetanus within the last 10 years).*
- *Conduct an inventory of damaged property and items. Do not throw away any damaged goods until after an inventory is made.*
- *The drugs exposed to flood or unsafe municipal water supplies may become contaminated. You should consider replacing any medications stored onsite if there's a possibility that your supply was contaminated.*
- *Determine if patient records have been damaged or contaminated by water.*
- *Evaluate packaged supplies (i.e. bandages packaged in paper, sterile supplies in paper-peel packs) for dampness, mold or water stains/discoloration. Discard if any signs are present.*

For more information:

Centers for Disease Control and Prevention Emergency Preparedness & Response Flood Website
http://www.bt.cdc.gov/disasters/floods

Hurricanes

Familiarize yourself with the terms that are used to identify a hurricane.

- *A hurricane watch:* A hurricane is possible in your area. Be prepared to evacuate. Monitor local radio and television news outlets or listen to NOAA Weather Radio for the latest developments.
- *A hurricane warning:* A hurricane is expected in your area. If local authorities advise you to evacuate, leave immediately.

If a hurricane is likely in your area, you should:

- *Cover your practice's windows with pre-cut ply wood or hurricane shutters to protect your windows from high winds.*
- *Move valuables and important documents to higher areas of the building or higher shelves, if possible.*
- *Turn off utilities, if instructed to do so. Otherwise, turn the refrigerator thermostat to its coldest setting and keep its doors closed to preserve medications.*

After a Hurricane:

Hurricane hazards come in many forms: Lightning, tornadoes, flooding, storm surge, high winds, even landslides or mudslides can be triggered in mountainous regions:

- *Ensure that all staff members visiting the building or participating in cleanup have received their appropriate vaccinations (Tetanus within the last 10 years).*
- *Reenter the building with caution and only after local officials have opened the area again.*

- *If the practice has been closed for several days, enter briefly to open doors and windows and let the building air out for awhile (at least 30 minutes), before you stay for any length of time.*
- *Conduct an inventory of damaged property and items. Do not throw away any damaged goods until after an inventory is made.*

For more information:

Centers for Disease Control and Prevention Hurricane Information for Healthcare Professionals – http://www.bt.cdc.gov/disasters/hurricanes/hcp.asp

Landslides

Landslides, also known as mudslides or debris flow, occur in all U.S. states and territories, and can be caused by a variety of factors including earthquakes, storms and fires.

- *Become familiar with the land around you. Learn whether debris flows have occurred in your area by contacting local officials.*
- *Watch the patterns of storm-water drainage on slopes near your practice and note especially the places where runoff water converges, increasing flow over soil-covered slopes.*
- *During a severe storm, stay alert and awake. Many deaths from landslides occur while people are sleeping.*
- *Listen to local news stations on a battery-powered radio for warnings of heavy rainfall.*
- *Move away from the path of a landslide or debris flow as quickly as possible.*
- *Stay away from the slide area. There may be danger of additional slides.*
- *If you are near a stream or channel, be alert for any sudden increase or decrease in water flow and notice whether the water changes from clear to muddy.*
- *Watch for flooding, which may occur after a landslide or debris flow.*
- *Check for injured and trapped persons near the slide, without entering the direct slide area. Direct rescuers to their locations.*

For more information:

US Geological Survey Landslides Hazards Program – http://landslides.usgs.gov/

Thunderstorms & Lightening

Each year in the United States, lightning kills 300 people and on average, injures 80. All thunderstorms produce lightning and all have the potential for danger.

Familiarize yourself with the terms that are used to identify a thunderstorm

- *A thunderstorm watch:* There is a possibility of a thunderstorm in your area.
- *A thunderstorm warning:* A thunderstorm is occurring or will likely occur soon. If you are advised to take shelter, do so immediately.

If a thunderstorm is likely in your area, you should:

- *Remember the 30/30 Lightning Safety Rule: Go indoors, if, after seeing lightning, you cannot count to 30 before hearing thunder. Stay indoors for 30 minutes after hearing the last clap of thunder.*
- *Secure outdoor objects that could blow away or cause damage.*
- *Remove dead or rotting trees and branches that could fall and cause injury or damage during a severe thunderstorm.*
- *Unplug any electronic equipment well before the storm arrives.*

During a thunderstorm:

- *Avoid contact with corded phones. Use a corded telephone only for emergencies. Cordless and cellular telephones are safe to use.*
- *Do not lie on concrete floors and do not lean against concrete walls*
- *Take shelter in a sturdy building. Avoid isolated sheds or other small structures in open areas.*

After a thunderstorm:

- *Never drive through a flooded roadway.* Turn around, don't drown!
- *Stay away from downed power lines and report them immediately*
- *Stay away from storm-damaged areas to keep from putting yourself at risk from the effects of severe thunderstorms.*

Winter Storm

Nearly all Americans, regardless of where they live, are likely to face some type of severe winter weather at some point in their lives. This could mean snow or subfreezing temperatures, as well as strong winds or even ice or heavy rain storms.

Familiarize yourself with the terms that are used to identify winter storms.

- *A Winter Weather Advisory:* Cold, ice and snow are expected.
- *A Winter Storm Watch:* Severe weather such as heavy snow or ice is possible in the next day or two.
- *A Winter Storm Warning:* Severe winter conditions have begun or will begin very soon.
- *A Blizzard Warning:* Heavy snow and strong winds will produce a blinding snow, near zero visibility, deep drifts and life-threatening wind chill.
- *A Frost/Freeze Warning:* Below freezing temperatures are expected.

When a winter storm WATCH is issued:

- *Listen to NOAA Weather Radio, local radio, and television stations, or cable television such as The Weather Channel for further updates.*
- *Avoid unnecessary travel.*

When a winter storm WARNING is issued:

- *Stay indoors during the storm. If you must go outside, several layers of lightweight clothing will keep you warmer than a single heavy coat.*
- *Avoid traveling by car in a storm.*
- *Conserve fuel, if necessary, by keeping your practice cooler than normal. Temporarily close off heat to some rooms.*

Winter Storm Preparations

- *Make sure your practice is well insulated and that you have weather stripping around your doors and windowsills to keep the warm air inside.*
- *Insulate pipes with insulation or newspapers and plastic and allow faucets to drip a little during cold weather to avoid freezing.*
- *Learn how to shut off water valves (in case a pipe bursts).*

For more information:

National Weather Service "Winter Storms…The Deceptive Killers" – Information and facts for how to prepare for winter storms and what to do in a winter storm. http://www.nws.noaa.gov/om/brochures/wntrstm.htm

Additional Resources & Information

- *Avoiding Hurricane Damage: A Checklist for Homeowners* – FEMA resources for preparing a home for hurricane season. www.fema.gov/library/viewRecord.do?id=3340
- *American Red Cross Repairing Your Flooded Home* – Information about how to perform simple home repairs after flooding, including cleaning, sanitation and determining which professionals to involve for various needed services. http://www.redcross.org/www-files/Documents/pdf/Preparedness/file_cont333_lang0_150.pdf
- *FEMA Earthquake Resource Center* – FEMA resources for recovery in case of an earthquake. http://www.fema.gov/hazard/earthquake/
- *Centers for Disease Control and Prevention Extreme Cold: A Prevention Guide to Promote Your Personal Health and Safety* – Information and resources for planning ahead for cold weather; understanding safety, both indoors and outdoors, in cold weather; and exploring cold weather health conditions. http://emergency.cdc.gov/disasters/winter/pdf/cold_guide.pdf
- *National Fire Protection Association* – Resources and fact sheet for preparing for fire emergencies. http://www.nfpa.org/index.asp
- *Centers for Disease Control and Prevention Impact of Power Outages on Vaccine Storage* – Information developed from the 2003 power outage that will provide guidelines on how to manage vaccines after a power outage. http://www.bt.cdc.gov/disasters/poweroutage/vaccinestorage.asp
- *US Food and Drug Administration Safe Drug Use After a Natural Disaster* – FDA recommendations for the use of medications after a natural disaster or emergency. http://www.fda.gov/Drugs/EmergencyPreparedness/ucm085200.htm
- *FEMA Earthquake Safety Checklist* – FEMA resources for preparing a home for earthquakes. http://www.fema.gov/library/viewRecord.do?id=1664
- *National Weather Service Heat Wave: A Major Summer Killer* – Information and resources describing the heat index, heat disorders and heat wave safety tips. http://www.nws.noaa.gov/om/brochures/heat_wave.htm.

Mental Health Services

After a disaster or traumatic event, everyone in a community is affected by psychological stress. Previous events have shown that there does not have to be physical injury for individuals to suffer mental health distress. Many times, the physical symptoms after an event can be attributed to mental health distress.

There are several factors that can influence the response to a traumatic event. These factors include:

- History of mental illness
- Intensity and duration of exposure
- Multiple traumatic exposures
- Low socio-economic status (SES).
- Gender
- Age
- Culture

There are multiple response patterns for a typical disaster response. And depending upon the individual, they may, or may not, show clearly defined symptoms, symptoms from one pattern or symptoms across patterns.

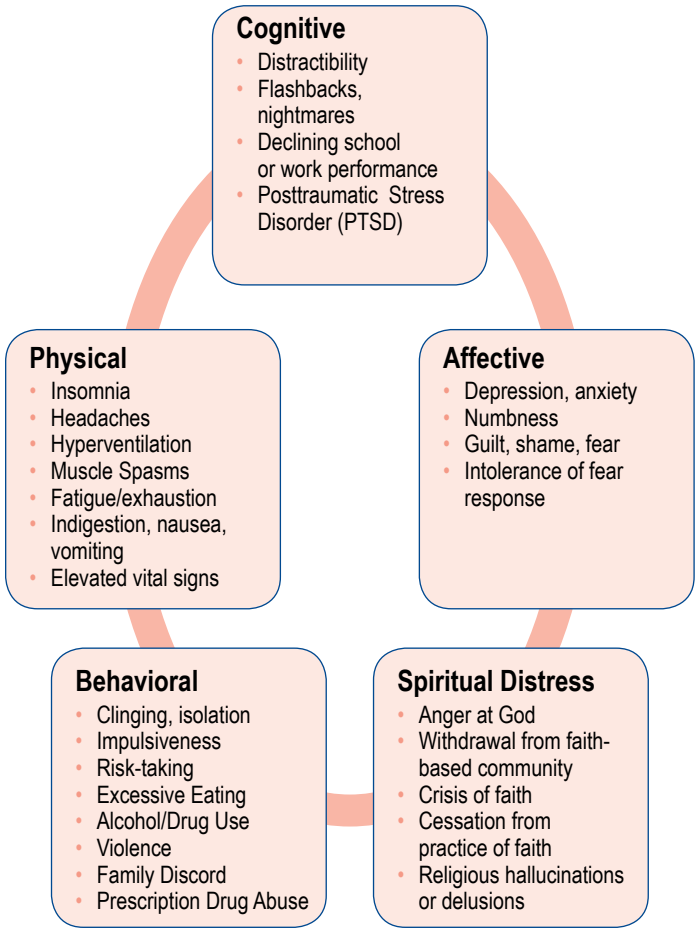


Figure 5.1 — Symptoms of Mental Health Distress

Psychological first aid (PFA)

Psychological first aid (PFA) is a model of response that involves supportive and practical assistance. After an event, PFA helps create safe surroundings, connection to others, empowerment and hope. PFA can be delivered by a variety of individuals as they assist in supporting communities. Some of the persons who provide PFA include:

- Medical first responders
- Victim assistance teams
- Faith-based professionals
- Government recovery teams
- Mental health first responders and Disaster workers.

When providing Psychological First Aid, some of the things to remember include:

- Provide a supportive, calm, courteous and organized environment.
- Help individuals meet their basic needs of food, shelter, and medical attention.
- Provide accurate information about the event and where they can receive services.
- Be friendly and compassionate even in the case of difficult or rude behaviors.
- Provide assistance for helping contact loved ones and friends.
- Keep families together.
- Encourage individuals to meet their own needs by developing a plan and offering to check in for support.
- Help identify individual's current needs and possible solutions. Find out the types of services being offered and direct to the resources that meet their needs.
- Maintain confidentiality.
- Remain in the scope of your role and expertise. Refer to others when additional expertise is needed or requested.
- **DO NOT** force an "event debriefing" or ask individuals to share their stories with you.
- **DO NOT** say "everything will be alright" or "it could have been worse".
- **DO NOT** tell individuals how to respond or why you believe they have suffered as they have based on their behaviors or beliefs.
- **DO NOT** complain about response efforts or services in front of people who need these services.

Additional Resources

Other resources that may be helpful in learning more about how to provide mental health services to the survivors of an event are listed below.

- **Psychological First Aid Field Operations Guide**

  Produced by the National Child Traumatic Stress Network and the National Center for PTSD

  Available for complete download, at no charge, at http://www.nctsn.org/content/psychological-first-aid

- **Introduction to Mental Health Preparedness**

  Produced by the University of North Carolina Center for Public Health Preparedness

  Available for complete download, at no charge, at http://cphp.sph.unc.edu/trainingpackages/mental_health_prep/

- **Mental Health First Aid Training Course**

  Produced by the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health

  Training class information available at http://www.mentalhealthfirstaid.org/

The following pages also contain additional resources that can be used as reference materials for providing mental health services to individuals in the event of a disaster.

- **Coping With a Traumatic Event**

  Produced by the Centers for Disaster Control and Prevention

- **Psychological Impact of Disaster and Terrorism: Tending to the Hidden Wounds - A Desk Reference Card**

  Produced by the Medical Society of the State of New York

- **Psychological First Aid for First Responders: Tips for First Responders**

  Produced by the Substance Abuse and Mental Health Services Administration

Coping With a Traumatic Event: Information for Health Professionals

What Is a Traumatic Event?
An event, or series of events, that causes moderate to severe stress reactions, is called a traumatic event. Traumatic events are characterized by a sense of horror, helplessness, serious injury, or the threat of serious injury or death. Traumatic events affect survivors, rescue workers, and friends and relatives of victims who have been directly involved. In addition to potentially affecting those who suffer injuries or loss. They may also affect people who have witnessed the event either firsthand or on television. Stress reactions immediately following a traumatic event are very common, however, most of the reactions will resolve within ten days.

Common Responses to a Traumatic Event

Cognitive	Emotional	Physical	Behavioral
• poor concentration • confusion • disorientation • indecisiveness • shortened attention span • memory loss • unwanted memories • difficulty making decisions	• shock • numbness • feeling overwhelmed • depression • feeling lost • fear of harm to self and/or loved ones • feeling nothing • feeling abandoned • uncertainty of feelings • volatile emotions	• nausea • lightheadedness • dizziness • gastro-intestinal problems • rapid heart rate • tremors • headaches • grinding of teeth • fatigue • poor sleep • pain • hyperarousal • jumpiness	• suspicion • irritability • arguments with friends and loved ones • withdrawal • excessive silence • inappropriate humor • increased/decreased eating • change in sexual desire or functioning • increased smoking • increased substance use or abuse

How Do You Interact with Patients after a Traumatic Event?
The clinician should be alert to the various needs of the traumatized person.

- Listen and encourage patients to talk about their reactions when they feel ready.
- Validate the emotional reactions of the person. Intense, painful reactions are common responses to a traumatic event.
- De-emphasize clinical, diagnostic, and pathological language.
- Communicate, person to person rather than “expert” to “victim,” using straightforward terms.

What Can You Do to Help Patients Cope with a Traumatic Event?
Explain that their symptoms may be normal, especially right after the traumatic event, and then encourage patients to:

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(continued from previous page)

- Identify concrete needs and attempt to help. Traumatized persons are often preoccupied with concrete needs (e.g., How do I know if my friends made it to the hospital?).
- Keep to their usual routine.
- Help identify ways to relax.
- Face situations, people and places that remind them of the traumatic event— not to shy away.
- Take the time to resolve day-to-day conflicts so they do not build up and add to their stress.
- Identify sources of support including family and friends. Encourage talking about their experiences and feelings with friends, family, or other support networks (e.g. clergy and community centers).

Who Is at Risk for Severe and Longer Lasting Reactions to Trauma?

Some people are at greater risk than others for developing sustained and long-term reactions to a traumatic event including disorders such as post traumatic stress disorder (PTSD), depression, and generalized anxiety. Factors that contribute to the risk of long-term impairment such as PTSD are listed.

- Proximity to the event. Closer exposure to actual event leads to greater risk (dose-response phenomenon).
- Multiple stressors. More stress or an accumulation of stressors may create more difficulty.
- History of trauma.
- Meaning of the event in relation to past stressors. A traumatic event may activate unresolved fears or frightening memories.
- Persons with chronic medical illness or psychological disorders.

What Can You Do to Treat Patients in Response to a Traumatic Event?

Helping survivors of traumatic events, their family members, and emergency rescue personnel requires preparation, sensitivity, assertiveness, flexibility and common sense.

- Refer patients to a mental health professional in your area who has experience treating the needs of survivors of traumatic events.
- Provide education to help people identify symptoms of anxiety, depression, and PTSD (see resources).
- Offer clinical follow-up when appropriate, including referrals to mental health professionals.

For more information, visit www.bt.cdc.gov/masscasualties,
or call CDC at 800-CDC-INFO (English and Spanish) or 888-232-6348 (TTY).

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MSSNY

Medical Society of the State of New York

PSYCHOLOGICAL IMPACT OF DISASTER AND TERRORISM

TENDING TO THE HIDDEN WOUNDS

Dear Physician:

The events of September 11th changed our state and our country in ways we still can't fully understand. One of the most devastating and pervasive results of this tragic day was the impact it had on mental health. Those who were directly affected, such as families who lost loved ones and survivors of the tragedy, suffered substantially increased rates of mental disorders including, most frequently, depression, anxiety and post traumatic stress disorder. But the sheer maganitude of the event shattered the sense of safety and security which had previously characterized the lives of the vast majority of us. Resultant psychological disorders have been extensive. It is now evident, beyond argument, that providing care following a major disaster requires that serious attention be given to mental disorders as well as physical injuries.

New York State is committed to addressing the need for adequate care of mental health problems following disasters. The State's Project Liberty provides counseling services in New York City and 10 surrounding counties. More than 100 mental health professionals participated in individual and group crisis counseling, educational services and referrals More recently, the state Department of Health has worked with the Medical Society of the State of New York to create a program to train physicians to treat patients who are suffering mental health problems resulting from a disaster. At the Medical Society, we recognize that people turn to their physician when they are encountering either physical or mental problems. We know, therefore, that this training program is essential to treat New York State's population adequately in the event of a public health disaster or terrorist attack.

The training program created by MSSNY is entitled, "The Psychological Impact of Disaster and Terrorism: Tending to the Hidden Wounds". It consists of four separate training modules accredited with continuing medical education credits. Physicians can take this training program online. Information on both the online and live programs is available at www.mssny.org. This particular reference card draws some of the key information from the training program in a format that can be quickly accessed. Additionally, there are 16 different modules on biological, chemical and nuclear agents which a physician may also take online or by attending one of MSSNY's live bioterrorist seminars. We encourage each of you to take these free continuing medical education accredited courses on the biological components and the psychological consequences of living in a world when the use of weapons of mass destruction is no longer a threat, but a reality.

In the years to come after 9/11, it is so very important that we care for our patients fully and that we treat all their "wounds". As a New York State physician, I am proud of how physicians responded to 9/11. I am equally proud today, in how we are continuing to respond to the changes which confront us in the new age in which we now live.

Sincerely,

William Rosenblatt, MD
President, Medical Society of the State of New York

RESOURCES

Medical Society of the State of New York (MSSNY)
www.mssny.org
Phone: 518-465-8085 (Albany)
Phone: 516-488-6100 (Lake Success)

Disaster Psychiatry Outreach
www.disasterpsych.org
Phone: 212-598-9995
Fax: 212-598-5957
E-mail: info@disasterpsych.org

Project Liberty—24-hour mental health information and referral hotline.
1-800-LIFENET
1-800-543-3638
1-212-995-5824

New York State Office of Mental Health
www.omh.state.ny.us
Phone: 518-474-4403
Fax: 518-474-2149

New York State Department of Health (NYS-DOH)
www.health.state.ny.us/home.html
After hours NYSDOH Duty Officer: 518-465-9720
After hours State Emergency Management Office (SEMO) State Warning Point: 518-457-2200

New York City Department of Health (NYC-DOH)
www.nyc.gov/html/doh/home.html

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Produced under a federal grant from the Centers for Disease Control and Prevention and the New York State Department of Health.

MANAGING ACUTE PHASE
IN THE FIELD

PSYCHOLOGICAL FIRST AID

What it is: Simple psychological interventions that enlist victim's innate coping strategies and facilitate the healing process.

Why it is needed: Disasters can worsen pre-existing psychiatric illness or activate maladaptive coping stratgies; simple and thoughtful interventions can contain and reverse the psychiatric symptoms.

Key concepts:

- Provide for basic needs
- Protect from further harm
- Contain agitation & arousal
- Support those in most distress
- Keep families together and provide social support
- Be aware of impact on entire family
- Provide information, educate and foster communication
- Orient victim to available services

WHEN WORKING AT DISASTER SITE:

- *Conditions In the Field*—Unfamiliar, makeshift setting with other activities taking place in the same space.
- *When On-Site*—Be willing to help with **any** needs that are within your capacity, from provision of medical care to setting up site for providing care to handing out blankets.
- You may need to assist in establishing a safe and effective site for providing care.

Survivors are more likely to seek medical rather than psychological care in the field. Utilize medical encounters as opportunities to provide psychological support.

1 Engage the Victim

ENGAGING THE VICTIM

Use informal conversation progressing to general inquirites about victim's well-being.

Ask questions that assess victim's needs:

- Are you hurt?
- Have you eaten?
- Have you slept?
- Have you washed?
- Have you made contact with your loved ones?
- How are you getting by?
- With everything that's happened, what is on your mind?

Engaging victims is difficult. Be flexible, but use a directed approach that is informed by physical and emotional proximity to the disaster.

2 Address Physical Safety & Basic Needs

PHYSICAL SAFETY & BASIC NEEDS

Victim's basic needs critical for survival must first be addressed:

- Medical care
- Pain relief
- Food and drink

Provide physical shelter from:

- Ongoing disaster
- The elements
- Onlookers

3 Assess Psychological Safety

PSYCHOLOGICAL SAFETY

- Provide a calm physical space.
- Use a reassuring manner that reduces agitation and arousal.

Unless the victim wishes to discuss the event, avoid "debriefing" of the victim's experience during the disaster as this may prolong the trauma experience or may lead to re-traumatization.

MANAGING ACUTE PHASE
FROM THE FIELD TO OFFICE

ACUTE PHASE DEFINITION

The acute phase encompasses the trauma's immediate impact occurring minutes, hours, or days following the event. In the acute phase, severe reactions can be adaptive—most do resolve.

Social connectedness is critical
- Keep family and friends together.
- Help victims reconnect with loved ones.
- Foster communication, in particular among survivors.

Help survivors assert their ability to help themselves
- Provide information about the event and orient the survivor to services available.
- Educate about expected reactions, coping strategies, and self care.

EXPOSURE ASSESSMENT

Amount or dose of exposure correlates to risk of developing psychological symptoms. Use following questions to assess exposure:
- Are you hurt?
- Has anyone close to you been hurt?
- Have you suffered any losses? (home, job, other property, etc.)
- Have you seen others hurt?
- What did you see?

TREATING CHILDREN IN THE ACUTE PHASE

- Attending to parents' needs can help their children, who take their cues from their parents during stressful times.
- Calm the adult first because child reacts to adult.
- Employ an age appropriate approach to children (e.g., permit younger children to join the parent in their bed for comfort while sleeping).
- Encourage parents to talk to their children about their experience of the disaster in an age appropriate manner.
- Encourage parents to restore child's daily routine as soon as possible.
- Involve children in family's recovery from the disaster—a sense of empowerment is important for children.

PSYCHOPHARMACOLOGY IN THE ACUTE PHASE

Using medications to manage psychiatric symptoms in the acute setting is effective and appropriate. Limit prescription to a few days supply and make sure to arrange a follow-up appointment.

Anxiety and insomnia
- Short course of benzodiazepines and hypnotics (lorazepam, clonazapan, zolpidem, zaleplon, diphenhydramine)

Anti-psychotics
- Use only for extreme agitation and disorginazation in the acute settings.
- Victims with emerging or exacerbation of pre-existing psychosis should be referred to emergency rooms.

Antidepressants
- Depression is difficult to diagnose in acute setting, therefore initiating treatment with antidepressant medication is not appropriate in the acute phase.
- *SSRI warning for adolescents—Studies show increased suicide risk amongst adolescents taking SSRI's.* Consider use of Prozac for adolescents. It is the only SSRI not linked to increased suicide risk.

POST-ACUTE PHASE

The post-acute phase begins once the immediate threat is removed and encompasses trauma's long-term sequelae in the days, weeks or even months following the trauma. In the post-acute phase a transition to "everyday life" is seen.

POST TRAUMATIC STRESS DISORDER

POST TRAUMATIC STRESS DISORDER - OVERVIEW

PTSD - A pathological stress response syndrome that can be defined as the maladaptive persistence (at least one month) of disabling symptoms long after the resolution of an extreme stressor.

Symptoms fall under 3 chief domains:

- Avoidance and emotional numbing
- Re-experiencing
- Hyper-arousal

PHYSICIAN ADMINISTERED SCREENING TOOL FOR PTSD

The following is a useful screening instrument which is administered by a physician. A patient is instructed to respond with Yes / No answers.

- Do you avoid being reminded of this experience by staying away from certain places, people or activities?
- Have you lost interest in activities that were once important or enjoyable?
- Have you felt more isolated or distant from other people? - In the last month?
- Have you found it hard to have love or affection for other people? - In the last month?
- Have you felt that there was no point in planning for the future? - In the last month?
- After this experience, were you having more trouble than usual falling asleep or staying asleep?
- Do you become jumpy or get easily startled by ordinary noises or movements?

Four or more positive responses is strongly associated with PTSD and is an indication of further assessment. The clinician should also probe for other symptoms of PTSD and explore their daily impact on the patient's life.

If less than 4 postive responses, watch for sub-syndromal or PTSD which can also be profoundly disabling and treatment should be considered.

PTSD's severity can range from sub-syndromal to profoundly disabling.

PTSD – RISK FACTORS

There are a number of factors that can predispose the victim to clinical PTSD:

- Pre-Trauma Factors
  - — Past history of trauma
  - — Family history
  - — Medical history
  - — Past psychiatric history
  - — Individual resilience
- Traumatic Event
  - — Dose of exposure
  - — Experience of trauma
- Post-Trauma Factors
  - — Social supports

TREATMENT OPTIONS

Medications

- Long-term pharmacotherapy with antidepressants: SSRIs are effective medications for the long term treatment of PTSD.
- Treatment with SSRI's result in better outcomes when used in combination with specialized psychotherapies and social interventions.

— Go to page 2 for adolescent use warning.

Encourage self-care and use of relaxation techniques

- Basic self-care—meals, walking, etc.
- Regular sleep/wake schedule
- Regular relaxing evening routine
- Routine deep breathing exercises

Grounding techniques are useful for relief of dissociation and flashback symptoms.

- Instruct patients to focus on immediate surroundings.
- Unstructured relaxation can exacerbate dissociation.

MAJOR DEPRESSIVE DISORDER

DEPRESSIVE DISORDER OVERVIEW

Primary symptoms must include (for at least two weeks):

- Depressed mood most of the day every day, *or*
- Diminished interest or pleasure in nearly all activities

Related disorders:

- **Dysthymia**—2 years of depressed mood more days than not
- **Adjustment Disorders**—Significant emotional or behavioral symptoms causing distress within 3 months of exposure to an identifiable stressor

SCREENING TOOL BASED ON DIAGNOSTIC CRITERIA FOR MAJOR DEPRESSION

Begin by asking:

- Have you been feeling down, depressed, or hopeless?
- Do you have little interest or pleasure in doing things?

If yes to either question, continue with SAD-A-FACES questions. If no and still suspect depression, go through to screen for sub-clinical depression.

SAD-A-FACES—For a diagnosis of major depression, presence of 5 or more within 2-week period is required.

Sleep	insomina/hypersomnia
Appetite	increase/decrease/weight change
Dysphoria	sadness/irritability
Anhedonia	lack of interest/pleasure/sex drive
Fatigue	decreased energy
Agitation	psychomotor agitation/slowing
Concentration	reduced ability to focus
Esteem	decreased self-esteem/guilt
Suicide	passive: life not worth living/active: plan, means

TREATMENT APPROACH

- Better educate patients regarding symptoms of depression.
- Reassure that treatment is effective.
- Explain that symptoms can be a product of one's biology, life experience.
- Provide support: listen, highlight patient's strengths, lend permission to cry.
- Medication: SSRI's are a safe and effective first line agent, although there are many other options. In the short term, add symptomatic medication to target insomnia or anxiety.

SUICIDE RISK

Individuals struggling with depression are at a high risk for suicide.

Always ask a depressed person about suicide--you will not precipitate an attempt by asking.

Profile of repeat suicide attemptors: Young female, borderline personality, impulsivity, disrupted intimate relationship, prior attempts

Profile of suicide completors: Older white male, lives alone, recent loss, chronic health problems, substance abuse, prior attempts

SUBSTANCE ABUSE AND DEPENDENCE

OVERVIEW

- Increase in use of alcohol and other substances after exposure to traumatic event is common.
- Men more likely to cope with traumatic event through substance abuse.
- Substance users more likely to experience traumatic event because of activities related to obtaining substances and impairment while intoxicated.
- Abuse and dependence defined as pattern of substance use leading to clinically significant impairment or distress.

ABUSE

- Recurrent substance use resulting in a failure to fulfill major role obligations.
- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.

DEPENDENCE

- The substance is taken in larger amounts or over a longer period than was intended.
- Persistent desire or unsuccessful efforts to cut down or control use.
- A great deal of time is spent in activities to obtain the substance.

RAPID SCREEN FOR ALCOHOL ABUSE/DEPENDENCE

CAGE Questionnaire— "Have you ever?"

Cut down—Have you ever thought about cutting down on your drinking?
Annoyed—Have you ever been annoyed by criticism of your drinking?
Guilt—Have you ever felt guilty about your drinking?
Eye opener—Do you ever have a drink in the morning?

More than one postive response should alert you that individual might be having a problem with alcohol.

ACUTE STRESS DISORDER

OVERVIEW

ASD is characterized by the development of dissociative, anxiety, hyper-arousal, avoidance, and re-experiencing symptoms within 1 month of traumatic stressor and lasting between 2 days and 4 weeks.

- Key difference from PTSD is duration and presence of dissociative symptoms in ASD.
- ASD and PTSD may represent individual's inability to recover from a normal array of adaptive reactions to trauma in the short and long term.

DIAGNOSTIC CRITERIA

All must be present for diagnosis of ASD:
— Dissociation
— Re-experiencing
— Avoidance
— Increased arousal

Dissociative symptoms either during or after the trauma (3 or more):

- Sense of numbing, detachment, or absence of emotional responsiveness
- A reduction in awareness of one's surroundings
- **Derealization**—A state of unreality—normal sense of reality is experienced as lost and one's surroundings are experienced as strange, unreal, or somehow altered.
- **Depersonalization**—Normal sense of personal identity is experienced as lost.
- **Dissociative amnesia**—Partial or total loss of memory of events that occurred during the dissociative state.

OTHER ANXIETY DISORDERS

Following a traumatic event, individuals may develop anxiety disorders other than ASD or PTSD.

- **Panic Attack**—Individual experiences a time-limited period of extreme anxiety with a host of concomitant somatic symptoms.
- **Panic Disorder**—Anxiety disorder in which an individual experiences recurrent panic attacks, and changes his or her behavior and thinking as a result.
- **Generalized Anxiety Disorder**—Worries and anxiety are global and debilitating. .

Managing Intense Emotions

When people are first faced with disaster and you first meet them, intense emotions are often present and appropriate. They are a result of intense fear, uncertainty, and apprehension.

DO:

Communicate Calmly: Use SOLER

- Sit squarely or stand using the L-stance (shoulder 90º to the other person's shoulder).
- Open posture.
- Lean forward.
- Eye contact.
- Relax.

Communicate Warmth:

- Use a soft tone.
- Smile.
- Use open and welcoming gestures.
- Allow the person you are talking with to dictate the distance between you.

Establish a Relationship:

- Introduce yourself if they do not know you.
- Ask the person what they would like to be called.
- Do not shorten their name or use their first name without their permission.
- With some cultures, it is important to always address the person as Mr. or Mrs.

Use Concrete Questions to Help the Person Focus:

- Use closed-end questions.
- Explain why you are asking the question.

Come to an Agreement on Something:

- Establish a point of agreement that will help solidify your relationship and gain their trust.
- Active listening will help you find a point of agreement.

Speak to the Person with Respect:

- Use words like please and thank you.
- Do not make global statements about the person's character.
- Lavish praise is not believable.
- Use positive language.

If the Person Becomes Agitated, He or She May—

Challenge or Question Authority:

- Answer the question calmly.
- Repeat your statement calmly.

Refuse to Follow Directions:

- Do not assert control. Let the person gain control of self.
- Remain professional.
- Restructure your request in another way.
- Give the person time to think of your request.

Lose Control and Become Verbally Agitated:

- Reply calmly.
- State that you may need assistance to help them.

Become Threatening:

- If the person becomes threatening or intimidating and does not respond to your attempts to calm them, seek immediate assistance. (2)

(1) Adapted from "Psychological First Aid," the Center for the Study of Traumatic Stress at www.centerforthestudyoftraumaticstress.org and used with permission.

(2) Adapted from "Nebraska Disaster Behavioral Health Psychological First Aid Curriculum" at www.mentalhealth.samhsa.gov/dtac/EducationTraining.asp.

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

NMH05-0210

Psychological First Aid for First Responders

Tips for Emergency and Disaster Response Workers

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

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Psychological First Aid for First Responders

Information Clearinghouses

National Mental Health Information Center (NMHIC)
P.O. Box 42557, Washington, DC 20015
(800) 789-2647 (English and Español)
(866) 889-2647 (TDD)
www.mentalhealth.samhsa.gov

National Clearinghouse for Alcohol and Drug Information (NCADI)
P.O. Box 2345, Rockville, MD 20847-2345
(800) 729-6686 (English and Español)
(800) 487-4889 (TDD)
www.ncadi.samhsa.gov

Treatment Locators

Mental Health Services Locator
(800) 789-2647 (English and Español)
(866) 889-2647 (TDD)
www.mentalhealth.samhsa.gov/databases

Substance Abuse Treatment Facility Locator
(800) 662-HELP (4357) (Toll-Free, 24-Hour English and Español Treatment Referral Service)
(800) 487-4889 (TDD)
www.findtreatment.samhsa.gov

Hotlines

National Suicide Prevention Lifeline
(800) 273-TALK (8255)
(800) 799-4889 (TDD)

SAMHSA National Helpline
(800) 662-HELP (4357) (English and Español)
(800) 487-4889 (TDD)

Workplace Helpline
(800) WORKPLACE (967-5752)
www.workplace.samhsa.gov/helpline/helpline.htm

When you work with people during and after a disaster, you are working with people who may be having reactions of confusion, fear, hopelessness, sleeplessness, anxiety, grief, shock, guilt, shame, and loss of confidence in themselves and others. Your early contacts with them can help alleviate their painful emotions and promote hope and healing.

Your goal in providing this psychological first aid is to promote an environment of safety, calm, connectedness, self-efficacy, empowerment, and hope.

DO:

Promote Safety:

- Help people meet basic needs for food and shelter, and obtain emergency medical attention.
- Provide repeated, simple, and accurate information on how to get these basic needs.

Promote Calm:

- Listen to people who wish to share their stories and emotions, and remember that there is no right or wrong way to feel.
- Be friendly and compassionate even if people are being difficult.
- Offer accurate information about the disaster or trauma, and the relief efforts underway to help victims understand the situation.

Promote Connectedness:

- Help people contact friends and loved ones.
- Keep families together. Keep children with parents or other close relatives whenever possible.

Promote Self-Efficacy:

- Give practical suggestions that steer people toward helping themselves.
- Engage people in meeting their own needs.

Promote Help:

- Find out the types and locations of government and nongovernment services and direct people to those services that are available.
- When they express fear or worry, remind people (if you know) that more help and services are on the way.

DO NOT:

- Force people to share their stories with you, especially very personal details.
- Give simple reassurances like “everything will be OK” or “at least you survived.”
- Tell people what you think they should be feeling, thinking, or how they should have acted earlier.
- Tell people why you think they have suffered by alluding to personal behaviors or beliefs of victims.
- Make promises that may not be kept.
- Criticize existing services or relief activities in front of people in need of these services.[1]

Biological Attacks

Biological attacks are the deliberate release of germs or other biological substances that can make you sick. An attack may or may not be immediately obvious. It is likely that a biological attack will become known after local healthcare providers report a pattern of unusual illness or there will be a wave of sick people seeking emergency medical attention.

If There is a Biological Threat:

If you become aware of an unusual and suspicious release of an unknown substance nearby, there are ways to be protected.

- *Cover your mouth and nose with layers of fabric that can filter the air but still allow breathing.* For example, two to three layers of cotton such as a t-shirt, handkerchief or towel. Otherwise, several layers of tissue or paper towels may help.
- *Wash with soap and water.*

During a Declared Biological Emergency:

- *If a family member or patient becomes sick, it is important to be suspicious.*
- *Use common sense, practice good hygiene and cleanliness to avoid spreading germs, and seek medical advice.*
- *Consider if you are in the group or area authorities believe to be in danger.*
- *Do not assume, however, that you should go to a hospital emergency room or that any illness is the result of the biological attack. Symptoms of many common illnesses may overlap.*

If You are Potentially Exposed:

- *Follow instructions of public health officials.*
- *If the disease is contagious, expect to receive medical evaluation and treatment. You may be advised to stay away from others or even deliberately quarantined.*
- *For non-contagious diseases, expect to receive medical evaluation and treatment.*

Symptoms

If a patient develops any of the symptoms below, keep them separated from others if possible, practice good hygiene and cleanliness to avoid spreading germs, and seek medical advice.

- Nausea and vomiting
- Diarrhea
- Headache
- Earache
- Sore throat
- Red or pink eyes
- Stomachache
- Pale or flushed face
- Cough
- Thick discharge from nose
- Rash or infection of the skin
- Loss of appetite
- A temperature of more than 100 degrees
- Loss of energy or decreases in activity

Additional Resources

Other resources that may be helpful in learning more about providing diagnosis or treatment in the aftermath of an event are listed below.

- *Centers for Disease Control and Prevention Emergency Preparedness & Response Bioterrorism Website*
  Information available at http://www.bt.cdc.gov/bioterrorism/
- *Introduction to Chemical Agents*
  Produced by the John Hopkins Public Health Preparedness Programs. Training available for complete download, at no charge, at http://www.jhsph.edu/preparedness/training/online/intro_chem_agents.html

The following pages also contain additional resources that can be used as reference materials for providing mental health services to individuals in the event of a disaster.

- **Biological, Chemical and Radiological Terrorism: An Overview of Indicators and Response—A Desk Reference Card**
  Produced by the Medical Society of the State of New York
- **Guidance on Initial Responses to a Suspicious Letter / Container With a Potential Biological Threat**
  Produced by jointly by the Federal Bureau of Investigation (FBI), Department of Homeland Security and the Centers for Disaster Control and Prevention

MSSNY

Medical Society of the State of New York

BIOLOGICAL, CHEMICAL, AND RADIOLOGICAL TERRORISM:

An Overview of Indicators and Response

INTRODUCTION

This guide provides physicians and other healthcare providers with basic information to help identify and respond to patients affected by biological, chemical, or nuclear/radiological agents. Healthcare workers should be alert to illness patterns and reports of biological, chemical, or radiological exposure that might signal an act of terrorism. This guide is intended to provide an overview of some of those potential threats.

RECOGNIZING A TERRORISM-RELATED EVENT

Biological Agents

- Unusual numbers of sick or dying people and/or animals, especially over a short period
- Severe disease in previously healthy people
- Out-of-season or region disease outbreaks
- Outbreak of previously rare disease
- Unscheduled and unusual aerial spraying
- Abandoned spray devices

Chemical Agents

- Mass casualties
- Definite pattern of casualties and physical syndromes
- Illness associated within a confined geographic area
- Dead insects/animals/birds/fish
- Vegetation dies out of season
- Unusual liquid droplets
- Unexplained odors
- Unexplained low-lying clouds
- Unusual metal debris, especially if wet and no rain

Radiological Events

- Acute radiation sickness unfolds over days or weeks
- Within 2-3 weeks, cluster of people presenting with nausea, vomiting, skin redness (in the absence of a known heat source), tendency to bleed, and/or hair loss

INFECTION CONTROL

Standard Precautions

For procedures likely to generate splash or contact w/ blood or body fluids/secretions/excretions: gowns, masks, protective eyewear, gloves, hand washing after gloves are removed

Contact Precautions

Standard precautions; plus gown if clothing will contact patient or if patient has diarrhea, ileostomy, colostomy, or uncontained wound drainage; gloves when entering patient room; medicated handwashing agent

Droplet Precautions

Standard precautions; plus mask for those entering room of patient, surgical mask on patient during transport

Airborne Precautions

Standard precautions; plus N95 mask or respirator for those entering room of patient, surgical mask on patient during transport

REPORTING

Report suspected or confirmed cases of any of the biological, chemical, or nuclear agents listed in this brochure immediately to your local or state department of health.

New York State Department of Health, Office of the Commissioner: **518-474-2011**
New York City Department of Health, Office of Communicable Diseases: **212-788-9830**
If not in New York City, locate your local health department in New York.

New York State Association of County Health Officials: **518-456-7905**
www.nysacho.org/Directory/directory.html

RESOURCES

New York State Department of Health (NYS-DOH)
www.health.state.ny.us/home.html
Bureau of Environmental Radiation Protection: 518-402-7550
Bureau of Toxic Substance Assessment: 518-402-7870
Communicable Disease Control: 518-473-4436
Wadsworth Center Laboratories: 518-474-4177
After hours NYSDOH Duty Officer: 518-465-9720
After hours State Emergency Management Office (SEMO) State Warning Point: 518-457-2200

New York City Department of Health (NYC-DOH)
www.nyc.gov/html/doh/home.html
Bureau of Radiological Health: 212-676-1572 (After hrs 212-764-7667)
NYC Public Health Laboratories: 212-447-2864
Poison Control Center: 212-764-7667

Medical Society of the State of New York (MSSNY)
www.mssny.org
Phone: 518-465-8085 (Albany)
Phone: 516-488-6100 (Lake Success)

Armed Forces Institute of Pathology (AFIP)
www.afip.org
Information Desk: 202-782-2100

Centers for Disease Control and Prevention (CDC)
www.cdc.gov, www.bt.cdc.gov
Bioterrorism Preparedness and Response Program
Hotline: 770-488-7100
National Immunization Hotline: 800-232-2522

Federal Bureau of Investigation (FBI) Operations Center
www.fbi.gov/terrorinfo/terrorism.htm
Phone: 202-324-6700

Federal Emergency Management Agency (FEMA)
www.fema.gov
Phones: 800-480-2520, 202-646-4600
FEMA Operations Center: 800-634-7084, 540-665-6100, 703-771-6100
FEMA National Preparedness Office: 202-324-9025

AppleCare Foundation
www.applecarefoundation.org/research2.html

Poison Control Centers
Hotline: 1-800-222-1222

State public-health locator for officials, agencies, and public hotlines
www.statepublichealth.org,
www.cdc.gov/other.htm#states

Strategic National Stockpile (SNS)
www.bt.cdc.gov/stockpile
Phone: 404-639-0459

U.S. Army Medical Research Institute of Chemical Defense (USAMRICD)
ccc.apgea.army.mil
Phone: 410-436-2230

U.S. Army Medical Research Institute of Infectious Diseases (USAMRIID)
www.usamriid.army.mil
Response Line: 888-USA-RIID (888-872-7443)

U.S. Department of Health and Human Services
www.hhs.gov
Phone: 202-619-0257

U.S. Department of Homeland Security
www.whitehouse.gov/homeland
Homeland Security state contact list:
www.whitehouse.gov/homeland/contactmap.html

U.S. Food and Drug Administration (FDA)
www.fda.gov,
www.fda.gov/oc/opacom/hottopics/bioterrorism.html
Phone: 1-888-INFO-FDA (1-888-463-6332)

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Produced under a federal grant from the Centers for Disease Control and Prevention and the New York State Department of Health.

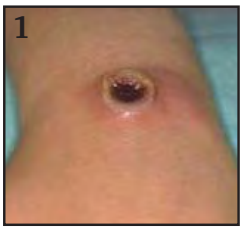
Anthrax

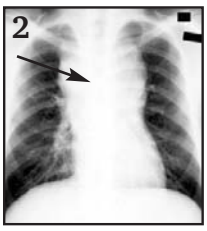
Biological Agent
The bacteria *Bacillus anthracis*

Indications of Terrorist Release
The sudden appearance in a region of a large number of patients with flulike illness (particularly off flu season), respiratory symptoms, and a high fatality rate, with nearly ½ of all deaths occurring w/in 24-48 hrs from time that symptoms begin, would suggest a release of inhalation anthrax as a biological weapon.

Possible Means of Exposure
Inhalation, ingestion, and cutaneous

Incubation
Cutaneous: 1-12 days
Gastrointestinal: 3-7 days
Inhalational (most likely in bioterror attack)**:** 1-60 days





(1) Cutaneous anthrax lesion on hand, about 5 days after exposure. (2) Inhalational anthrax; arrows point to the widened mediastinum.

Primary Symptoms of Inhalational Anthrax
Flulike symptoms (e.g., fever, malaise, myalgias, headache, abdominal pain, vomiting, coughing, chest pain) but no nasal congestion; increasingly severe respiratory symptoms, including dyspnea, stridor, and cyanosis, and expansion of the mediastinum seen on chest X-ray.

Diagnostic Tool of Choice
Tissue/blood culture

Treatment
Immediate initiation of IV antibiotics (1st choice = penicillin in non-allergic pts, penicillin-sensitive organisms)

Post-Exposure Prophylaxis
Antibiotic therapy P.O. (1st choice = ciprofloxacin)

Vaccine
Available

Infection Control
- Use standard precautions.
- Isolation of patient not indicated.
- Note that anthrax spores are resistant in the environment and decontamination efforts will be difficult.

Botulism

Biological Agent
Botulinum toxin produced by the bacteria *Clostridium botulinum*

Indications of Terrorist Release
In a bioterrorism attack, botulinum toxin would likely be released as an aerosol, hence respiratory symptoms could accompany neurological manifestations (GI symptoms may be present as well).

Possible Means of Exposure
Inhalation, ingestion of contaminated food or untreated water, contamination of an open wound by live bacteria

Incubation
Foodborne: 2 hrs to 8 days
Inhalational: 12-72 hrs

Primary Symptoms/Foodborne Botulism
Begins as acute, afebrile, symmetric, descending paralysis. Effects always begin at the head; prominent findings include ptosis, diplopia, blurred vision, dilated or sluggishly reactive pupils (only <50% of pts), dysarthria, dysphonia, and dysphagia. Mouth may appear dry and pharynx injected. Loss of head control, hypotonia, and generalized weakness become prominent. Dysphagia and loss of protective gag reflex may follow. Deep tendon reflexes may diminish or disappear. If untreated, paralysis will travel symmetrically down body, affecting arms, torso, legs, and respiratory muscles. Other symptoms include fatigue, constipation, urinary retention, dizziness, anorexia, nausea, and vomiting. There are no sensory deficits.

Primary Symptoms/Inhalational Botulism
Symptoms similar to foodborne form but could include chest pain, nonproductive cough, and other respiratory symptoms.

Diagnostic Tool of Choice
Mouse bioassay (must be sent to state health department or CDC)

Treatment
Antitoxin: trivalent (types A, B, E) equine serum

Post-Exposure Prophylaxis
To preserve scarce supplies of antitoxin, asymptomatic exposed persons should delay prophylactic Rx and remain under observation

Vaccine
Under development

Infection Control
- Use standard precautions.
- The toxin is not dermally active and secondary aerosols are not a hazard.

Brucellosis

Biological Agent
Bacteria of the genus, *Brucella*

Indications of Terrorist Release
In a bioterrorism attack, brucellae would likely be released as an aerosol and inhaled; terrorism indicators are a number of brucellosis cases within a short period and without animal contact or other risk factors.

Possible Means of Exposure
Ingestion of/or contact with contaminated animals or animal products, or by inhalation; person-to-person transmission possible but unlikely

Incubation
5-60 days (usually 2-3 wks)

Primary Symptoms
Flulike symptoms including intermittent fevers, myalgias, arthralgias, back pain, generalized weakness, fatigue, cough, pleuritic chest pain; nausea, vomiting, diarrhea, and/or constipation may also be present.

Diagnostic Tools of Choice
Blood or bone marrow culture; serologic testing

Treatment
Doxycycline + gentamycin, streptomycin, or rifampin for 6 wks

Post-Exposure Prophylaxis
Doxycycline (+ rifampin if large exposure suspected)

Vaccine
Not available

Infection Control
- Use standard precautions.
- Rare cases of person-to-person transmission noted but considered insignificant.

Glanders

Biological Agent
The bacteria *Burkholderia mallei*

Indications of Terrorist Release
Occurrence in the absence of animal contact and/or in a human epidemic form is strong evidence of a bioterror attack.

Possible Means of Exposure
Inhalation (most likely in bioterror attack), through mucous membranes or abraded skin; person-to-person unlikely but possible; animal exposure

Incubation
10-14 days

Primary Symptoms of Pulmonary Glanders
High fever, chills, sweats, myalgias, rigors, headache, pleuritic chest pain, cervical adenopathy, pneumonia; bloody nodules or ulcers may form on mucous membranes.

Diagnostic Tools of Choice
Complement fixation test, Gram stain, chest X-ray

Treatment
Antibiotics (specific recommendations for best-choice vary) lasting for 60-150 days; 2-drug antibiotic therapy for severe cases

Post-Exposure Prophylaxis
TMP/SMX

Vaccine
Not available

Infection Control
- Use standard precautions.
- Use contact precautions when caring for patients with skin involvement.

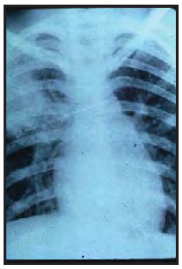
Melioidosis

Biological Agent
The bacteria *Burkholderia pseudomallei*

Indications of Terrorist Release
Occurrence in the absence of animal contact and/or in a human epidemic form is strong evidence of a bioterror attack.

Possible Means of Exposure
Inhalation (most likely in bioterror attack), through skin abrasions; person-to-person rare but possible

Incubation
2 days to years



Chest X-ray showing melioidosis infection involving the right upper lung.

Primary Symptoms of Pulmonary Melioidosis
High fever, chills, sweats, myalgias, rigors, headache, chest pain, cough (productive or non-productive), cervical adenopathy, anorexia, pneumonia; cutaneous abscesses may appear months later.

Diagnostic Tools of Choice
Complement fixation test, Gram stain, chest X-ray

Treatment
Antibiotics (specific recommendations for best-choice vary) lasting for 60-150 days; 2-drug antibiotic therapy for severe cases

Post-Exposure Prophylaxis
Ciprofloxacin, doxycycline, or amoxicillin-clavulanate

Vaccine
Not available

Infection Control
- Use standard precautions.
- Use contact precautions when caring for patients with skin involvement.

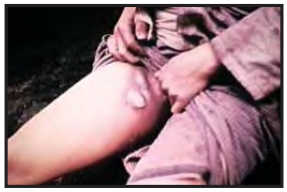
Plague

Biological Agent
The bacteria *Yersinia pestis*

Indications of Terrorist Release
In a bioterrorism attack, *Y. pestis* would likely be released as an aerosol and inhaled; a large number of previously healthy persons rapidly progressing from flulike symptoms to cough, dyspnea, chest pain, to severe pneumonia and death suggestive of attack; most natural cases in the U.S. occur in southwestern states.

Possible Means of Exposure
Inhalation; person-to-person

Incubation
Bubonic: 2-8 days
Pneumonic (most likely in bioterror attack): 1-8 days



Bubonic plague patient with swollen, ruptured inguinal lymph node ("bubo").

Right hand of a plague patient displaying acral gangrene.

Primary Symptoms of Pneumonic Plague
Fulminant onset w/ high fever, chills, headache, extreme malaise, and myalgias; cough and hemoptysis w/in 24 hrs; nausea, vomiting, and abdominal pain may also occur; rapidly progresses to dyspnea, stridor, cyanosis, respiratory failure, and circulatory collapse.

Diagnostic Tools of Choice
Culture, serology, Gram/Wright stain, chest X-ray

Treatment
Streptomycin or penicillin

Post-Exposure Prophylaxis
Doxycycline or ciprofloxacin

Vaccine
No longer available (discontinued by its manufacturers in 1999)

Infection Control
- Use standard precautions.
- Mask suspected pneumonic plague patients in ER/transport; isolate confirmed patients, using strict droplet precautions.
- Decontaminate surfaces, clothing, and bedding thoroughly.

Q Fever

Biological Agent
The bacteria *Coxiella burnetii*

Indications of Terrorist Release
In a bioterrorism attack, *C. burnetii* would likely be released as an aerosol and inhaled; a bioterrorist release would cause disease similar to that occurring naturally.

Possible Means of Exposure
Inhalation, ingestion, bites from infected ticks, contact with infected animals; person-to-person (rare)

Incubation
14-40 days

Primary Symptoms of Inhalational Exposure / Pneumonic Q fever
Flulike symptoms including high fever and severe headache; fatigue, weight loss, myalgias, pleuritic chest pain, abdominal pain, vomiting, diarrhea; pulmonary presentation, sometimes of rapid progression, is atypical with dry, non-productive cough, or may present as pneumonia w/o pulmonary symptoms; hepatitis may also develop; there are many clinical syndromes that Q fever can present with, though not likely to occur after an aerosol attack; in rare circumstances it progresses to culture-negative endocarditis and chronic disease.

Diagnostic Tools of Choice
Serology, PCR

Treatment
Doxycycline (first-choice) or tetracycline

Post-Exposure Prophylaxis
Doxycycline or tetracycline

Vaccine
A vaccine is currently under investigation; previous Q fever patients should not receive the vaccine

Infection Control
- Use standard precautions.
- Person-to-person transmission is rare.

Ricin

Biological Agent
Toxin from the castor bean plant (*Ricinus communis*)

Indications of Terrorist Release
Ricin intoxication should be considered in any cluster of patients with acute, unexplained, pulmonary injury or GI bleeding.

Possible Means of Exposure
Inhalation, ingestion, injection

Incubation
2 hours to 3 days

Primary Symptoms of Inhalational Ricin Intoxication
Fever, chest tightness, cough, dyspnea, nausea, arthralgias, progressive respiratory insufficiency, leading to cyanosis, necrotizing pneumonitis, and pulmonary edema; could be fatal within a few days. (Note that limited data exists, primarily animal studies.)

Primary Symptoms of Ingested Ricin
Abdominal pain, nausea, vomiting, profuse bloody diarrhea; severe GI lesions with irritation of the oropharynx, esophagus, or stomach; in severe cases shock may develop. Late-phase complications can include cytotoxic effects on the liver, CNS, kidney, and adrenal glands.

Diagnostic Tool of Choice
ELISA (serum and respiratory secretions)

Treatment
Supportive

Post-Exposure Prophylaxis
Under development

Vaccine
Under development

Infection Control
- Use standard precautions.
- The toxin is non-volatile and secondary aerosols are not expected to be a hazard.

Smallpox

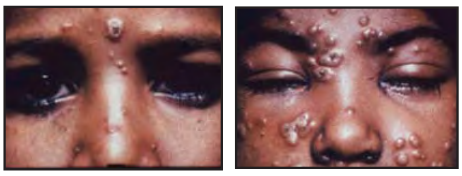
Biological Agent
The Variola major virus

Indications of Terrorist Release
Since smallpox has been eradicated in the world since 1977, even one confirmed case would indicate a probable terrorist attack.

Possible Means of Exposure
Inhalation of airborne droplets; contact with skin sores, secretions, or clothing or bedding

Incubation
7-17 days

1 2



1) Chickenpox patient with pustules (day 5),
2) Smallpox patient with pustules (day 5).

Primary Symptoms
Initial symptoms are flulike, including fever, vomiting, myalgias, physical exhaustion; rash appears ~ day 12 post-exposure, at which point patient becomes highly contagious; then formation of macular rash → papules → vesicles → pustules → scabs, most densely on face and limbs, including palms and soles of feet (i.e., centrifugal distribution, unlike chickenpox, in which lesions are distributed evenly over the body, beginning on the trunk); lesions go through stages at the same time (unlike chickenpox, in which new lesions form and scab over at different times).

Diagnostic Tools of Choice
Culture followed by PCR and RFLP (by BSL-4 laboratory), electron microscopy

Treatment
Vaccination up to 4 days after exposure

Post-Exposure Prophylaxis
Vaccination

Vaccine
Currently available to high-risk groups (1st responders, etc.)

Infection Control
- Use strict standard, contact, droplet, and airborne precautions.
- Patients and contacts should wear N95 mask or better.
- Consider bedding and clothing of patients potentially infectious.
- Quarantine/respiratory isolation/ vaccination program for patients and secondary contacts will be necessary in the event of an outbreak.

Staphylococcal Enterotoxin B

Biological Agent
The toxin Staphylococcal enterotoxin B (SEB), produced from a strain of the bacteria *Staphylococcus aureus*

Indications of Terrorist Release
In a bioterrorism attack, SEB could be released as an aerosol and inhaled; unlike natural food poisoning caused by SEB, pulmonary symptoms would be present and the source would not be traced to a common food source.

Possible Means of Exposure
Inhalation, ingestion

Incubation
Foodborne: 1-6 hrs
Inhalational: 3-12 hours

Primary Symptoms of Foodborne SEB
Begins abruptly with acute salivation, nausea, and vomiting, followed by abdominal cramps and diarrhea, which can be hemorrhagic; usually resolves within 8 hrs.

Primary Symptoms of Inhalational SEB
Flulike symptoms such as high fever, headache, chills, myalgias; nonproductive cough; conjunctivitis may be present; severe exposure may produce dyspnea, chest pain, nausea, vomiting, diarrhea, dehydration, hypotension; could progress to pulmonary edema and ARDS.

Diagnostic Tools of Choice
Obtain urine sample as soon as possible, as well as respiratory secretions and/or nasal swabs; antigen detection on environmental and clinical samples (ELISA, ECL)

Treatment
Supportive

Post-Exposure Prophylaxis
Experimental only

Vaccine
Under development

Infection Control
- Use standard precautions.
- SEB is not dermally active and secondary aerosols are not a hazard.

Tularemia

Biological Agent
The bacteria *Francisella tularensis*

Indications of Terrorist Release
In a bioterrorism attack, *F. tularensis* would likely be released as an aerosol and inhaled; due to its low incidence in the U.S., an outbreak of pneumonic or typhoidal tularemia should bring suspicion of an attack; natural cases in the U.S. are virtually all rural and/or involve animal contact.

Possible Means of Exposure
Inhalation, ingestion, through abraded skin and mucous membranes, insect bites, animal contact

Incubation
Pneumonic (most likely in bioterror attack): 1-21 days (average is 3-5 days)

General Symptoms
Abrupt onset of fever, chills, headache, anorexia, malaise, fatigue; other Sx include cough, myalgias, chest discomfort, vomiting, sore throat, abdominal pain, diarrhea.

Primary Symptoms/Pneumonic Tularemia
General Sx + localized lymphadenopathy, no or minimal sputum production, chest tightness and pain, rales; may have no symptoms of clinical pneumonia; lung abscesses may occur; can progress to severe respiratory symptoms, including respiratory failure.

Primary Symptoms/Typhoidal Tularemia
Defined as a febrile illness caused by *F. tularensis* w/o lymphadenopathy and that does not fit into other categories; immune-deficient or people w/ other medical disorders especially prone; Sx similar to general Sx; possible severe, fulminant pneumonia.

Diagnostic Tools of Choice
Direct fluorescent antibody stain, PCR, antigen detection

Treatment
Antibiotics (streptomycin or gentamycin) as early as possible

Post-Exposure Prophylaxis
Doxycycline or ciprofloxacin

Vaccine
Previously available for laboratory personnel; currently under review by FDA

Infection Control
- Use standard precautions.
- No patient isolation required due to lack of person-to-person transmission.

Viral Hemorrhagic Fevers (VHFs)

Biological Agents
Viruses from 4 major families: filoviruses (Ebola, Marburg fevers), arenaviruses (Lassa, New World fevers), bunyaviruses (Rift Valley fever, hantavirus infection), and flaviviruses (yellow fever)

Indications of Terrorist Release
In a bioterrorism attack, VHFs would likely be released as an aerosol and inhaled; any outbreak outside the area of a virus's natural occurrence should be highly suspect of a bioterror attack, particularly w/ no known risk factors (e.g., travel to Africa or Asia, handling of animal carcasses, contact w/ sick animals or people, or arthropod bites w/in 21 days of onset of symptoms).

Possible Means of Exposure
Inhalation, through mucous membranes; mosquito bite or direct contact with an infected person or animal or their secretions, depending on the VHF

Incubation
2-21 days

Primary Symptoms
Flulike symptoms such as high fever, headache, malaise, myalgias, and nausea; other possible symptoms, depending on syndrome, are extreme weakness, conjunctivitis, hypotension, edema, lymphadenopathy, rash, flushing of the skin, petechiae and bruising, hemorrhaging, renal dysfunction, tremors, jaundice, deafness.

Diagnostic Tools of Choice
ELISA, RT-PCR

Treatment
Ribavirin for some (used under IND protocol); for others, supportive care only

Post-Exposure Prophylaxis
Prophylactic post-exposure ribavirin is not recommended

Vaccine
Available for yellow fever only; Ebola, Rift Valley, and Hantavirus vaccines under investigation

Infection Control
- Use strict standard precautions.
- For some, contact, droplet, and/or airborne precautions also required.
- Patients generally have significant amounts of virus in their blood and other secretions (hantavirus is an exception).

Chemical Agents Overview

Examples of Chemical Agents
Nerve Agents; **Blister Agents** (also known as "vesicants" or "mustard agents"); **Chemical Asphyxiants** (also known as "blood agents"); **Pulmonary Irritants** (also known as "choking agents")

Indications of Terrorist Release
Most chemical agents work relatively fast, hence the presence of one would initially primarily be detected by the symptom pattern victims were experiencing.

PRIMARY CHARACTERISTICS

Nerve Agents
See next panel of this brochure.

Blister Agents
Examples: Lewisite (military code name L), mustards (HD, HN, HT), phosgene oxime (CX); **Common odors:** Odorless, garlic, mustard, onion, geraniums, pepper; **Onset of symptoms:** Immediate (L, CX) to 2-48 hrs (HD); **Symptoms:** Erythema, pruritus, burning of the skin, large blister formation, eye and airway irritation, sore throat, cough, chest pain, profuse rhinorrhea, copious pulmonary secretions, nausea and vomiting can also occur; **Rx:** Iodophors for skin; dimercaprol for L

Chemical Asphyxiants
Examples: Hydrogen cyanide (AC), cyanogen chloride (CK), arsine (SA); **Common odors:** Bitter almonds, garlic; **Onset of symptoms:** Most immediate, SA may be delayed by hrs; **Symptoms:** AC/CK—Irritation to eyes, nose, and airways; dyspnea, agitation, weakness, nausea, vomiting, muscular trembling; SA—Conjunctival redness, garlic breath odor, headache, thirst, shivering, weakness, abdominal pain; **Rx:** Sodium nitrite/sodium thiosulfate for AC and CK; supportive

Pulmonary Irritants
Examples: Phosgene (CG), chlorine (CL), diphosgene (DP), chloropicrin (PS), and ammonia; **Common odors:** Green corn, newly mown hay; **Onset of symptoms:** Usually rapid, effects of CL may be delayed; **Symptoms:** Burning eyes, nose, and throat; conjunctival injection, lacrimation, rhinorrhea, laryngal spasm, chest pain and tightness, dyspnea; after 3 hrs to days, respiratory symptoms may progress to pulmonary edema and respiratory failure; **Rx:** Supportive

Nerve Agents

Examples of Nerve Agents
Sarin (military code name GB), tabun (GA), soman (GD), cyclosarin (GF), VX, VE, VG, VM

Indications of Terrorist Release
Since nerve agents in their pure form are odorless and colorless, an attack would initially primarily be identified by the symptoms victims were experiencing.

Possible Means of Exposure
Inhalation, absorption through mucous membranes; dermal absorption upon contact with the liquid form (particular danger for VX, which is most commonly an oily, amber-colored liquid)

Time from Exposure to Illness
Inhalation: Seconds to minutes
Dermal absorption: 1 minute to 18 hours

Primary Symptoms of Inhalational Exposure
Miosis (13% will have dilated pupils); dimmed or blurred vision; lacrimation; rhinorrhea; sudden excess oral, nasal, and respiratory secretions; headache; dyspnea/wheezing; sweating; sneezing; urinary and fecal incontinence; vomiting; sudden loss of consciousness; muscle fasciculations; seizure; flaccid paralysis.

Primary Symptoms of Dermal Exposure
May include localized sweating, fasciculations, nausea, vomiting, diarrhea, generalized diaphoresis, generalized weakness, miosis; large exposure will resemble inhalational exposure.

Diagnostic Tools of Choice
Clinical syndrome + percent reduction of RBC-cholinesterase

Treatment
Atropine and pralidoxime

Prophylaxis
Under development for sarin

Decontamination
Thorough decontamination of patient is important as risk of secondary contamination is high.

Nerve agent antidote kits (NAAK), also known as Mark-1 kits, contain 1 dosage of the antidotes atropine and pralidoxime.

Nuclear / Radiation Emergencies

Examples of N/R Events
DIRTY BOMBS: Conventional explosive dispersing radiological substances. Most injuries would occur from the blast itself. Acute radiation poisoning extremely unlikely after dirty-bomb detonation since radioactive materials would most certainly be low grade.
AEROSOL RELEASE: Radioactive materials would likely be low-grade.
NUCLEAR REACTOR BREACH: Could result in radioactive fallout, including radioactive iodine.
NUCLEAR BOMB: Massive explosion of atomic, hydrogen, or neutron bomb. Widespread radioactive fallout could occur, including radioactive iodine. Neutron bombs create minimal blast and heat but a high degree of penetrative radiation.

Indications of Terrorist Release
The determination of radiation dispersal will likely be made rapidly after a suspected event. See **Symptoms** below for physical effects.

Possible Means of Exposure
Inhalation, ingestion, dermal absorption

Time from Exposure to Illness
Hours to years

Symptoms of Severe Radiation Exposure
Signs of severe radiation exposure ("radiation poisoning") include burning of skin with redness, blistering, and peeling; inflammation of skin and mucous membranes; dehydration; nausea; vomiting; diarrhea; convulsions; exhaustion. Delayed symptoms include open sores on skin and in mouth or along intestinal tract; bloody diarrhea; hematemesis; bleeding from the nose, mouth, and gums; bruising; and hair loss.

Diagnostic Tools of Choice
Geiger counters/dose-rate meters for external radiation measures; difficult to determine individual absorption but tests are available; WBC count helpful

Treatment
Potassium iodide (KI) w/in 3-4 hrs if radioactive iodine is present (priority to those under 18 yo); otherwise, supportive

Decontamination
External and internal decontamination should take place. For external, gently wash wounds and orifices first; chelating agents can be used for internal. At minimum, remove clothes, wash w/ soap and water, and flush eyes. Use standard precautions when caring for patients.

This is an FBI – DHS – HHS/CDC Coordinated Document

Guidance on Initial Responses to a Suspicious Letter / Container With a Potential Biological Threat

A large number of potentially suspicious letters and packages continue to be reported to federal, state, and local law enforcement and emergency response agencies nationwide. In some instances these letters or packages may include powders, liquids, or other materials. Federal, state, and local response agencies should be mindful of the potential for small-scale exposure, which could result from material contained in threatening or suspicious packages. While this guidance is generally focused on the initial response to potential biological threats, all personnel responding to such incidents must be aware of the potential for exposure to hazardous chemical and/or radiological materials in addition to biological hazards. Additionally, there may be a threat posed from secondary releases or devices. Consistent with established protocols, response agencies should follow standard law enforcement procedures and hazard risk assessments in response to calls, and should pre-identify the relevant local public health points of contact to be notified in the event of a potential bioterrorism event.

The following guidelines are recommendations for local responders, based on existing procedures (including recommendations from the International Association of Fire Chiefs). This document provides guidance on the initial response to a suspicious letter/container, while other follow-on response plans, such as portions of the National Response Plan (NRP), may be utilized if a threat is deemed credible. In general, these potential threats or incidents fall into one of five general scenarios. They are as follows:

1. Letter/container with unknown powder-like substance and threatening communication (with or without illness):

Since there is an articulated threat, it is likely that the substance was intentionally introduced into the package in an effort to validate that threat. An articulated threat itself (with or without the presence of a suspicious substance) is a federal crime and may also constitute a violation under state and local statutes. The local Federal Bureau of Investigation (FBI) Weapons of Mass Destruction (WMD) Coordinator and/or FBI Joint Terrorism Task Force (JTTF), a certified HAZMAT

unit, local law enforcement, and the local public health department should be notified. The role of Incident Commander (IC) will be assumed by the appropriate authority, as designated by state or local law. In many cases, the IC will be the most senior public safety officer (most likely the fire department chief or deputy chief, however, in many circumstances it may be a local sheriff or senior local or state police official). As such, it is the responsibility of the IC to establish the Incident Command System (ICS) and to ensure that notifications of the above-mentioned responders have been made or are in the process of being made. As the referenced agencies arrive, the IC will evolve into a Unified Command, as necessary.

At this stage, and later again as necessary, the FBI will conduct a timely WMD threat assessment with local law enforcement/fire/HAZMAT personnel. Depending on the nature of the threat, this assessment may include relevant interagency partners. This process utilizes coordination from FBI Headquarters elements to conduct an initial assessment of the credibility of the threat and provide technical support to responders who are on-scene. In coordination with recommendations from the threat assessment process and the unified command on-scene, an appropriately trained HAZMAT unit should screen evidence for the presence of chemicals and radiological material and double-bag in clear sealed bags (where possible), consistent with chain-of-custody requirements. Before packaging and when possible, photographs of the letter/container should be taken and relevant information should be documented, in coordination with the FBI WMD Coordinator. Under NO CIRCUMSTANCES should an unprotected responder, such as a law enforcement officer, attempt to package an unknown substance.

If this incident involves an unopened container such as a box, it must be evaluated by a certified bomb technician/explosives ordinance disposal personnel prior to being handled by HAZMAT. Any such letters/packages must also be evaluated by the HAZMAT unit for only a broad class of radiological and chemical threats prior to being released to law enforcement personnel for transport. This is required by the laboratory in an effort to protect the staff members who will ultimately be opening the container and performing definitive biological testing and/or forensic examinations.

The FBI, or the responding law enforcement agency, will ensure that a certified HAZMAT team has performed necessary field safety screening before transporting to an appropriate laboratory. This field safety screening should be clearly documented and limited to screening for pH (for liquids), radioactivity, volatile organic compounds, flammable materials, and oxidizing agents. Definitive analysis will only be performed by the appropriate laboratory.

A chain-of-custody form must be initiated along with an incident report. The FBI will then coordinate delivery of the evidence to the designated Laboratory Response Network (LRN) laboratory for further testing and analysis.

If individuals immediately present with illness in this scenario, the public health departments will have an increased role in the initial response. These issues are further addressed in the 'Critical Response Issues for Scenario #1' included below.

If the FBI Headquarters-led threat credibility assessment process deems the threat to be credible, the FBI will immediately notify the Centers for Disease Control and Prevention (CDC), the Department of Homeland Security Operations Center (HSOC), and other appropriate federal agencies. Appropriate response guidelines to a credible threat will be utilized from the NRP, including the Biological Annex and Terrorism Incident Law Enforcement and Investigation Annex. Depending on the nature and scale of the incident, the Department of Homeland Security (DHS) may choose to help coordinate response activities based on NRP procedures which, at a minimum, may include coordinating a joint public affairs statement.

2. Letter/container with a threat but no visible powder or substances present:

Merely threatening the use of a chemical or biological agent *is* a violation of federal law and merits investigation. As in scenario #1, all of the responders should be notified. Although no powder may be visible to the eye, there could be trace amounts of material present that could represent a health risk and also provide critical forensic evidence required for further investigation and prosecution. Therefore, the guidance in Scenario #1 also applies to responses to a letter/container containing a threat with no visible powder or substance.

3. Letter/container with unknown powder, no articulated threat, and no illness:

As there is no threat and no one is ill, it must be determined if there is a logical explanation for the presence of this substance. For example, HAZMAT teams have responded to a number of letters that contained crushed samples from vitamin and pain-relief companies. If a reasonable and defendable explanation can be given as to the source of the substance, that there is no articulated threat, and that no one is ill, then no further actions are necessary.

If, however, a reasonable source cannot be determined or there is any uncertainty, the steps outlined in scenario #1 must be conducted.

4. Letter/container with no visible powder, no threat, but recipients are ill:

This scenario has the most potential for ambiguity and confusion. Those who come in contact with *Bacillus anthracis* (anthrax), or other biological pathogens/toxins, may not immediately appear symptomatic. Although no powder or substance may be available to be collected for environmental testing, public health officials may decide to utilize clinical samples from potentially exposed individuals. Additionally, in this scenario it may be difficult to determine if a letter/container is actually associated with the illness. As there is no specific threat to investigate, this is primarily a public health and medical issue; but this scenario also represents a potential criminal act that should be jointly investigated by public health and law enforcement. The initial notifications will largely be the same as scenario #1, with public health taking a primary role in the response. While the primary concern is the treatment and well-being of the recipient, public health and law enforcement should maintain close contact, while public health determines the nature of the illness and law enforcement examines any relevant intelligence. Depending on the scale and nature of the incident, if HHS/CDC is notified they will maintain close contact and coordinate with DHS. If a potential criminal nexus is identified, the FBI will conduct an initial threat assessment and initiate appropriate actions and notifications listed under scenario #1.

5. Letter/container arrives with no powder, no threat, the recipient is not ill, but the recipient is concerned about the package:

With strict regard to federal criminal statutes, no investigative actions are necessary in this matter. However, if other threat indicators are present such as excess postage, misspelled names, unusual odors/colors, etc., law enforcement and the United States Postal Inspection Service should be notified to evaluate it for potential hazards. If the assessment determines that the letter/container is “suspicious,” then appropriate steps outlined in scenario #1 would be initiated.

Critical Response Issues for Scenario #1:

1. Request the assistance of the nearest certified hazardous materials response team to conduct risk assessments, field safety screening, sample (evidence) collection, decontamination, and other mitigation activities. Any sample (evidence) collection must be coordinated with law enforcement (FBI).

2. Notify appropriate law enforcement (local, state and local FBI WMD coordinator/JTTF, postal inspectors) when a potential threat is identified.

3. Do not touch, move, or open any suspicious package until an initial hazard risk assessment of the package can be performed in coordination with HAZMAT personnel and law enforcement.

4. An initial threat credibility assessment will be coordinated via the local FBI WMD Coordinator and the FBI Counterterrorism Division's Weapons of Mass Destruction Operations Unit (WMDOU). This will include the FBI Laboratory Division, Hazardous Materials Response Unit (HMRU) and other select interagency subject matter experts, tailored for the specific threat. This assessment includes an analysis of technical feasibility, operational practicability, behavioral resolve, and examination of any intelligence that might relate to the threat. If the threat is determined to be credible, other appropriate federal agencies will be notified, to include DHS and HHS/CDC. Additional information on this process is available from the NRP, including the Biological Annex and Terrorism Incident Law Enforcement and Investigation Annex.

5. Contact your local public health department (who should in turn notify state authorities and the CDC) if there is a threat of public health exposure or environmental contamination exists. HHS/CDC will then notify the HSOC, where appropriate.

6. In coordination with law enforcement, always notify the U.S. Postal Inspection Service, whenever it appears that the threat was delivered through the U.S. Postal Service. Assist with ensuring that origin and tracking information is obtained from the package (ideally, photographs of the front and back).

7. Treat the scene as a crime scene. Preserve evidence in coordination with law enforcement and ensure that materials are safely packaged. Take steps to retain enough suspicious material for:

a. Laboratory analysis;
b. Forensic examination of criminal evidence, regardless of whether the threat is ultimately determined to be accompanied by a hazardous material.

8. Transfer custody of evidence to a law enforcement officer as soon as possible. Maintain chain of custody by obtaining a record of names and signatures every time custody of a suspicious material or sample for laboratory analysis changes hands.

9. Perform basic field safety screening of the substance to rule out explosives, radiation, flammability, corrosives, and volatile organic compounds prior to transporting the materials to the appropriate LRN, as coordinated with the FBI WMD Coordinator. All field safety screening that is performed by responders should be clearly documented and shared with law enforcement and the LRN.

10. In coordination with the local FBI WMD Coordinator (and/or a responding law enforcement entity), transport samples to the designated CDC-qualified LRN facility. If field safety screening detects the presence of chemical or radiological hazards, the FBI WMD Coordinator will contact FBI Headquarters for guidance

regarding which laboratory is appropriate to perform the analysis. This will be done as part of the threat credibility assessment process noted above (see #4).

11. In coordination with public health and law enforcement, identify and list the names and contact information for anyone who may have been exposed to the suspicious substance so that they may be contacted when the LRN test results are available or if there is other additional information. If positive results are obtained, state and local public health departments will need to contact those potentially exposed as soon as possible to provide appropriate assistance (e.g., antibiotics, education, additional testing, vaccination, surveillance/symptom reporting).

12. In coordination with the FBI, identify a single point-of-contact for incident follow-up.

13. If LRN tests identify positive results for threat agents or a threat is determined to be credible, the FBI will immediately notify the DHS and other appropriate federal agencies to initiate relevant NRP actions, as necessary. The DHS will work closely with the FBI, HHS/CDC and other agencies to ensure a coordinated response.

Note on field screening

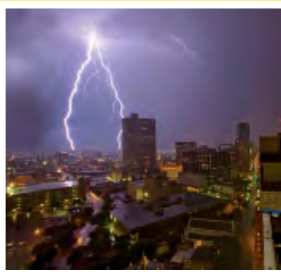
Once activities are complete to address immediate public safety concerns, every effort must be made to preserve evidence necessary for public health and law enforcement investigations.

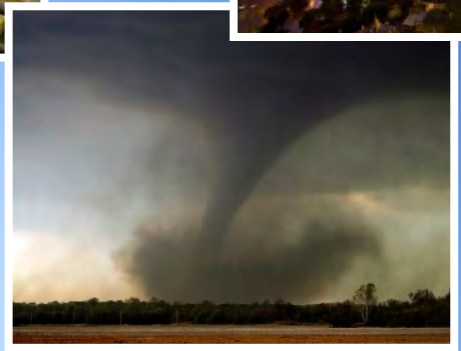
In situations where biological threat agents are suspected, the item(s) should be field safety screened and immediately transported in law enforcement custody to an LRN laboratory. This should be done in coordination with the local FBI WMD Coordinator.

Field safety screening should be limited to ruling out explosive devices, radiological materials, corrosive materials and volatile organic compounds. Currently, there are no definitive field tests for identifying biological agents. Additional field testing can mislead response efforts by providing incorrect or incomplete results, and destroy limited materials critical for definitive laboratory testing required to facilitate any appropriate public health and law enforcement response.

This information is provided for guidance. Questions related to the content of this document can be addressed to your local FBI WMD Coordinator.

Templates and Resources





Model Medical Clinic Emergency Operations Template

This document is adopted from content produced in the "Medical Clinic Emergency Operations Template," developed by the Lane County Medical Society and Oregon Hospital Preparedness Project Region 3 and the "Community Clinic and Health Center Emergency Operations Template," developed by The Wilson Group for the California Emergency Medical Services Authority under Contract EMS-02-351."

Medical Clinic Emergency Operations Template

Emergency Operations Plan Template—Table of Contents

Preface

How to Use This Template

The purpose of this template is to assist outpatient clinics in developing and maintaining an emergency management program to guide their response to all emergencies, regardless of cause. Please review, use and modify these for your circumstances.

This template emphasizes coordination with government emergency management agencies. Clinics will need to coordinate their emergency preparedness, response and recovery activities with their local government's medical and health response as well as coordinate requests of medical resources from outside the local area.

This template takes an "all-hazards" approach ensuring applicability to plans for both natural and manmade disasters. It is organized around the four phases of emergency management – mitigation, preparedness, response, and recovery – and provides a systematic approach to development and implementation of the clinic's emergency management program.

This template requires an active implementation effort. We recommend that the leadership of clinics initiate the development of their emergency management program. They should:

1. Read this template,
2. Appoint an emergency preparedness committee (EPC) to manage the development and maintenance of an emergency management program,
3. Set priorities and create a work plan for developing plans and preparing staff and organization for emergency response (All provisions of the template do not have to be implemented simultaneously),
4. Recognize the importance of training, drills, and keeping plan information up-to-date.

The template is written in **black**, **red** and **green** font. The green font alerts you to information specific to your clinic that should be filled in. Red font alerts you to descriptive information, instructions, or advice. Once you have tailored the template to your clinic's need, you should not have any **red** or **green** font remaining in your document.

Introduction

Purpose

The purpose of the <Name of Clinic> Emergency Operations Plan (EOP) is to establish a basic emergency program that provides a timely, integrated, and coordinated response to the wide range of natural and manmade events that may disrupt normal operations and require pre-planned response to internal and external disasters. The Emergency Operations Plan is an "all-hazards" plan that will guide <Name of Clinic's> response to any type of disaster or emergency.

The objectives of the emergency management program include:

- Protect patients, visitors, and staff safety
- Provide prompt and efficient medical care
- Establish a clear chain of command
- Maintain and restore essential services as quickly as possible
- Protect clinic property, facilities, and equipment

Local vs. Widespread Emergencies

- Local emergencies are disasters with effects limited to a relatively small area. In local emergencies, other health facilities and resources will be relatively unaffected and remain viable options for sending assistance or receiving patients from the disaster area.
- An external disaster is an event that occurs in the community. Examples include earthquakes, floods, fires, hazardous materials releases or terrorist events. An external disaster may directly impact the clinic facility and its ability to operate.
- In widespread emergencies, nearby medical resources are likely to be impacted and therefore less likely to be able to offer assistance to the clinic. Hospitals may also have a higher response priority than clinics for re-supply and other response assistance.

Policy

- <Name of Clinic> will be prepared to respond to a natural or man-made emergency in a manner that protects its patients, visitors, and staff, and that is coordinated with a community-wide response to a large-scale disaster.
- All employees will be prepared to join a team that will provide the best possible emergency care in any situation. Each supervisor, at each level of the organization, will ensure that employees are aware of their responsibilities.
- The <Name of Clinic> will work in close coordination with local emergency officials, agencies and health care providers to ensure a community-wide coordinated response to disasters.

Who's In Charge?

In the case of a medical emergency, such as infectious disease pandemic, there may be a stand-alone Medical Command Center directed by the local director of Health and Human Services in consultation with the local government Public Health Officer. In cases of widespread emergency, such as earthquake, or hazardous materials incident, the local Emergency Operations Center (EOC), will be directed by an Incident Commander from the local lead emergency management agency department and Medical Emergency Operations will be a section of that Command.

<Name of Clinic> Incident Command Structure

In order to coordinate with the local Emergency Response system, <Name of Clinic> has adopted the Incident Command Structure (ICS) as the management structure to be used in an emergency.

Under **ICS,** the clinic's overall response is directed by an Incident Manager. The Liaison Officer is responsible for coordination with other agencies and with County Incident Command.

[Incident Command System (ICS) is a standardized management system used by government agencies and hospitals in emergencies. We recommend, if clinic size indicates, the clinic adopt an Emergency Management Operational Structure to clearly define roles and responsibilities and quickly mobilize response resources.

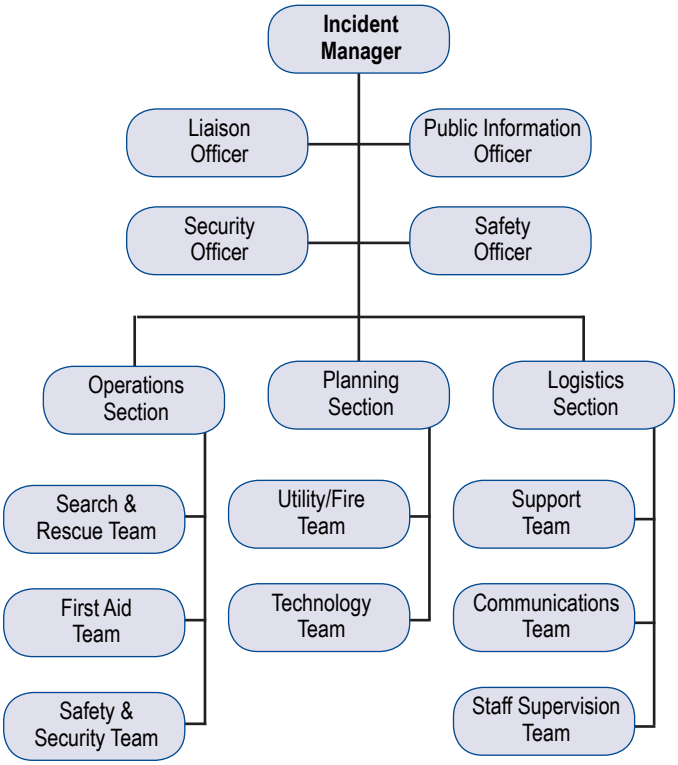
Under ICS, the clinic's overall response is directed by an Incident Manager. A capable senior manager should serve in that role. (Physicians should be reserved as advisors and care delivery clinicians.)

Also important for your clinic's coordination is a Liaison Officer, who is responsible for communication and coordination with other agencies and with the County Incident Command.

See Appendix C for an expanded organization chart and example of staff assignment to Emergency Response Team positions.]

<Name of Clinic> Emergency Management Team

Organization Structure



The following roles will be filled by the listed persons:

Incident Commander:
<_NAME HERE_____>

Incident Commander (backup) :
<_NAME HERE_____>

Liaison:
<_NAME HERE_____>

Liaison (backup) :
<_NAME HERE_____>

Mitigation

Introduction

This section of the <Name of Clinic> plan will address the perceived areas of vulnerability within the organization, identify important hazards and take steps to lessen those hazards or reduce their potential impact on the clinic.

Mitigation activities may occur both before and following a disaster.

Hazard Vulnerability Analysis

As part of its risk management program, <Name of Clinic> will also conduct a quarterly Management of Environment safety survey of its facilities.

[Appendix A provides a tool for conducting that survey, ranking problems and setting priorities for necessary changes-"remediation."]

Local Hazard Assessment

<Name of Clinic> will conduct a local assessment to determine which specific events are most likely to occur and how to prioritize preparedness events.

[Refer to Appendix B for an analysis of specific hazards that may occur.]

Risk Assessment

Insurance Coverage

<Name of Clinic> will review insurance coverage for relocation; loss of data, supplies and equipment; structural and nonstructural damage to the facility; and coverage for floods or earthquakes.

Clinic Emergency Response Roles

<Name of Clinic> may play a variety of roles in responding to disasters, including providing emergency medical care and expanding primary care services to meet increased community needs. <Name of Clinic> may also be asked to distribute important public information.

Clinic roles may be constrained by limited resources, technical capability and the impact of the disaster on the clinic facility.

Preparedness

Introduction

<Name of Clinic> has established an Emergency Preparedness Committee (EPC) with the authority to energize necessary preparedness action, to develop/update emergency plans and procedures, assure training, and conduct drills (see below for more about this committee.)

Integration with Community-wide Response

<Name of Clinic> will coordinate its response to community-wide disasters with the overall medical and health response directed by the <local emergency management coordinating agency.>

[See Appendix F for list of agencies and individuals who should be contacted in emergencies.]

Response Authority - Clinic personnel will cooperate fully with Emergency Medical Services and law enforcement personnel when they respond to emergencies at the clinic. This may include providing information about the location of hazardous materials and/or following instructions to evacuate and close the clinic.

Command Post - The <Name of Clinic> will identify a location for an emergency responder command and coordinating center.

Acquiring Resources

<Name of Clinic> will develop **procedures for augmenting supplies, equipment and personnel** from a variety of sources. Assistance may be coordinated through the following channels:

- Prior agreements with vendors for emergency re-supply
- Stockpiles of medical supplies and pharmaceuticals anticipated to be required in an emergency response
- From other clinics, hospitals or health care providers
- The local Medical Emergency Operations Center

Roles / Responsibilities

The <Name of Clinic> Emergency Preparedness Committee will coordinate the development and maintenance of the Emergency Operations Plan, and provide for ongoing training for clinic staff.

[The EPC should include such staff as the safety manager, facility manager and senior representatives from administration and health care staff. Part of the EPC's role may be assigned to existing committees of the clinic, such as the Infection Control or Safety Committee. See: Appendix C]

The Emergency Preparedness Committee will appoint teams and perform the following tasks:

- Develop procedures for 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. If required and safe, this team will perform additional search and rescue tasks that do not entail using equipment or disturbing collapsed structures.
- Assign staff emergency management duties and responsibilities.
- Activate the clinic's emergency response.
- Direct the overall response to the disaster/emergency
- Develop the criteria for and direct the evacuation of staff, patients and visitors when indicated.
- Ensure the clinic takes necessary steps to avoid interruption of essential functions and services or to restore them as rapidly as possible.
- Ensure a hazard vulnerability assessment is performed periodically.

All clinic staff have emergency and disaster response responsibilities. In addition, 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 Clinic> plans for response to and recovery from disasters
- All staff will also be encouraged to prepare family and home for consequences of disasters [See Appendix H for home preparedness information.]

Initial Communications and Notifications

<Name of Clinic> Staff Contact List

The clinic will compile and maintain an internal contact list that will include the following information for all staff: name, position title, home phone, cell phone, pager numbers, and preferred method of contact during off hours. [See Appendix E.]

(The Staff Call List will contain sensitive contact information and should be treated confidentially.)

The list of staff phone numbers should be kept, by key employees and at key locations, both offsite as well as onsite. It may also be provided to the Clinic's answering service.

<Name of Clinic> will also develop an email and/or a paging group for employees to facilitate rapid staff contact. The clinic may distribute emergency contact information for key staff to keep information readily accessible. [See Appendix E.]

External Notification

<Name of Clinic> will compile and maintain an external contact list of phone/fax numbers and/or e-contact information of emergency response agencies, key vendors, stakeholders,
and resources.

[Appendix D lists routine and emergency contact numbers for basic practice support services for clinic operations (e.g., utilities, repair services, etc.)

Appendix F lists contact information for use in response to disasters (e.g., government response entities, hospitals and clinics, etc.)]

Primary Communications Methods

The clinic has compiled a list of communication equipment available for use in an emergency.

[Refer to Appendix G for a list of communication equipment available]

Other alternate communications tools include:

- FAX, Pagers, Cell Phone, Internet/Email, Public Pay Phones, and Voice Messaging.
  [Learn to use your cell phones' text messaging capacity; include instructions in your communications procedures. Also keep compatible cell-phone chargers and fully-charged back up batteries at the clinic.]
- A working television and battery-operated radio in the clinic.
- Emergency operations area in order to remain up-to-date on official government announcements and other information during a disaster.
- Internet access.

Clinic Evacuation Plan

<Name of Clinic> will:

1. Develop an evacuation plan for all staff and clientele in the event of an emergency.
2. Develop plans to obtain needed medical supplies, equipment and personnel.
3. Plan for protection of medical records.

   To the extent possible, the clinic will protect medical records from fire, damage, theft and public exposure. If the clinic is evacuated, security will be provided to ensure privacy and safety of medical records, and protection of vital records, data and sensitive information.
4. Ensure off-site back-up of financial and other data.
   - *The clinic will store copies of critical legal and financial documents in an off-site location.*
   - *Measures will be taken to protect financial records, passwords, credit cards, provider numbers and other sensitive financial information.* [Write them down, make copies of the information, and store it offsite.]
   - *Plans will be developed for addressing interruption of computer processing capability.*
   - *A contact list of vendors, who can supply replacement equipment, will be maintained.*

continued

5. Protect information technology assets from theft, virus attacks and unauthorized intrusion. Protect medical and business equipment. Necessary steps shall include:
   - *Compiling a complete list of equipment serial numbers, dates of purchase and costs, and storing a copy of this information offsite.*
   - *Protecting computer equipment against theft through use of security devices.*
   - *Using surge protectors to protect equipment against electrical spikes.*
   - *Securing equipment to floors and walls to prevent movement during earthquakes.*
   - *Placing fire extinguishers near critical equipment, training staff in their use, and inspecting extinguishers according to manufacturer's recommendations.*
6. Maintain contact list of utility emergency numbers. [See Appendix D]
7. Ensure availability of phones and phone lines that do not rely on functioning electricity service.
8. Request priority status for maintenance and restoration of telephone service from its local telephone service provider. Let your provider know that your clinic will be providing medical care in the event of an emergency and needs priority status.

Clinic Patient Surge Preparedness

Surge capacity requires clinic resources to deliver medical care under situations which exceed normal capacity.

Surge functions may require areas in which patients may be triaged, managed, vaccinated, decontaminated, or simply located; available personnel of all types; necessary medications, supplies and equipment.

Normal clinic capacity could be exceeded during any type of emergency for reasons that include the following:

- Random spikes in numbers of presenting patients.
- Seasonal or other cyclical spikes (e.g., school required immunizations, flu epidemics, etc.).
- Convergence of ill, injured, or worried well resulting from disasters.

Events that create patient surge may also reduce clinic resources through exhaustion of supplies, pharmaceuticals and reduced staff availability. Staff may be directly impacted by the emergency, unable to reach the clinic or required to meet commitments at other health facilities.

Basic Office Medical Surge Strategies

<Name of Clinic> will consider the following medical office surge strategies and, if feasible, develop specific implementing response plans.

Modification of routine operations:

- Delay and/or deferral of routine office visits (e.g., cancel annual physicals).
- Extension of office hours (e.g., opening earlier, remaining open later).
- Modification of office hours to segregate and concentrate influenza-related (or other highly infectious respiratory illness) patients to defined time slots in order to minimize secondary disease spread.
- Implement more flexible human resources strategies to accommodate staff needs.
- Implement mutual aid agreements/understandings with other medical offices, including cross-staffing arrangements, designating one clinic as the "flu" clinic, sharing non-primary care physicians and staff to assist, etc.
- Identify methods to frequently update the command center regarding the status of the clinic and the ability to receive new patients.
- Plan for managing a staffing shortage within the organization due to illness in personnel or their family members.

Patient Flow and Site Planning

<Name of Clinic> clinical staff will:

- Periodically review patient flow and identify areas on clinic grounds that can be converted to triage sites, patient isolation areas, decontamination or treatment areas.
  - — Sites should be selected based on patterns of access, airflow and ventilation, availability of adequate plumbing and waste disposal, and patient holding capacity.
  - — Triage and isolation areas will be accessible to emergency vehicles and to patients.
  - — Triage, decontamination and isolation sites should have controlled access.
- Plan for the following surge strategies for an infectious disease emergency (Pandemic Illness) triage:
  - — Identify persons who might have communicable illness.
  - — Separate them from others to reduce the risk of disease transmission, and
  - — Identify the type of care they require (i.e., home care or hospitalization).
- Develop a strategy for triage, diagnosis, and isolation of possible infectious patients. The following triage mechanisms may be considered:
  - — Using phone triage to identify patients who need emergency care versus those who can be seen in your medical office or other non-urgent facility.
  - — Assigning separate waiting areas and a separate triage evaluation area for persons with infectious symptoms.
  - — Assigning a "triage coordinator" to manage patient flow, including deferring or referring patients who do not require emergency care.
  - — Reviewing procedures for the clinical evaluation of patients to facilitate efficient and appropriate disposition of patients.
  - — Reviewing admission procedures and streamlining them as needed to limit the number of patient encounters in the office (e.g., direct admission to an examination room for infectious patients).

Disaster Medical Resources

Personnel

<Name of Clinic> will rely primarily on its existing staff for response to emergencies and will, therefore, take the following measures to estimate staff availability for emergency response:

- Identify clinical staff with conflicting practice commitments.
- Identify staff with distance and other barriers that limit their ability to report to the clinic.
- Identify staff that are likely to be able to respond rapidly to the clinic.

<Name of Clinic> will take steps to facilitate response by its staff when their homes and families may be impacted by an emergency. These steps will include:

- Incorporating disaster preparedness information into the clinic's normal communications and education programs for staff and patients, including home and family preparedness. [See Appendix H for guidelines.]
- Identifying childcare resources that are likely to remain available following a disaster, including possible on-site child care.

Pharmaceuticals / Medical Supplies / Medical Equipment

<Name of Clinic> will determine the level of medical supplies and pharmaceuticals 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 should be rotated to the extent possible.

The <Name of Clinic> 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.

Strategic National Stockpile (SNS)

In an infectious disease emergency event, if mass quantities of pharmaceuticals are needed then local government will request mobilization and delivery of the Strategic National Stockpile (SNS). The CDC has established the Strategic National Stockpile program as a repository of antibiotics, chemical antidotes, life support medications, IV administration sets, airway maintenance supplies including ventilators, and other medical/surgical supplies. The SNS is designed to supplement and re-supply state and local public health and medical response teams in the event of a biological and/or chemical terrorism incident anywhere in the U.S.

Personal Protective Equipment (PPE)

<Name of Clinic> 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 personal protective equipment. <Name of Clinic> will obtain and maintain a minimum of <insert number> complete sets of PPE.

The recommended PPE for clinic personnel is at a minimum, well-fitted N95 HEPA masks, covering gowns, gloves and booties. (TYVEK Coverall with hood and booties with TYVEK booties, face shield, and Nitrile Gloves.)

The Emergency Planning Committee will designate clinical staff that are to receive PPE when a patient with a suspected infectious agent is present.

Protective equipment is located in <location in clinic>, and will be accessed by <position of person> or <position of person> when a patient with a suspected infectious disease presents.

Training

All employees should attend periodic training and updates on emergency preparedness, including elements of this plan. Employee essential knowledge and skills include:

- The location and operation of fire extinguishers.
- The location of fire alarm stations and how to shut off fire alarms.
- How to notify clinic staff regarding an emergency.
- How to dial 911(access the Emergency Response System) in the event of any emergency.
- How to assist patients and staff in the evacuation of the premises.
- Location and use of oxygen (licensed staff).
- Location and use of medical emergency equipment (medical staff and staff trained on AED).
- How emergency codes are called in the clinic and appropriate initial actions.
- Actions to be taken during fire and other emergency drills.
- Employment expectations regarding attending work during an emergency.

Clinician Infectious Disease Emergency Training

All physician and nursing staff will receive documented training on procedures to treat and respond to patients infected with an infectious disease. (Such training is easily appended to require OSHA training in Blood Borne Pathogens and infectious disease. Possible training available thru CDC website: http://www.cdc.gov/ncidod/dhqp/bp.html.) Training should include:

1. Information about most-likely agents
2. Possible behavioral responses of patients
3. Infection control practices, including:
    a. *Use of and location of Personal Protective Equipment*
    b. *Reporting requirements*
    c. *Patient management*
    d. *Behavioral responses of patients to biological and chemical agents and to medical emergencies*
    e. *Roles and responsibilities in an infectious disease emergency*

Drills and Exercises

<Name of Clinic> will rehearse this disaster plan periodically. All drills shall include an after-action debriefing and report evaluating the drill or exercise. Effective Exercises may include one or more of the following response issues in their scenarios:

- Clinic evacuation.
- Infectious Disease Emergencies.
- Mental Health response.
- Coordination with government emergency responders
- Continuity of operations.
- Expanding clinic surge capacity.

Evaluation

The effectiveness of the administration of this plan can be evaluated following plan activation during actual emergencies or exercises. Staff knowledge and responsibilities may be critiqued by the Emergency Preparedness Committee (EPC) and reported to the clinic Executive Director.

Based on the after-action evaluation, the clinic EPC could develop recommendations for:

- Additional training and exercises.
- Changes in disaster policies and procedures.
- Plan updates and revisions.
- Acquisition of additional resources.
- Enhanced coordination with response agencies.

Plan Development and Maintenance

The (EPC) will review and update this plan at least annually and following any emergency or drills, or following changes such as remodeling, construction, installation of new equipment, and changes in key personnel.

When these events occur, the EPC could review and update the Plan to ensure:

- Evacuation routes are reviewed and updated.
- Emergency response duties are assigned to new personnel, if needed.
- The locations of key supplies, hazardous materials, etc. are updated.
- Vendors, repair services and other key information for newly installed equipment are incorporated into the plan.

Response

Response Priorities

<Name of Clinic> has established the following disaster response priorities:

- Ensure life safety – protect life and provide care for injured patients, staff, and visitors.
- Contain hazards to facilitate the protection of life.
- Protect critical infrastructure, facilities, vital records and other data.
- Resume the delivery of patient care.
- Support the overall community response.
- Restore essential services/utilities.
- Provide crisis public information.

Medical Care

It is the policy of <Name of Clinic> that the following will be maintained as far as possible given the nature of the emergency:

- Confidentiality of patient information.
- Transportation restraints due to legal liabilities.
- Documentation of patient discharges AMA.
- Custody of children.

Medical Management

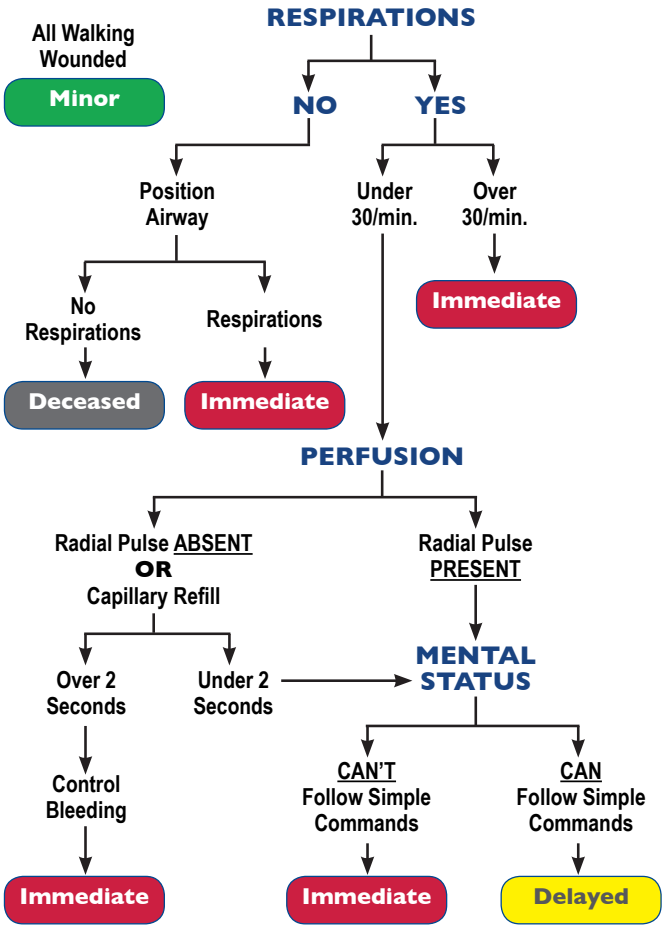
- To the extent possible, patients injured during an internal disaster will be given first aid and treatment by the clinic staff unless their injuries require more acute immediate attention.
- Visitors or other non-established patients who require medical evaluation or minor treatment will be treated and referred to their own physician.
- As directed by the Incident Commander (Person in Charge), clinic staff will take the following actions:
  a. *Triage/First Aid:* The Incident Commander will establish a site for triage and first aid under the direction of a medical provider. Triage decisions will be based on the patient condition, clinic status, availability of staff and supplies and the availability of community resources.
  b. *Assessing and administering medical attention:* A clinician will assess victims for the need for medical treatment. The medical care team will provide medical services within the clinic's capabilities and resources.

Increase Surge Capacity

- The Incident Commander of the clinic will activate the clinic's procedures for increasing surge capacity when (1) civil authorities declare an emergency that affects the community or (2) clinic utilization or anticipated utilization substantially exceeds clinic day-to-day capacity with or without the occurrence of a formally declared disaster.

<Name of Clinic> will take the following actions to increase clinic surge capacity:

- Via the identified clinic Liaison, establish a communication link with local government Medical Emergency Operations Center. Be prepared to report clinic status, numbers of ill/injured, types of presenting conditions and resource needs and other information requested.
- Reduce patient demand by modifying scheduling to cancel or postpone routine appointments.
- Triage procedures
  1. *The <Name of Clinic> will establish a triage area in the <location of triage area> of the clinic. The area will be clearly delineated, secured and have controlled access and exit.*
  2. *The START flowchart is a quick way to learn the system, in this case for multiple traumatic injuries. As you move through the patient assessment, sequentially evaluate the current status for RESPIRATIONS, PERFUSION, and MENTAL STATUS (RPM). You either assign the victim a classification or you move to the next level of the flowchart.*



3. *All patients entering the triage area should be registered. If a large number of patients is expected, use of a triage tag is encouraged.*
4. *Triage converging patients to immediate and delayed treatment categories.*
5. *Consider use of PPE, and isolation of patients if indicated. Implement decontamination procedures as appropriate.*
6. *Arrange for transport of patients requiring higher levels of care as rapidly as possible through 9-1-1.*
7. *Direct uninjured yet anxious patients to an area designated for counseling and information.*
8. *Recognize that some chemical and biological agents create symptoms that manifest themselves behaviorally.*
9. *Provide written instructions as possible for patients seen and dis-charged. In the case of an infectious disease emergency, such patient information will be available from the local Medical EOC.*

Acquiring Response Resources

Emergency Operations Center (EOC) Request Process

- In response to a disaster, additional personnel, supplies, or equipment may be required. Existing resources for supplies should be used as possible (neighboring pharmacies, usual suppliers.)
- If additional resources are unavailable, there may be assistance from the local EOC. Requests should be made by an identified and designated staff person (Liaison) to the local EOC.
- Vendors - As information develops about current and future resource needs, clinics should contact vendors of critical supplies and equipment to alert them of pending needs and to ascertain vendor capacity to meet those needs.

Communications

The Clinic should identify a single person (Liaison) responsible for Communications with:

- The local emergency management agency, if operational.
- Emergency response agencies.
- Outside agencies and other clinics.

Communication Procedures

Outgoing and incoming messages should be documented, either on specific forms or in an easily retrievable format

Security

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

The Incident Manager may appoint a Security staff person who will be responsible for ensuring the following security measures are implemented:

- 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.
- Supervisors will ensure that all clinic staff wear their ID badges at all times. Security will issue temporary badges if needed.
- Security staff may use yellow tape to assist in crowd control, if needed.
- The Security staff will ensure that the clinic site is, and remains, secured following an evacuation.

Response to Internal Emergencies

An Internal Emergency is an event that causes or threatens to cause physical damage and injury to the clinic, personnel or patients. Examples are fire, explosion, hazardous materials releases, violence or bomb threat.

External events may also create internal disasters.

The following procedures provide guidance for initial actions for internal emergencies (refer to <Name of Clinic> Fire Emergency Plan for complete information):

1. If the event is a fire within the clinic, institute **RACE**:

   R = *Remove patients and others from fire or smoke areas.*

   A = *Announce <CODE RED (clinic's fire code)> (3 times) and Call 9-1-1*

   C = *Contain the smoke/fire by closing all doors to rooms and corridors.*

   E = *Extinguish the fire if it is safe to do so.*

   Evacuate the facility if the fire cannot be extinguished

2. If the internal emergency is not a fire, the person in charge will determine if assistance from outside agencies is necessary. Such notification will be done by calling 911.
3. Notify on-duty employees of an emergency event, telling them of the situation or calling for help, as appropriate. During the early stages of an emergency, information about the event may be limited. If the emergency is internal to the clinic, it is important to communicate with staff as soon as possible.

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 <Name of Clinic> Facility Evacuation Plan for complete information.

<Name of Clinic> will ensure the following instructions are communicated to staff:

1. All available staff members and other able-bodied persons should do everything possible to assist personnel at the location of the fire or emergency in the removal of patients.
2. Close all doors and windows.
3. Turn off all unnecessary electrical equipment, but leave the lights on.

4. Evacuate the area/building and congregate at the predetermined site. Evacuation routes are posted throughout the clinic.
5. Patients, staff, and visitors should not be readmitted to the clinic until cleared to do so by fire, police, other emergency responders, or upon permission of the Incident Manager.

Procedures for Evacuation of Patients

1. Patients will be evacuated according to the following priority order:
   a. Persons in imminent danger.
   b. Wheelchair patients.
   c. Walking patients.
2. Staff should escort ambulatory patients to the nearest exit and direct them to the congregation point. Wheelchairs will be utilized to relocate wheelchair-bound patients to a safe place.
3. During an evacuation, a responsible person will be placed with evacuees to reassure them and to prevent patients from re-entering the dangerous area.
4. If safety permits, all rooms will be thoroughly searched by the Search and Rescue Team upon completion of evacuation to ensure that all patients, visitors, and employees have been evacuated.
5. Lists of evacuated patients will be prepared by the Nursing Director or designee and compared to the patient sign-in log. This list, including the names and disposition of patients, will be sent to the Medical Director, Incident Manager and Executive Director.
6. The Nursing Director or designee will report the numbers of patients and staff evacuated, as well as any injuries or fatalities, to the clinic director, Incident Commander, Safety Officer or designee.
7. When patients are removed from the clinic, staff should remain with them or designate another person to remain with them until they are able to safely leave or are transported to an appropriate facility for their continued care and safety.

Evacuation Information

In the case of a partial or full facility evacuation, the following information should be used to facilitate the evacuation:

- Floor plan and map of exits with the building; location of emergency equipment including fire extinguishers and phones; fire route out of the building; and first aid supplies
- Where and how to shut-off the utilities, including emergency equipment, gas, electrical timers, water, computers, heating, AC, compressor, and telephones.

Decision on Clinic Operational Status

The decision on the operational status of a clinic 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 depends on:

- *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*
- *Environmental hazards near the clinic*

Extended Clinic Closure

If the <Name of Clinic> experiences major damage, loss of staffing, a dangerous response environment or other problems that severely limit its ability to meet patient needs, clinic operations may be suspended until conditions change. If that decision is made, the clinic staff will:

- If possible, ensure clinic site is secure
- Notify staff of clinic status and require that they remain available to return to work unless permission is provided to take time off
- Notify the <local emergency management coordinating agency> of its change in status
- Implement business recovery operations
- Allow clinic to remain fully or partially operational
- Review plans and procedures
- Update contact information
- Check inventory of supplies and pharmaceuticals, augment as needed
- Reduce clinic operations to essential services
- Cancel non-essential appointments
- Ensure safety of patients and staff
- Communicate status to <local emergency management coordinating agency> as requested

Response to External Emergencies

Weapons of Mass Destruction (WMD)

Preparations for an event involving weapons of mass destruction - chemical, biological, nuclear, radiological, 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 victims to prevent further contamination within the facility
- Contact appropriate clinician
- Secure personal protective equipment and wait for instructions
- Comfort the victims
- Contact 911 or appropriate Operational Area authorities [Appendix F]

Determining <Name of Clinic> Response Role

If <Name of Clinic> remains fully or partially operational following a disaster, the Incident Commander (person in Charge) and other members of the Emergency Management Team will define the response role the clinic will play, depending on:

- The physical impact of the disaster on <Name of Clinic>
- Staff and other resources available for response
- The clinic may be requested by the <local emergency management coordinating agency> to assume specific treatment, triage and transportation roles depending on the nature of the disaster.

Extended Clinic Closure

If the <Name of Clinic> experiences major damage, loss of staffing, a dangerous response environment or other problems that severely limit its ability to meet patient needs, clinic operations may be suspended until conditions change (see Extended Clinic Closure above).

Infection Control Practices for Patient Management

<Name of Clinic> will use Standard Precautions to manage all patients, including symptomatic patients with suspected or confirmed bioterrorism-related illnesses or other infectious disease.

In general, the transport and movement of patients with any epidemiologically important infections should be limited to movement that is essential to provide patient care, thus reducing the opportunities for transmission of microorganisms within healthcare facilities.

<Name of Clinic> has in place adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces, and other frequently touched surfaces and equipment, and ensures that these procedures are being followed.

- Facility-approved germicidal cleaning agents are available in patient care areas to use for cleaning spills of contaminated material and disinfecting non-critical equipment.
- Used patient-care equipment soiled or potentially contaminated with blood, body fluids, secretions, or excretions is handled in a manner that prevents exposures to skin and mucous membranes, avoids contamination of clothing, and minimizes the likelihood of the transfer of microbes to other patients and environments.

<Name of Clinic> has policies in place to ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed, and to ensure that single-use patient items are appropriately discarded.

- Sterilization is required for all instruments or equipment that normally enter sterile tissues or through which blood flows.
- Contaminated waste is sorted and discarded in accordance with federal, state and local regulations.
- Policies for the prevention of occupational injury and exposure to blood borne pathogens in accordance with Standard Precautions and Universal Precautions are in place.

If exposed skin comes in contact with an unknown substance/powder, recommend washing with soap and water only. If contamination is beyond the clinic's capability, call 911. Local government, fire departments and hospitals are able to decontaminate patients and facilities exposed to chemical agents.

Mass Prophylaxis

If the disruption to clinic operations would not negatively affect the health of the community the clinic serves, <Name of Clinic> encourages its clinicians to participate in a mass prophylaxis program. Health care providers from clinics throughout the county could be called to distribute medication or provide vaccines in response to a large-scale attack. Under this scenario, <local emergency management coordinating agency> may establish mass prophylaxis sites that can accommodate large groups of people. These sites would require a large number of healthcare providers to administer medications.

Recovery

Introduction

Actions to assess, manage and coordinate the recovery may take place concurrently with response activities and are directed at restoring essential services and resuming normal operations.

Post-event assessment of the emergency response should be conducted to determine the need for improvements.

These activities include:

1. *Deactivation of emergency response and return to normal clinic operations.*
2. *Establishment of employee support as needed.*
3. *Accounting for disaster-related expenses to include: direct operating cost; costs from increased use; damage or destruction; replacement of capital equipment; and construction related expenses.*

Documentation

<Name of Clinic> will immediately begin gathering complete documentation including photographs and detailed financial information.

Inventory Damage and Loss

Damage and losses of equipment may be easily tracked using a preexisting current and complete list of equipment serial numbers, costs, and dates of inventory.

Lost Revenue through Disruption of Services

All expenses incurred from the disaster should be documented to assist in applying for Federal disaster reimbursement assistance, if available.

Insurance Carriers

<Name of Clinic> will file claims with its insurance companies for damage to the clinic. (The clinic will not receive federal reimbursement for costs or losses reimbursed by the insurance carrier)

Restoration of Services

If necessary, repair, decontaminate or relocate clinic services

a. Replace or repair damaged medical equipment.

b. Facilitate the return of clinic staff to work.

c. Replenish expended supplies and pharmaceuticals.

d. Follow-up on rescheduled appointments.

After-Action Report

<Name of Clinic> will conduct an after-action evaluation of the adequacy of the clinic's plans, preparation and mitigation efforts.

Staff Support

The clinic 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.

Appendices

Appendix A: Management Of Environment Hazard Surveillance/Risk Assessment Report Form

Date: _____ Building: _____

Program	Hazard Surveillance/Risk Assessment Item	1	2	3	4	5	Comments
Safety Management	1. Are grounds clean and free of hazards?						
	2. Are floors clean, dry, in good repair, and free of obstruction?						
	3. Are mechanisms for access (i.e. ramps, handrails, door opening mechanisms, etc.) operational?						
	4. Is the parking area free of potholes or other hazards?						
	Subtotals						**Program Total:**
Security Management	1. Are doors functioning and locked as appropriate?						
	2. Are medical records centrally located and accessible ONLY to authorized personnel?						
	3. Are alarms functioning, tested, and maintained in accordance with manufacturer's specifications?						
	4. Are systems/mechanisms in place to quickly notify officials or other staff in the event of a security related problem?						
	Subtotals						**Program Total:**
Hazardous Materials & Waste Management	1. Are OSHA Hazard Communication and Exposure Control Documents Available?						
	2. Have all biohazard and toxic substances present been identified?						
	3. Are MSDS sheets quickly available for all identified toxic substances?						
	4. Are all waste contaminated with blood/body fluid considered and handled as infectious?						
	5. Are sharps containers puncture resistant and in accordance with require safety standards?						
	6. Are sharps and disposable syringes placed in approved Sharps containers?						
	7. Are all engineering, personal protective equipment and workplace controls in effect?						
	Subtotals						**Program Total:**

Scoring Legend:

1 = Outstanding 2 = Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory

Appendix A: Management of Environment Hazard Surveillance/Risk Assessment Report Reform

Program	Hazard Surveillance/Risk Assessment Item	1	2	3	4	5	Comments
Emergency Preparedness Management	1. Is there an updated disaster plan in the department?						
	2. Has a non-fire related emergency drill been performed in the past six months?						
	3. Is staff aware of at least three different types of potential non-fire emergencies and their role in eliminating or reducing the risk of patients, staff and property?						
	4. Is staff aware of the primary and secondary exits from the facility?						
	Subtotals						**Program Total:**
Life Safety Management	1. Is the evacuation plan posted and can staff demonstrate knowledge of the plan?						
	2. Are fire extinguishers located in accordance with NFPA standards?						
	3. Are fire extinguishers inspected monthly and documented on/near the extinguisher?						
	4. Are smoke/fire alarm systems functioning, tested, and maintained in accordance with manufacturers specifications?						
	5. Are exit hallways well lit & obstacle free?						
	6. Is emergency exit lighting operational and tested in accordance with NFPA standards?						
	7. Are fire/smoke doors operating effectively?						
	8. Are no smoking policies in effect and signs are posted appropriately?						
	Subtotals						**Program Total:**
Medical Equipment Management	1. Is there a unique inventory of all medical equipment in the facility?						
	2. Has all equipment evaluated and prioritized (Form EC 1.8) prior to use?						
	3. Has all equipment been tested/maintained according to manufacturer's specifications?						
	4. Are maintenance records complete, are they capable of tracking the maintenance history of a particular piece of equipment, and do they record the results of both electrical safety as well as calibration, as appropriate?						
	5. Are systems/mechanisms in place to respond appropriately to a medical equipment failure?						
	Subtotals						**Program Total:**

Scoring Legend: 1 = Outstanding 2 = Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory

Appendix A: Management of Environment Hazard Surveillance/Risk Assessment Report Reform

Program	Hazard Surveillance/Risk Assessment Item	1	2	3	4	5	Comments
Utility Management	1. Are the lights, emergency lights, and power plugs operational and in working order?						
	2. Does the water/sewage system appear to be working properly and has the water quality been tested within the past year?						
	3. Is the telephone system operational?						
	4. Has the HVAC system been inspected in accordance with manufacturer's specifications and have the filters been checked quarterly?						
	5. Are fire suppression (sprinkler) systems checked at least once a year, or as appropriate by a qualified individual?						
	6. Are shut-offs for all utility systems clearly marked, and accessible for all staff in the event of an emergency?						
	7. Are systems/mechanisms in place to respond in the event of a failure of any utility system?						
	Subtotals						**Program Total:**
Infection Control Monitoring Issues	1. Is all staff utilizing Universal Precautions (i.e. utilizing appropriate PPE, handwashing, etc.) in the performance of their job duties?						
	2. Are cleaning solutions secured, mixed, and utilized appropriately throughout the facility?						
	3. Are potentially "infectious patients" aggressively identified and processed in a manner which would minimize the risk of infection of staff and other patients?						
	4. Can staff intelligently describe their role in infection control within the organization?						
	Subtotals						**Program Total:**

Scoring Legend: 1 = Outstanding 2 = Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory

Appendix A: Management of Environment Hazard Surveillance/Risk Assessment Report Reform

Program	Hazard Surveillance/Risk Assessment Item	1	2	3	4	5	Comments
Other Key Safety Monitoring Issues	1. Are Utility Rooms locked, clean and clear of debris?						
	2. Are Storage Rooms secure, clean, and free of flammables?						
	3. Are Emergency Carts present, as appropriate, fully stocked, and checked per schedule?						
	4. Are all medications, including samples, secured and accounted for by lot number?						
	Subtotals						**Program Total:**
	Overall Assessment Totals						**Total:**

Scoring Legend: 1 = Outstanding 2 = Good 3 = Satisfactory 4 = Marginal 5 = Unsatisfactory

Inspection Conducted By: _____

Reports Noted: _____ Date: _____
(Safety Officer)

Appendix B: Local Hazard Assessment Template

This document is an abbreviated version of a local hazard analysis tool. It is not meant to be a substitute for a comprehensive disaster/emergency preparedness program or all hazards assessment. The form is meant to assist in determining which specific hazards are most likely to occur in your practice area and how to prioritize preparedness efforts.

Instructions for Use:
Review and rate each type of hazard to determine response using the hazard scale. Assume that all incidents occur during peak patient treatment times. Consider the below issues for each category. After completing each section, total the number to determine the overall risk level for each hazard.

Categories for "Local Hazard Assessment Template" and Issues for Consideration

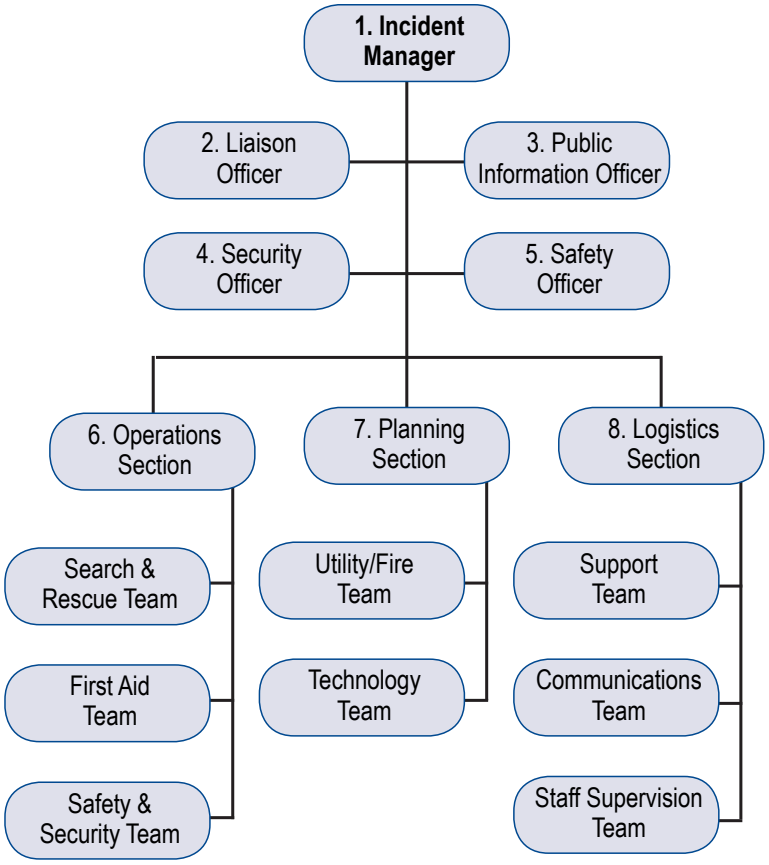
		Magnitude			Mitigation		
EVENT	**Probability**	**Human Impact**	**Property Impact**	**Business Impact**	**Preparedness**	**Internal Response**	**External Response**
ISSUES	• Known risk • Historical data • Manufacturer/ vendor	• Potential for staff death or injury • Potential for patient death or injury	• Cost to replace • Cost to set up temporary replacement • Cost to repair • Time to recover	• Business interruption • Employees unable to report to work • Customers unable to reach facility • Company in violation of contractual agreements • Imposition of fines and penalties or legal costs • Interruption of critical supplies • Interruption of product distribution • Reputation and public image • Financial impact/ burden	• Status of current plans • Frequency of drills • Training status • Insurance • Availability of alternate sources for critical supplies/ services	• Types of supplies on hand/will they meet need • Volume of supplies on hand/will they meet need • Staff availability • Availability of back-up systems • Internal resources ability to withstand disasters/ survivability	• Types of agreements with community agencies/ drills • Coordination with local and state agencies • Coordination with proximal health care facilities • Coordination with treatment specific facilities • Community resources

Instructions for Use:
Review and rate each type of hazard to determine response using the hazard scale. Assume that all incidents occur during peak patient treatment times. Consider the issues for each category. After completing each section, total the number to determine the overall risk level for each hazard.

		Magnitude			Mitigation			Total Risk
EVENT	**Probability**	**Human Impact**	**Property Impact**	**Business Impact**	**Prepared-ness**	**Internal Response**	**External Response**	
	Likelihood to occur	Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community & staff and supplies	
SCORE (Hazard Scale)	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	0 = N/A 1 = High 2 = Moderate 3 = Low or none	
Biological Threat								
Blackouts								
Chemical Threat								
Earthquakes								
Explosions								
Extreme Heat								
Fires								
Floods								
Hurricanes								
Influenza Pandemic								
Nuclear Threat								
Radiation Threat								
Thunderstorms								
Tornadoes								
Wildfires								
Winter Storms & Extreme Cold								

Adopted from *Hazard Vulnerability Analysis Tool Developed* by Kaiser Permanente. Accessed at http://www.calhospitalprepare.org/category/content-area/planning-topics/healthcare-emergency-management/hazard-vulnerability-analysis on January 13, 2011.

Appendix C: Sample Organization Chart and Example of Responsibilities for Emergency Management Team Positions



1. Incident Manager

Line of Authority

The Incident Manager reports to the Executive Director. The EOC Section Chiefs report directly to the Incident Manager. The EOC provides additional recovery management functions through the Liaison, the PIO, the Safety Officer, and Security.

Duties

The Incident Manager is responsible for: activating the Clinic EOP, activating and deactivating the EOC, disseminating information to the EOC Incident Manager, management staff and Section Chiefs, directing specific actions as required, approving issuance of press releases, and providing liaison with other agencies. A summary list of overall responsibilities follows.

The Incident Manager is responsible for response and recovery activities including :

- *Develop and implement strategic decisions and approve the ordering and releasing of resources*
- *Obtain situation briefing from prior shift Incident Manager (if running more than one shift)*
- *Assess situation regularly—using threat action checklists for basic actions to take*
- *Conduct initial briefing for all staff*
- *Activate elements of ICS as needed*
- *Brief management staff and section chiefs*
- *Ensure planning meetings are conducted*
- *Approve and authorize implementation of recovery Action Plan*
- *Determine information needs and inform management personnel of needs*
- *Coordinate staff activity*
- *Manage overall operations*
- *Approve requests for additional resources and requests for release of resources*
- *Authorize release of information to news media*
- *Approve plan for demobilization*

2. Liaison Officer

Line of Authority

The Liaison Officer is a staff assistant to the Clinic Executive Director, and is not in the direct line of authority.

Duties

The Liaison Officer provides direct support to the Executive Director. The Liaison Officer is responsible for: answering telephone calls and managing messages from other organizations in government and the private sector; coordinating with key stakeholders in government, including regulators and those with direct service agreements with the Clinic; requesting assistance directly to other organizations when there is no formal emergency declaration; and keeping the Clinic Executive Director and Incident Manager informed about concerns and pressures from outside organizations.

The Liaison Officer is a member of the management staff and is the point of contact for assisting and cooperating with agency representatives, this includes social services-related government agency representatives, administrative agencies, law enforcement, regulators, colleges and universities, and non-profit and private sector interests involved with Clinic operations. The Liaison Officer works very closely with the PIO. During emergency response and recovery, the Liaison Officer should:

- *Obtain initial briefing from the Incident Manager or EOC Incident Manager*
- *Provide point of contact for assisting/cooperating with agency representatives*
- *Identify agency representatives from each agency including communications links and locations*
- *Respond to requests from Clinic staff for inter-organizational contacts*
- *Monitor recovery operations to identify current or potential inter-organizational problems*
- *Assist the Incident Manager to craft strategies for coordinating with other organizations*

3. Public Information Officer (PIO)

Line of Authority

The Public Information Officer is a staff assistant to the Incident Manager, and is not in the direct line of authority.

Duties

The Public Information Officer (PIO) advises the Incident Manager on the potential effects of proposed actions on external and internal relations. The PIO serves as the dissemination point for all news releases from the Clinic. Other Clinic groups that want to release information to the public, employees, stakeholders, or regulators should coordinate through the PIO. The PIO reviews and coordinates all information releases from other Clinic sources. The PIO coordinates to ensure that: employees, their families, regulators, and other stakeholders receive timely and accurate information about the Clinic's situation. The PIO should follow the communications guidelines already established for Clinic emergencies. The PIO also prepares fact sheets about the Clinic with sidebars about the Clinic's business continuity program before interruptions occur.

The PIO, a member of the management staff, is responsible for the formulation and release of information about the response and recovery to the news media and other appropriate agencies and organizations, including the Clinic Director. During an emergency response and recovery, the PIO should:

- *Obtain briefing from the Incident Manager*
- *Contact other involved agencies to coordinate public information activities*
- *Establish single recovery information point of contact whenever possible*
- *Arrange for necessary workspace, materials, telephones, and staffing for PIO staff*
- *Prepare initial information summary as soon as possible after arrival*
- *Observe constraints on the release of information imposed by the Incident Manager*
- *Obtain approval for release from the Incident Manager.*
- *Release information to news media and post information in EOC and other appropriate locations*
- *Attend meetings to update information releases*
- *Arrange for meetings between media and Clinic Executive Director*
- *Provide escort service to the media and VIP's*
- *Respond to special requests for information*

Appendix C: Sample Organization Chart and Example of Responsibilities for Emergency Response Team Positions—continued

4. Security Officer

Line of Authority

The Security Officer reports directly to the Incident Manager, and is not in the direct line of authority. When Clinic site security is supplanted or enhanced by outside security (CHP, local law enforcement, FBI), then the line of authority will be a point of coordination between Clinic security and external agency security.

Duties

Security provides direct support to the Incident Manager. Security is responsible for: controlling ingress and egress into the area, including the maintenance of a sign-in and out log; controlling the location of parking and general traffic around the clinic HQ site after a major emergency; verifying identification and reason to enter the EOC or recovery area; preventing criminal acts upon Clinic staff or facilities; providing protection for the Executive Director, PIO and Incident Manager during public press briefings or general public briefings regarding recovery operations. Security is also responsible for preparing a security plan in coordination with the Logistics Section Chief.

Security must ensure that only authorized personnel are allowed access to the Clinic during emergency operations. Their responsibilities include:

- *Receive initial briefing from Incident Manager*
- *Coordinate with Logistics Section Chief*
- *Establish and maintain a controlled entry area, including the use of a formal entry log*
- *Verify identification and entrance needs for all wishing to enter the EOC area*
- *Ensure the staff wears ID badges. Provide badges for visitors and staff, as necessary*
- *Deny entrance when there is reason to suspect the need for admittance is not warranted*
- *Coordinate with building security and/or law enforcement, if present*
- *Request external law enforcement assistance as needed*
- *Record staff entering for response / recovery activities in the entry log. This includes entrance and exit times*
- *Provide a copy of the log to the Logistics Section Chief before the end of each operational period in order to track staffing.*
- *Provide a copy of the log to the Finance and Administration Section Chief so they can track time for possible reimbursement*

5. Safety Officer

Line of Authority

The Safety Officer is a staff assistant to the Incident Manager, and is not in the direct line of authority.

Duties

The Safety Officer provides direct support to the Incident Manager. The Safety Officer is responsible for: developing the medical plan; continuously monitoring the work environment to ensure the health and safety of Clinic personnel and visitors; developing safety strategies for the recovery with the Incident Manager and Logistics Section Chief; coordinating the provision of Critical Incident Stress management for staff; and providing direct medical attention to ill or injured personnel until professional medical help can arrive .

The Safety Officer is responsible for monitoring and assessing hazardous and unsafe situations and developing measures for assuring personnel safety. Although the Safety Officer may exercise emergency authority to stop or prevent unsafe acts when immediate action is required, the Safety Officer will generally correct unsafe acts or conditions through the regular line of authority. The Safety Officer maintains awareness of active and developing situations, approves the medical plan, and includes safety messages in each Action Plan. During emergency response and recovery, the Safety Officer should:

- *Obtain initial briefing from the Incident Manager or EOC Incident Manager*
- *Identify hazardous situations associated with the response/ recovery to ensure personnel avoid them or are prepared to manage operations in that environment without harm*
- *Participate in all planning meetings*
- *Develop the medical plan (NOTE: Medical plan refers to treatment of injuries at the EOC or related to response and recovery actions.)*
- *Review Action Plans*
- *Identify potentially unsafe situations*
- *For all reportable injuries conduct an initial investigation and write a report and submit it to appropriate officials within required timeframes*
- *Exercise emergency authority to stop and prevent unsafe acts*
- *Investigate accidents that have occurred within the response/recovery operations area, including arranging for investigation of accidents in field operations involving Clinic personnel*

6. Operations Section Chief

Line of Authority

The Operations Section Chief is in direct line of authority, reporting directly to the Emergency Operations Center (EOC) Incident Manager.

Duties

The Operations Section Chief oversees continuity of Operations, assesses response and recovery support situations, and oversees operational response and restoration throughout the Clinic's facilities, coordinating with the other Section Chiefs.

The Operations Section Chief should contact, inform, and coordinate with the other Clinic units. Initial contacts should be oriented on needs evaluations. Second priority should be to establish care and shelter operations.

The Operations Section Chief should consult with the Logistics Section Chief and the Planning and Intelligence Section Chief. Together they determine if full or partial closure of Clinic facilities is likely (both HQ and field sites).

The Operations Section Chief, a member of the general staff, is responsible for the management of all operations directly applicable to the primary response and recovery missions. The Operations Chief activates and supervises organization elements in accordance with the Action Plans and directs their execution. The Operations Chief also directs the preparation of Operations Section plans, requests or releases resources, makes expedient changes to the Action Plans as necessary and reports such to the Incident Manager. During emergency response and recovery, the Operations Chief should:

- *Obtain briefing from the Incident Manager*
- *Develop the operations portion of the Action Plans*
- *Brief and assign operations personnel in accordance with the Action Plan*
- *Supervise Operations Section staff and activities to move the recovery forward*
- *Determine response / recovery action needs and request additional support resources*
- *Review the suggested list of resources to be used in response and recovery and initiate recommendations for when the resources will be used and for what purpose*
- *Assemble and disassemble teams assigned to Operations Section*
- *Report information about special activities, events, and occurrences to the EOC Incident Manager*

7. Planning Sections Chief

Line of Authority

The Planning Section Chief is in direct line of authority, and reports directly to the Incident Manager.

Duties

Responsibilities include: collecting, analyzing and displaying situation information; preparing periodic situation status reports with the Incident Manager, and the other Section Chiefs; developing goals and objectives for the forthcoming operational period's Action Plan. During each operational period, begin advance planning for forthcoming periods. As the workload decreases, begin planning for deactivation and demobilization. Provide information management and related support to the other Section Chiefs and staff support positions in the EOC. Keep the Incident Manager updated on significant Planning and Intelligence findings (e.g., advance planning reports, serious changes in weather or safety issues, and projected reductions in resources or support, etc.).

The Planning Section Chief, a member of the ERT general staff, is responsible for the collection, evaluation, dissemination and use of information about the development of recovery and status of resources. Information is needed to: 1) understand the current situation; 2) predict probable course of recovery events; and, 3) prepare alternative strategies and control operations for the recovery. Raw data must be prepared and analyzed into meaningful information known as intelligence. The Planning Section Chief is responsible to:

- *Obtain initial briefing from Incident Manager*
- *Activate Planning Section*
- *Establish information requirements and reporting schedules for all organizational elements for use in preparing the Action Plans*
- *Post the names of the activated staff in the EOC, including locations of assigned personnel. The names should be available from the Logistics Section*
- *Establish a weather data collection system, and other threat assessment techniques, as necessary. This could include traffic, fire, hazmat, and flood reports*
- *Supervise preparation of Action Plans as facilitator for the action-planning meeting*
- *Assemble information on alternative strategies for response and recovery*

continued

Appendix C: Sample Organization Chart and Example of Responsibilities for Emergency Response Team Positions—continued

7. Planning Sections Chief continued

- *Identify need for use of specialized resource(s) for Logistics*
- *Provide periodic predictions on recovery schedule status—evaluate milestones and percent completion of objectives*
- *Use status boards to compile and display the response or recovery status summary information*
- *Advise general staff of any significant changes in response or recovery status*
- *Provide a traffic plan, including safe routes for evacuation to another site, or return to Headquarters, or the field station*
- *Prepare and distribute the Action Plan and other written orders from the Director*
- *Ensure that normal agency information/ reporting requirements are being met*
- *Prepare recommendations for release of resources for the Director/Deputy*

8. Logistics Section Chief

Line of Authority

The Logistics Section Chief is in direct line of authority, and reports directly to the Incident Manager.

Duties

Responsibilities include: transportation, coordination with security, and logistics resources to match the other Section Chiefs' needs.

The Logistics Section Chief, a member of the general staff, is responsible for providing facilities, services, and material in support of the emergency. The Section Chief participates in development and implementation of the Action Plans, and activates and supervises the work within the Logistics Section. During response and recovery, the Section Chief should:

- *Obtain a briefing from the Incident Manager*
- *Plan the organization of the Logistics Section*
- *Provide work locations for all ERT personnel, whether in or out of the EOC*
- *Record and track the activated ERT members, including names and locations of assigned personnel*
- *Participate in preparation of Action Plans for support and service elements*
- *Identify service and support requirements for planned and expected operations*
- *Provide input and review communications plan, medical plan, and security plan*
- *Coordinate and process requests for additional resources with other sections*
- *Estimate all Section's needs for next operational period*
- *Ensure Communications Plan is prepared*
- *Assist Planning and Intelligence Section to develop an EOC Demobilization Plan*
- *Recommend release of resources in conformity with the Demobilization Plan*
- *Ensure general welfare and safety of all EOC personnel in coordination with the Safety Officer*
- *Assist the Security Officer with any needs for establishing and maintaining security of the EOC and ERT staff, which could include escorts to and from personal vehicles*

Appendix D: Practice Support Services List

Date of Last Update: _____ Updated By: _____

Contact List: Vendors / Funding Sources / Community Liaisons

	Telephone (999) 999-9999	Email	Contact Person
EMS Provider			
Fire Service			
Law Enforcement			
Gas or Propane			
Telephone			
• Equipment Provider			
• Equipment Repair			
• Service Provider			
Facility Management			
Facility Maintenance			
Property Insurance			
Liability Insurance			
Information Technology Support			
Medical Supply and Equipment			
• Vendor			
• Vendor			
• Vendor			
• Repair			
• Repair			
• Repair			
• Maintenance			
• Maintenance			

Contact List: Vendors / Funding Sources / Community Liaisons

	Telephone (999) 999-9999	Email	Contact Person
Local Emergency Management Agency			
Local Red Cross			
Community Partners			
• Partner			
• Partner			
• Partner			
Other Numbers			

Appendix E: Contact Lists

Staff Contact List

If a response is activated, each person will call the next two people on the list. Redundant calls are ok. If you cannot reach one of the people you call, leave a message (if possible) and call the next person. Note the name of the person you could not reach and call again one hour later. If unsuccessful, report name to Incident Manager.

Date of Last Update: _____ Updated By: _____

THIS LIST CONTAINS SENSITIVE INFORMATION AND SHOULD REMAIN CONFIDENTIAL						
Name/ Position	**Prefer:** Home/ Cell/ Other	**Home Phone**	**Cell Phone**	**Office Phone**	**Other** (Pager, etc.)	**Email**
Executive Director						
Medical Director						
Nursing Director						
Operations/ Office Manager						
HR Director						
Finance Director						
Facilities Director						
Risk Manager						
Safety Manager						
ERT Member						
ERT Member						
ERT Member						
ERT Member						
ERT Member						

Appendix F: Disaster Response Contact Lists

Date of Last Update: _____ Updated By: _____

Contact List – Disaster Response Officials

	Telephone (999) 999-9999	Email	Contact Person
County EMA/ Warning Center			
Med/Health Op Area Coordinator			
<Name of County> Division of Epidemiology: Bioterrorism Emergency Number			
CDC Emergency Response Office			
Nearest Hospital Emergency Department			
Nearest Clinic / Medical Group			
Local EMS Agency			
<Name of County> Health Department (general)			
<Name of County> County Medical Society			
<Name of County> Office of Emergency Services Director			
Regional Amateur Radio Contact			
Media – Television			
Media – Radio			

Appendix F: Disaster Response Contacts List

Contact List – Disaster Response Officials

	Telephone (999) 999-9999	Email	Contact Person
Media – Newspaper			
Other Numbers			

Appendix G: Clinic Communications Equipment Inventory

Date of Last Update: _____ Updated By: _____

Clinic Communications Equipment Inventory

Equipment Type	Number of Items	Location in Clinic	Date of Testing / Maintenance	Staff Contact
Telephone				
Clinic Phone System		Phones throughout clinic. Digital switchboard located:		
Fax Machines				
Analog telephone jacks				
Analog telephones				
Cellular telephones				
Satellite telephones				
Computer				
Email		Computers throughout clinic. Server location:		
Satellite Internet Connectivity				
Telemedicine				
Videoconference – camera and video monitor				
Radio-based				
Email		Location of radio:		Operator contact information:
Handheld radios / Walkie – Talkie				
Other Radios				
EMS – Ambulance				
Hospital Status Radio				

Create a Family Emergency Plan

Prepare a family emergency plan to be included in your home emergency supply kit. The family plan will list the name, date of birth, social security number, medical information and the work/ school locations for each family. It should also list the important contacts for the family such as doctors, veterinarians, medical insurance, and homeowners/rental insurance. The FEMA, Ready Campaign and the Ad Council have prepared a website to assist your family in developing a family emergency plan. The site and its tools can be found at http://ready.adcouncil.org/beprepared.

As part of your plan, families should also:

- *Identify meeting locations in case you are not able to return to your home or must evacuate quickly.* One meeting location should be within walking distance of your home. Another can be within your local area but not within walking distance of your home. A final location could be a friend or relative's home outside of your local area.
- *Identify an out-of-town contact.* It may be easier to make a long-distance phone call than to call locally, so make one person the out-of-town contact that all family members will contact in case of emergency.
- *Make sure every family member knows the out-of-town contact and their phone number.* Program that person as "ICE" (In Case of Emergency) in your phone. If you are in an accident, emergency personnel will often check your ICE listings in order to get a hold of someone you know. Make sure to tell your family and friends that you've listed them as emergency contacts.
- *Create emergency response cards for all of your family members and place copies in wallets, purse and backpacks.*
- *Teach all family members how to use text messaging.* Text messages can often work when cell phones are unable to be completed.
- *Subscribe to alert services.* Visit your local Office of Emergency Management and/or local government website to sign up for emails, newsletters and other alerts that will inform you of bad weather, road closings, local emergencies or other disasters.

You may also want to inquire about emergency plans at places where your family spends time: work, daycare and school. If no plans exist, consider volunteering to help create one. You will be better prepared to safely reunite your family and loved ones during an emergency if you think ahead and communicate with others in advance.

Prepare the Whole Family

After creating a plan, share the plan with your entire family. Talk with your family at an age appropriate level about potential emergencies and how your family has prepared. Show the family actions that have been taken to prepare your household and simple steps that can increase their safety.

- *Create emergency response cards for each member of the family.* For children or vulnerable adults include his/her full name, nicknames, address, phone number, responsible adult's phone numbers and out of state contact.
- *Point out the home emergency supply kit and go bags to the whole family.*
- *Share the neighborhood meeting place.*
- *Practice your evacuation routes and Stop, Drop & Roll drills.*
- *Make sure all family members know who the out-of-town contact is and how to call this person to let them know where they are.*
- *Teach children basic personal information and parents' full names in case they become separated from a parent or guardian.*
- *Teach children to dial their home telephone number and Emergency 9-1-1.*

Determine Your Risk

Investigate your community to determine what types of emergencies/disasters are most likely to occur in your community and make sure your emergency plans consider all types. Consider both climate as well as the landmarks (i.e. streams, train tracks, high-rise buildings, valleys, etc.) in your area. Learn what methods might alert you to an emergency. Your family might hear a siren, get a telephone call from a local alert system or hear an emergency radio and TV broadcast.

Deciding to Stay or Go

For any emergency/disaster, the first decision for your family is to stay where you are or evacuate. In creating a plan for your family, you should prepare for both leaving and staying in your community. Most often, the information provided by local authorities on evacuation plans are based on the best information they have available and should be headed. Use your common sense and the information on hand, including this sheet, to determine the danger (i.e. lack of food, damage to physical structure, power outages) to your family and "worst case scenarios" should you choose to stay after an evacuation has been ordered. You should continue to watch TV, listen to the radio and check the Internet for new information as it becomes available. You may also want to inquire about emergency plans at places where your family spends time: work, daycare and school. If no plans exist, consider volunteering to help create one. You will be better prepared to safely reunite your family and loved ones during an emergency if you think ahead and communicate with others in advance.

Personal Preparedness Checklist

In the event of an emergency, utilities and usual services, such as running water, electricity and gas, may be unavailable. Experts recommend that your family should be prepared for at least three days. Store your home emergency supply kit in an easy to access location in your home. Put the contents in a large, watertight container that you can easily move.

This list was adapted from *Survival: How Being Prepared can Keep You & Your Family Safe* by Lt. General Russel L. Honoré, US Army (Ret).

Recommended Items to Include in Home Emergency Supply Kit

Water

Plan at least one gallon of water per person per day for at least three days.Children, nursing mothers and ill will need more. Store the water in containers that will not break or decompose.

Food

Include at least a three-day supply of non-perishable food for all members of the family (including infants or others on special diets). Consider high-protein and ready to eat foods that don't require refrigeration, preparation, cooking or little/no water. Make sure to include a can-opener if canned foods are included. Examples– packaged milk and juices, granola bars, peanut butter & crackers, canned meats and fruits.

Clothing & Basic Supplies

Include at least one complete change of clothing per person with a long sleeve shirt, long pants and sturdy shoes. Update the clothing to reflect the current time of year and sizes of family members.

- Go Bag for each member of the family*
- Personal hygiene items including toilet paper, feminine supplies, hand sanitizer, soap, toothbrushes and toothpaste
- Diapers
- Denture needs
- Hats & Gloves
- Rain gear
- Warm blankets or sleeping bags for each person
- Moist towelettes or baby wipes, garbage bags and plastic ties for personal sanitation

First Aid & Medical Supplies

- Extra Prescription Drugs & Glasses or Copies of Prescriptions
- List of all currently prescribed medications for all family members with the name of the medication, dosage, frequency and the prescribing doctors name.
- First aid kit
  - —Bandages in various sizes
  - —Antiseptic Wipes
  - —Germicidal Hand Wipes
  - — Cold Pack
  - — Sterile Dressings & Gauze Pads
  - — Tweezers
  - — Adhesive Tape
  - — Scissors
  - — First Aid Manual
  - — Antibacterial ointment
  - — Medical Grade Non-Latex Gloves
- Nonprescription Drugs (Adult, Infant & Children Strengths)
  - —Aspirin or nonaspirin pain reliever
  - —Antacid
  - — Antidiarrhea medication
  - — Laxative

Personal Preparedness Checklist continued

Tools & Supplies

- Cell phones and chargers
- Cash or traveler's checks and change
- Matches in a waterproof container
- Wrench or pliers to turn off utilities
- Duct Tape
- Flashlight and extra batteries
- Fire Extinguisher
- Whistle to signal for help
- Insect Repellent
- Plastic Sheeting
- Mess Kits, or paper cups, plates & plastic utensils
- Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries
- Any communication devices (landline phones, wireless laptops, walkie-talkies, GPS devices, text messaging devices, portable radio, etc)
- Household chlorine bleach and medicine dropper – When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.

Other Items

Copies of important family documents in a waterproof, portable container
- — Driver's license or identification card, passports, social security cards
- — Birth and death certificates
- — Insurance policies
- — Bank account numbers, credit card numbers and companies
- — School records, transcripts, diploma and degrees
- — Important telephone numbers

- Local maps
- Books, games, puzzles or other activities for children
- Permanent marker, paper and pencil
- Portable music or video device

***Go-bag**

The following items should be put together in a backpack or other easy to carry bag in case of a quick evacuation. Prepare one Go-bag for each family members and make sure the bag has an I.D. tag.

- Some water and food
- Toothbrush and toothpaste
- Copy of health insurance and identification cards
- Any special needs items for children and seniors.
- Extra keys to your house and vehicle
- Prescription medications and first aid supplies
- List of emergency point-of -contact phone numbers
- Sturdy shoes, a change of clothes, and a warm hat
- List of allergies to any drug (especially antibiotics) or food
- Emergency cash in small denominations and quarters for phone calls
- Extra prescription eye glasses, hearing aid or other vital personal items
- For children, include a family picture and favorite toy or game to help calm them.

Additional Suggested Resources

Honore', R.L. & Martz, R. (2009). *Survival: How Being Prepared can Keep You & Your Family Safe. New York, NY: Atria Books.*

Ready.gov Get a Kit offered by: ready.gov – http://www.ready.gov/america/getakit/index.html

Emergency Preparedness & You offered by the Centers for Disease Control and Prevention – http://www.bt.cdc.gov/preparedness/

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Household Information Sheet

Home Address:	
Home Phone Number:	Nearest Cross Streets:
Emergency Contact Name:	Phone Number:
Out-of-Town Contact Name:	Phone Number:
Out-of-Neighborhood Meeting Place:	

Fill out the following for each member of your household and keep it up to date. Consider putting recent pictures to assist with identification.

A	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
B	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
C	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
D	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
E	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		

Work/School Locations

	Name	Address	Phone Number
A			
B			
C			
D			
E			

Household Information Sheet—continued

Personal Resources Contact Information

	Name	Phone Number	Policy Number
Physician			
Pediatrician			
Pharmacy			
Dentist			
Church			
Medical Insurance Company			
Medical Insurance Company			
Homeowners/Renters Insurance			
Auto Insurance			
Veterinarian			
Medical Supply Company			

Utility Companies

	Name	Phone Number	Account Number
Electrical Service Provider			
Gas Service Provider			
Water Service Provider			
Phone Service Provider			

Local Emergency Contacts

Emergency Police, Fire & Ambulance: **911**

Non-Emergency Police: _____

Local Government Alert Website: _____

Local Emergency Management Agency Office: _____

Information Sources

Local Radio Stations: _____ TV Stations: _____

FEMA Ready.gov – A resource to assist in preparing your family. www.ready.gov

American Red Cross Safe & Well Website
After a disaster, register to let your family and friends know that you are safe and well or to check the safety of family members.
https://safeandwell.communityos.org

Emergency Preparedness & You - Centers for Disease Control and Prevention (CDC) and the American Red Cross have teamed up to answer common questions and provide step-by-step guidance you can take now to protect you and your loved ones. http://www.bt.cdc.gov/preparedness/

Wallet Emergency Response Card

Name:

DOB:

Local Emergency Contacts:

Name	Phone

Out-of-state Contact/Phone:

Name	Phone

Health Information

Physician:

Phone:

Chronic Conditions & Allergies

Pharmacy:

Phone:

Medications:

Name	Dosage	Frequency

TO PREPARE FOR AN EMERGENCY

- Keep your emergency contacts and medication lists correct and up-to-date.
- Keep emergency supplies in your car, including comfortable shoes, water, food and warm clothes.
- Designate an out-of-state contact to relay family emergency information.

Wallet Emergency Response Card

Name:

DOB:

Local Emergency Contacts:

Name	Phone

Out-of-state Contact/Phone:

Name	Phone

Health Information

Physician:

Phone:

Chronic Conditions & Allergies

Pharmacy:

Phone:

Medications:

Name	Dosage	Frequency

TO PREPARE FOR AN EMERGENCY

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Model Continuity of Operations Plan

This guide is adopted from content produced in the "Continuity of Operations Plan Guidance for Indian Health Centers" developed by the California Area Office of the Indian Health Service (IHS) and the California Indian Health Program (IHP), in collaboration with the Emergency Preparedness Resources for Native Americans (EPRNA).

Continuity Of Operations Plan Guidance

Read Me First

This model Continuity of Operations Plan illustrates key elements in the development of a Continuity of Operations Plans (COOP). It shows what a COOP could look like for a moderate-sized practice site experiencing an emergency that requires reduction of services at its primary site or relocation of services to an alternate location. The model plan does not address many of the COOP issues created by an influenza outbreak, such as social distancing and other protective measures. While it is not a "fill-in-the-blank" template, this model illustrates how some of the key planning, preparedness, response and recovery issues are often addressed.

As with all planning templates, the model text and examples will not cover all circumstances. While terminology (e.g., Emergency Preparedness Committee or Emergency Response Team or Emergency Relocation Team), organizational structures and governance vary somewhat among practices and health centers, this model plan is designed to present COOP planning elements that are likely to be common across practice sites regardless of size, location and governance.

This document also includes two appendixes. Appendix A is an example of a "Restoration Plan" for an essential function. This restoration plan provides a summary of all the elements required for continuing to perform this function at the original clinic site or at an alternate location.

Appendix B consists of worksheets that are useful for organizing and recording the results of the planning effort. These forms can be kept available for rapid access and for routine updating and as information changes.

Three final points:

1. COOP planning begins with a robust safety and emergency management program. Ensuring the safety of patients, visitors and staff is the first priority of emergency management.
2. The planning process is essential and must involve key elements of the organization to create a plan that is accurate, understood across the organization and capable of implementation. Likewise, the finished plan must be updated at least annually.
3. Undertaking a COOP planning process has benefits beyond emergency preparedness. It requires a strategic review and understanding of the functions that are core to the mission of the health center. It also helps identify day-to-day strengths, weaknesses and vulnerabilities in emergencies.

Model Continuity Of Operations Plan

Model COOP Plan — Table of Contents

Coop Plan Approvals

By their signatures below, the following senior level officials certify that they approve this Continuity of Operations Plan and fully understand the continuity of business operation procedures that are to be followed in the event of an emergency that impacts the facilities and employees for which they are responsible.

Approved *[Name/Executive Director]:* Date

Approved *[Name/Title]:* Date

FOR OFFICIAL USE ONLY

Insert agency text for this restrictive marking.

All personnel are reminded that information contained in this document is FOR OFFICIAL USE ONLY. It is to be used only to contact organization personnel in response to an emergency situation. Unauthorized use of this information may constitute an invasion of privacy.

Executive Summary

The purpose of the ABC Practice Continuity of Operations (COOP) Plan is to ensure the continuity of essential functions of the ABC during emergencies created by a variety of hazard threats and times when normal, standard operations become overwhelmed. This plan applies specifically to ABC and the programs that operate within ABC. It is consistent with the Emergency Operations Plan and related specific hazard contingency plans.

While the ABC COOP Plan is an all hazards plan, it incorporates the findings of the Hazard Vulnerability Assessment performed by ABC. It addresses emergencies, regardless of hazard, that occur during normal work hours or off-hours that disrupt the performance of designated essential functions. The plan is based on a worst-case scenario in which the ABC facility is not usable, most personnel are not available, and outside assistance is not immediately available. It reflects an expectation that essential functions can be restored to an acceptable level within 24-72 hours and ABC can maintain operations for 30 days with external support even if the ABC facility is unusable.

ABC has identified the following essential functions:

- Priority A: Medical care for victims in the immediate aftermath of a disaster that occurs during ABC's normal business hours.
- Priority B: Ongoing essential medical services for area residents following a disaster.

This plan describes:

1. How ABC will implement its COOP plan and address critical COOP elements including activation and relocation, alternate facility operations, and reconstitution.
2. The executive decision process that takes into account the nature and extent of the emergency, then determines the best course of action for response and recovery.
3. Measures to ensure the succession of organization leadership, pre-delegation of emergency authority and active command and control.
4. The operational details to implement the plan and to meet the logistic requirements for plan execution (Click to access Appendix A – Essential Function Restoration Plan).

Introduction

COOP Planning

Continuity of Operations (COOP) Planning is an effort within organizations to ensure the continued performance of minimum essential functions during a wide range of potential emergencies. Essentially, it is using development of plans, comprehensive procedures, and provisions for alternative facilities, personnel, resources, interoperable communications, and vital records/databases to maintain the business of the organization under all eventualities. It also includes ensuring the succession of organization leadership, pre-delegation of emergency authority and active command and control.

Plan Design

The ABC COOP Plan is comprised of a number of component parts that meet the needs of various plan users and their roles in the overall COOP program. The Plan addresses high level, overview information about how an organization is supposed to respond to disruptions and, in Appendix A, the operational detail necessary to support the response to these disruptions. Given the sensitivity of some of the information in this Plan, the distribution of the Plan and its associated documents is limited.

The ABC COOP Plan addresses events that disrupt or threaten to disrupt health center operations that are vital and time-critical to patients, clients and the community. Existing ABC contingency and emergency plans are not replaced by but are incorporated or referenced in the ABC COOP Plan.

Purpose

The purpose of this plan is to ensure the continuity of essential functions of ABC during emergencies created by a variety of hazard threats and during times when normal, standard operations become overwhelmed.

This Plan identifies recovery strategies only for essential functions that are mission and time critical. An Essential Function [Click to access: Worksheets 1 ABC Functions & 2 ABC Essential Functions] is defined as a function that enables ABC to:

1. Provide vital or "essential" services.
2. Maintain the health and safety of patients, visitors, staff and the community it serves.
3. Maintain its financial and legal foundation.

Essential functions are prioritized and classified according to the maximum tolerable duration between the occurrence of a disruption and the resumption of the function under emergency conditions, i.e. the maximum amount of time the function can be down.

A: Emergency response functions (0-2 hours)

B: High impact on public safety and health or on critical operations (up to 72 hours)

C: Moderate impact on public safety, health or critical operations (1-3 weeks)

Concept Of Operations

Applicability

This plan will be activated when an emergency, or threat of an emergency, disrupts the performance of essential functions of the ABC. This plan applies specifically to the ABC and the programs which operate within ABC.

Scope

This plan addresses emergencies, regardless of hazard, that occur during normal work hours or off-hours and disrupt the performance of designated essential functions. The plan is based on a worst case scenario in which the ABC facility is not usable, most personnel are not available, and outside assistance is not immediately available. It reflects an expectation that essential functions can be restored to an acceptable level within 24-72 hours and ABC can maintain operations for 30 days with external support even if the ABC facility is unusable.

ABC's COOP Plan also addresses emergencies of extended duration such as pandemic influenza outbreaks, wild land fires and floods.

Planning Assumptions

The ABC COOP Plan is based on the following assumptions:

- Emergencies or threatened emergencies may adversely affect ABC's ability to continue essential internal operations required to provide services to patients and clients or respond to emergencies.
- ABC intends to remain open and to respond to community health needs, to the extent possible, in emergencies, consistent with its capabilities.
- In a major emergency, ABC will employ the Incident Command System (ICS) and activate its Emergency Operations Center (EOC) to manage its response. ABC will establish a Command Center using ICS to manage on-site operations.
- ABC does not operate on a 7-day per week, 24 hours per day basis. While emergency circumstances may require 24-hour operations for some period of time, this plan is not designed to guide 24-hour operations for an extended period.
- Personnel and other resources, along with other government and non-governmental agencies outside of the area affected by the emergency or threat, will be made available if required to continue essential operations.
- This COOP Plan is an all-hazards plan and may be activated in response to a wide range of possible emergencies.

COOP Elements

The Concept of Operations describes how ABC will implement its COOP Plan and plans to address each critical COOP element during the three phases: activation and relocation, alternate facility operations, and reconstitution. It also describes the executive decision process that allows for a review of the nature and extent of the emergency then determines the best course of action for response and recovery.

This system precludes premature or inappropriate activation of the ABC COOP Plan and provides operational details necessary to implement the plan and meet the logistic requirements for plan execution.

A. Plans and Procedures

To be successful, COOP planning requires upper management support. The organization's leader sets the tone by authorizing planning to take place and directing senior management to get involved. Developing the COOP program is a dynamic process. Planning, although critical, is not the only component. Other important functions are implementation and validation.

Activities in the development of a COOP plan cannot be explicitly defined altogether, but it is key to remember the PROCESS of planning is invaluable. The process should involve all organizational units and personnel levels working in concert.

Coordination amongst all functions and organizational levels is important, it implies a willingness to share responsibility and eliminates duplication of efforts. The preparation process should include:

- Establishment of planning team.
- Assignment of authority.
- Development of plan.
- Preparation for challenges.

Risk Analysis

The ABC Hazard Vulnerability Assessment identifies a variety of hazards that can potentially disrupt its operations:

- Natural hazards, especially earthquakes and influenza pandemics.
- Human-related hazards or technological events, including wild fires, electrical power failures hazardous material releases, and communications systems failures including failure of data networks.
- Pro-active human hazards involving deliberate actions by people to cause harm, including workplace violence, bomb threats, civil disturbances and terrorism attacks.

These hazards are likely to impact ABC whether they are directed at the facility, or impact the community in which ABC operates.

Vulnerability Assessment

Essential functions may be disrupted through one or more of the following scenarios:

1. ABC facility damage or disruption;
2. Region-wide disruptions affecting all or many government buildings in the surrounding community;
3. Disruption of communications and transportation systems;
4. Loss of services from vendors (including utilities) or government agencies;
5. Unavailability of key personnel for any reason due to illness (e.g., pandemic influenza), inability to travel to the ABC site or other reasons.

ABC has the capability, within normal day-to-day operations, to fully or partially mitigate these disruptions to ABC under certain circumstances. Examples include:

- Use of alternate communications systems.
- Multiple vendors and stockpiles of essential supplies and pharmaceuticals.
- Sheriff response to facility disruptions involving bomb threats or other criminal activity.
- The ability to temporarily re-assign personnel to augment ABC staff.

If the facility experiences significant structural damage or if local emergency services are overwhelmed or damaged, these measures may prove inadequate.

COOP Response Phases

Phase I – Readiness and Preparedness.

Phase II – Activation and Relocation: Plans, procedures, and schedules to transfer activities, personnel, records, and equipment to alternate facilities are activated.

Phase III – Continuity Operations: Full execution of essential operations at alternate operating facilities commences.

Phase IV – Reconstitution: Operations at alternate facility are terminated and normal operations resume.

Resource Requirements

[Click to access: Worksheets 4: Alert System and 5: Emergency Team and Employee Contact Information]

ABC requires the following resources to maintain or restore its essential functions:

- Primary facility or alternative work site. Possible work sites include a triage tent set up in the ABC parking lot or an ABC satellite site.
- Redundant communications systems including telephone, email and other computer communication systems; satellite telephone; 440 Mhz radio (TBD), and amateur radio.
- Physicians, nurses and medical assistants in sufficient numbers to triage, stabilize and hold converging injured victims for up to six hours. ABC personnel may be augmented by emergency medical services personnel and community medical resources.
- Medical supplies and equipment provided through ABC Go Kits and augmented by re-supply from key vendors.
- Behavioral health services to support staff and their families throughout the emergency response. [Click to access: Worksheet 6 and 7: Family Support and Counseling Teams]
- Support from other county and local programs including law enforcement, fire, and EMS services.

Functional Dependencies

While ABC has the personnel and resources to sustain or restore essential functions following a disaster, resource support is required to maintain those services beyond twelve hours following a major emergency. ABC will require personnel, supply and equipment support from outside organizations for extended response and full reconstitution of operations.

Line of Authority [Click to access: Worksheet 3: Current Agency Organization Chart]

During a response to emergencies, the line of authority flows from the ABC Executive Director to his/her designees. The ABC Executive Director and staff are responsible for taking immediate action in emergencies to ensure the safety of patients, visitors and staff and to protect the facility, its equipment and other resources.

Response Roles [Click to access: Worksheet 5]

The ABC Manager has the following roles and responsibilities during ABC emergency response and recovery operations:

- Designates the ABC Incident Commander and authorizes establishment of the ABC Command Center.
- Acts as a liaison to local emergency response and support services.
- Ensures provision of ABC emergency operations information to staff, patients and community stakeholders.

The ABC Executive Director receives status updates from the ABC Incident Commander and develops the overall guidance for emergency response and recovery, including:

- The activation of this COOP plan and the level of its activation.
- Identifying operations still at risk.
- Establishing restoration priorities.
- Authorizing expenditure of funds for emergency acquisitions and additional personnel expenditures, as needed.

ABC Emergency Management Coordinator (EMC)

The EMC position is filled by the ABC Safety Directory or other position designated by the Executive Director. During day-to-day operations, the EMC convenes the ABC Safety Team and is responsible for:

- Maintaining and improving the overall ABC emergency program including the building evacuation plan and various emergency response plans and procedures.
- Ensuring all emergency plans are periodically updated, remain complementary, and adhere to NIMS and SEMS.
- Coordinating and monitoring drills and exercises and participating in setting training standards for Essential Function Personnel and the Emergency Response Team (ERT).
- Serving as a member of the ERT and maintaining capability to fill a number of response roles including Incident Commander or any of the Command Center Section Chief positions.

Emergency Response Team (ERT)

[Click to access: Worksheet 5 and 15: Recall List]

The ABC Safety Team, which consists of staff representing the various work areas of the ABC, acts as the ABC Emergency Response Team (ERT) during emergencies. This group fills the core positions for the ABC response during an emergency. The Incident Manager is the leader of the ERT. The ERT includes the following ABC staff:

- ABC Executive Director.
- ABC Safety Coordinator.
- Members of the ABC Safety Team.
- During a COOP response, ABC Essential Function Personnel (see below).

Essential Function Personnel

Under this plan, ABC personnel who are mobilized and/or relocated under this plan to the selected alternate facility to continue operations and the performance of essential functions are known collectively as Essential Function Personnel. Essential Function Personnel include staff with the technical ability and decision making authority to continue operations of essential functions. Essential Function Personnel may include staff with day-to-day responsibility for the functions as well as staff from other organizational units (e.g., information technology or facilities management) who are required to support the operations of essential functions. ABC maintains 24-hour contact information for Essential Function Personnel.

Essential Function Personnel are designated by position for each of ABC's essential functions.

Immediately following the onset of an emergency (Emergency Response Phase I) the COOP Plan is activated and relocation from the primary facility to the alternate facility is initiated if indicated that it's safe to undertake.

Decision Process

Notification of an emergency or imminent threat may be provided by:

- Local emergency management agency or public health department, or other alerting devices.
- County Sheriff's Office or local Police Department or Fire Department.
- The occurrence of the event (e.g., an earthquake).

If the County Office of Emergency Services issues a warning of an impending emergency affecting the locale of the ABC, the ABC Executive Director assesses the likely impact on ABC and may direct the Emergency Management Coordinator to take one of the following actions:

1. Activation during normal working hours:

- *If the hazard is not imminent or poses no threat to the ABC or its occupants, maintain operations, alert staff of the situation and potential consequences, review emergency procedures, and check the contents of Go-Kits*
- *If the hazard is imminent and poses a threat to the ABC or its occupants, take appropriate protective measures which may include closing the facility and sending patients and staff home; updating call-up lists; checking contents of Go-Kits; and informing staff of when and where they are expected to report. Other response actions may include adopting protective measures to reduce the probability of the spread of infection.*
- *If the hazard is immediate and poses a threat to the ABC or its occupants and it is unsafe to leave the facility, shelter in place until emergency services indicate it is safe to exit.*
- *If an emergency strikes during business hours with no warning or with insufficient warning to confer with the Executive Director, the ABC Clinic Manager implements the ABC emergency plan to protect patients, visitors, and staff, and reports health center status to the Executive Director who determines if and to what extent the ABC COOP Plan should be activated.*

2. Activation outside of normal working hours:

- *Open ABC for business as usual, open ABC with limited staffing for urgent procedures only, or keep the ABC closed until the hazard passes.*
- *The Director may also direct ABC staff to report to work at an alternative work site.*

Alert, Notification, and Implementation Process

[Click to access: Worksheet 5]

If ABC staff receives an alert, she/he will contact the Executive Director who will, if appropriate, activate the ABC response through the EMC.

During normal work hours, the EMC will issue a general alert (e.g., for shelter-in-place or health center evacuation) or notify members of the Safety Committee of the situation and the appropriate protective and response actions to be taken according to the ABC Emergency Plan. Safety Committee members will communicate this information to the staff within their work areas to initiate the response.

During off-hours, once alerted, the Executive Director or EMC will initiate the ABC off-hours calling tree to notify the ERT and provide them with situation status and safety information, and instructions to relay to staff. The ERT will contact staff at their off-hour emergency contact numbers. ERT and other staff will be instructed to tune to local radio or television stations, or other media, for additional situation status information, information about travel routes and conditions, school closings, etc.

Essential Function Systems & Equipment
[Click to access: Worksheet 9, 10, 11]

ABC has identified the supplies, equipment and systems required for maintenance of each essential function. ABC has also identified primary and back-up sources for these resources.

(TBD – Includes Go-Kits, medical supplies and equipment required for triage, and immediate care, and for essential ongoing healthcare services).

Vendors & Other Agency Functions [Click to access: Worksheet 10]

ABC utilizes the following vendors for medical supplies and equipment as well as equipment repairs/maintenance.

B. Essential Functions

ABC has identified the following essential functions [Click to access: Worksheet 2]:

(1) Priority A: Medical care for victims in the immediate aftermath of a disaster that occurs during ABC's normal business hours.

(2) Priority B: On-going essential healthcare services for local area following a disaster. Services may be required to treat injuries or illnesses resulting from the emergency; to reflect increased demand due to loss of hospital and other ambulatory care services, or to relieve patient surge pressures on other community health care providers.

C. Delegations of Authority [See Worksheet 8]

If the ABC Executive Director is unavailable at the time of the emergency, his/her authority is delegated to the following positions:

Position 1: _____

Position 2: _____

Position 3: _____

Delegations of Authority have also been established for other key ABC staff including: Medical Director/Lead Clinician, Finance Director, Safety Director, and other key staff. If other key ABC staff are unable to respond, the ABC Executive Director will ensure their authority is transferred to appropriate ABC staff.

D. Orders of Succession

ABC has developed written orders of succession. If the ABC Executive Director is unavailable for the duration of the emergency, his/her duties and responsibilities are assumed by the following positions:

Successor 1: _____

Successor 2: _____

Successor 3: _____

If the ABC EMC is unavailable, his/her duties are assumed by the following positions:

Successor 1: _____

Successor 2: _____

Successor 3: _____

Additional successors to key positions may be selected by the Executive Director.

E. Alternate Operating Facility(ies)
[See Worksheet 12]

If the ABC is not habitable or loss of utilities and services prevent provision of health care services at that location, ABC staff may, at the direction of the Executive Director, relocate to one or more of the following sites:

- A triage tent setup in the parking lot of the ABC
- *Alternate ABC site 1 (add address)*
- *Alternate site 2 (add address)*

Criteria for selection of the alternate location include:

- Safety;
- Patient accessibility;
- Staff accessibility;
- Availability of utilities and other services;
- Amount of space and appropriateness of configuration for healthcare services;
- Availability of medical supplies and equipment.

The selected alternate site must also allow for 24-hour security and controlled entry.

If the primary ABC facility is safe to enter, medical supplies and equipment can be retrieved for use at the alternate site. Otherwise, these resources will be provided from surviving facilities, stockpiles, or available vendors.

During normal work hours, if safe to travel, ABC staff will self-transport or carpool to the alternate location (if distant) at the assigned reporting time. If the emergency occurs during off hours, staff will report directly to the alternate site.

Immediately following the emergency, ABC staff may provide limited services for several days in the ABC parking lot. For extended operations, ABC will identify a site with utilities that meets requirement criteria and that can be configured for clinical services until ABC can be re-established or another permanent site is located.

F. Interoperable Communications

[See Worksheet 13 and 14: Emergency Contact Information]

ABC maintains redundant critical communication systems that can be moved to the alternate facility. These systems provide the ability to communicate within ABC and with external emergency responders.

ABC will establish and maintain communications between its primary or alternate site, EMS and law enforcement using the following methods:

- Cellular telephones.
- Satellite telephones.
- 440 Mhz radio.
- Hand –held radios (walkie-talkies).
- Pagers.
- Non-secure Telephones.
- Internet connection for email and web access.
- Facsimile.

Collectively, these communications provide:

- Capability commensurate with ABC's essential functions.
- Ability to communicate with essential personnel.
- Ability to communicate with other agencies, organizations, patients and other stakeholders.
- Access to data and systems.
- Communication systems for use in situations with and without warning.
- Ability to support COOP operational requirements.

G. Vital Records and Databases [See Worksheet 9]

ABC ensures patient records are maintained in a secure manner during day-to-day operations. If the health center is evacuated, patient records are maintained in a secure file room.

If the ABC facility is unusable for an extended period, ABC will arrange for recovery of supplies, equipment, and key records as soon as it is safe to do so. The recovery operation will maintain the confidentiality of patient records and other confidential information and security over controlled substances.

If patient records cannot be immediately retrieved, ABC staff will create temporary records for patients served during and immediately following the emergency.

H. Human Capital

Protection of Personnel

ABC's primary human resources strategy is to protect the health and safety of staff during emergencies and to promote preparedness strategies that increase the likelihood that staff will be able to respond. The ABC Emergency Plan has procedures to protect personnel through strict adherence to safety policies and procedures and rapid response to emergencies.

Human Resource Requirements for Performing Essential Functions

This section identifies personnel with key skills or experience and available back-up resources. Human resources planning takes into account:

a. Specialized training or skills that are required to perform the essential function

b. The minimum number of personnel required to perform the essential function

c. Availability of other personnel, with transferable skills, to support essential functions.

Human Resource Policies

All ABC personnel are expected to understand their role in responding to emergencies, be familiar with basic fire and evacuation procedures, participate in emergency preparedness training and exercises, and participate in the ABC response as directed by ABC management.

If an emergency occurs outside normal work hours, ABC staff are required to report to the health center at the start of their normal work shift unless notified to report to work at an earlier or later time or until further notice. If notified not to report to work or if unable to report, ABC staff will provide updated contact information and remain available for callback to work.

All ABC staff are encouraged to develop family preparedness plans that include:

- Emergency supplies including a first aid kit, battery-operated radio and flashlight and water and food.
- A family reunification and communication plan, in the event an emergency occurs during work/school hours.
- Plans for contact, reunification, or support for significant extended family.
- Plans for care of pets.

I. Tests, Training and Exercises

Routine tests, training, and exercises familiarize ABC staff with their roles and responsibilities during emergencies, ensure that systems and equipment are ready to use, and validate certain aspects of the COOP Plan. ABC may use power outages, server crashes, and other ad-hoc opportunities to assess COOP preparedness.

All ABC staff participate in the planning, implementation, and critique of exercises that test the COOP plan. Testing the COOP Plan validates the plans, policies, procedures and systems; identifies Plan deficiencies; and allows for subsequent correction.

ABC provides:

1. Individual and team training of organization personnel.
2. Internal organization testing and exercising of COOP plans and procedures.
3. Testing of communication and coordination.
4. Testing of alert and notification procedures.
5. Refresher orientation for COOP personnel.

The effectiveness of training exercises is documented in post exercise assessment reports and meetings.

J. Devolution of Direction and Control

If ABC is unable to return to operations at its usual site or an alternative site, it will, fully or in part and with the approval of its Board of Directors, transfer its responsibility for its essential functions to another health care provider or providers. These providers include other private practices, community clinics, health centers and hospital outpatient services. ABC will coordinate this step with the County Public Health Department. ABC has identified health care organizations that can accept its patients and made arrangements to transfer patient records to those organizations.

K. Reconstitution

ABC will take the following actions to resume health center services in the County area:

- If feasible, restore services at the previous ABC site by making needed repairs, mitigating hazards, restoring utilities, and replacing/repairing damaged equipment.
- If services cannot be restored at the original ABC site, identify interim or permanent sites for temporary or permanent restoration of essential services.
- ABC staff will be kept informed of decisions and progress in restoring services. Staff will also be notified of interim work sites and schedules.

ABC will also conduct an after-action review of COOP responses and publish a written report detailing successes and needed changes in the COOP Plan, staff training, and response execution.

COOP Maintenance

ABC ensures that the COOP Plan contains the most current information by annually updating the Plan, performing quarterly updates of ABC staff and other contact information, and annually reviewing potential alternate sites and their capabilities. If a disaster requires activation of the ABC COOP Plan, ABC will undertake a comprehensive review of the Plan as part of its after action review.

Appendix

Appendix A: Sample Essential Services Restoration Plan

Provides operational guidance for restoration of essential healthcare services following disruption of ABC services.

Appendix B: Tables and Worksheets

ABC has developed a number operational tables and worksheets for use during a COOP event. They include:

- Key Personnel Roster and Essential Functions Checklists including physicians, nurses and other staff for triage, set-up and logistic support of essential functions.
- Day-to-Day, Weekend and After Hours Service Numbers and Procedures
- General Staff Call-up List and Procedure

Appendix A

ABC—Essential Services Restoration Plan
Function Title: Essential Medical Services (Priority A)

1. Service Restoration Goal

Provide medical services to converging disaster victims.

2. Timeframe Criteria

During normal operating hours: Within two hours
Outside normal operating hours: Within 12 hours

3. Critical Functions

- If required, establish alternate site for services–ABC facility or parking lot.
- Establish triage and stabilization capability with existing staff or request for EMS personnel.
- If facility is damaged, initiate establishment of ongoing medical services at reduced level at an alternate site.

4. Program Description

ABC is responsible for providing a variety of primary care and preventive health services to tribal members and community residents. During a major disaster, area residents may converge on the ABC primary site with disaster-related illnesses and injuries that require immediate attention.

ABC may also be required to provide ongoing services at alternate sites even if its facility is unusable.

5. Support for Other Functions

ABC staff may also be required to support operations at other organization sites.

6. Planning Concepts

- The ABC EMC has primary responsibility for developing and maintaining the ABC Emergency Plan and COOP Plan.
- Occupant safety is the highest priority immediately following a disaster.
- Steps should be taken to ensure occupant safety in accordance with the ABC Emergency Plan.
- The ABC EMC may activate the ABC Emergency Plan.
- This restoration plan may be activated by the Executive Director or EMC.
- Information Management Services will operate from the Logistics Section of the Health Center Command Center. Given the nature of the restoration of this essential function, the leader of the restoration team may be located in the EOC or at a separate alternate facility with a communications link to the Logistics Section Chief at the EOC.
- The ABC Command Center will coordinate provision of support required by the Information Management Services function to implement this restoration plan. Resources may include, but not be limited to, equipment, staff, communications support, administrative support, and necessary supplies.

7. Preparedness Tasks

- Develop a callback list for key ABC staff. Provide copies of ABC Go-kits to staff for in the office and offsite. Update quarterly.
- Establish and maintain a response Go-kit that includes essential forms, supplies, plans, staff roster, and notification lists.
- Establish and maintain a triage Go-kit with medical supplies required for initial triage and stabilization of converging casualties.
- Train selected medical care providers in START triage method.
- Ensure NIMS training for ABC Executive Director, EMC, and Safety Committee.

8. Restoration Assumptions

- Alternate facilities are identified and prepared for occupation.

9. Restoration Team Positions

Restoration Planning Team Members include:

- ABC EMC
- ABC Safety Committee
- Medical/nursing staff for triage function planning

Restoration Plan Implementation Team Members include:

- ABC Executive Director
- ABC Emergency Management Coordinator/ Safety Director
- ABC Safety Committee
- Medical Response Team (TBD)
- Logistic Support (TBD)

10. Line of Succession / Delegation of Authority

- ABC Executive Director
- ABC Deputy Director/Finance Director

11. Initial Actions

- Ensure safety of patient, visitors, and staff.
- Activate ABC Emergency Plan.
- Assess capability to provide essential services.
- Report status to ABC EMC who reports to Executive Director.
- If time permits, ABC staff secures work area and sensitive material.

12. Support Required for Restoration

- Alternate site procurement
- Medical staff augmentation
- Medical supplies and equipment
- Medical transportation coordination

Other:

- Law enforcement support for security

13. Security and Confidentiality Considerations

- Maintain security of patient records
- Maintain security of controlled substances
- Ensure overall site security

14. Alternative Methods to Provide Critical Business Functions

- Transfer services to Health Center
- Refer patients to other healthcare providers in County

15. Alternate Facility

Facility requirements for this function include:

- (TBD – Should be defined in terms of the number of patients who can be seen and number of physicians, nurses, medical assistants and other staff who need work space).

16. Communications Requirements

- Telephone, fax, satellite phone

17. Critical Records, Documents, Databases, and Forms

- Patient records, prescription pads, patient intake forms

18. Testing, Training, and Exercises

- All ABC staff should be oriented to the COOP Plan and to this function restoration plan.
- All ABC staff should participate in an annual exercise of this plan as well as participate in department-wide exercises and training.
- The ABC Clinic Manager, Clinic Coordinator, and Safety Committee should receive training in SEMS and ICS.

Appendix B: Implementing Continuity of Operations Planning Worksheets

Worksheet 1: <Your Practice Name Here>

Practice Center Functions

1. List all agency functions. These functions may be identified through the following sources: agency mission statement, legislation authorizing the agency, regulations promulgated by the agency, standard operating procedures and emergency operating procedures, and former and current agency employees.
2. Determine if the function is essential. By consulting with agency staff and management, reconsider the sources for agency functions. Consider which agency functions should be resumed within 12 hours and should be sustainable for up to 30 days. Many of the services that the agency provides to other agencies and the public will be essential functions. Also, consider those functions that will only be essential during an emergency, and mark them as essential.

1. All Agency Functions	2. Essential?
Adult General Medicine	No
Chronic Disease Management	Yes
Pediatric Services	Yes
Adult Dental	Yes
Home Visitation	No

Worksheet 2:

Essential Functions, Critical Processes and Services and Key Personnel

1. List the functions identified as essential in Worksheet 1.
2. Describe the essential function in terms of what processes and services are necessary to perform that function. (Remember that a very simple essential function may need little description, so the critical process or service may be the same as the essential function.)
3. Prioritize the essential functions based on which essential functions must be resumed first.
4. Identify key positions by comparing the functions identified in Worksheet 1 with the Current Agency Chart on Worksheet 3. Those positions whose functions include critical processes and services are key positions.

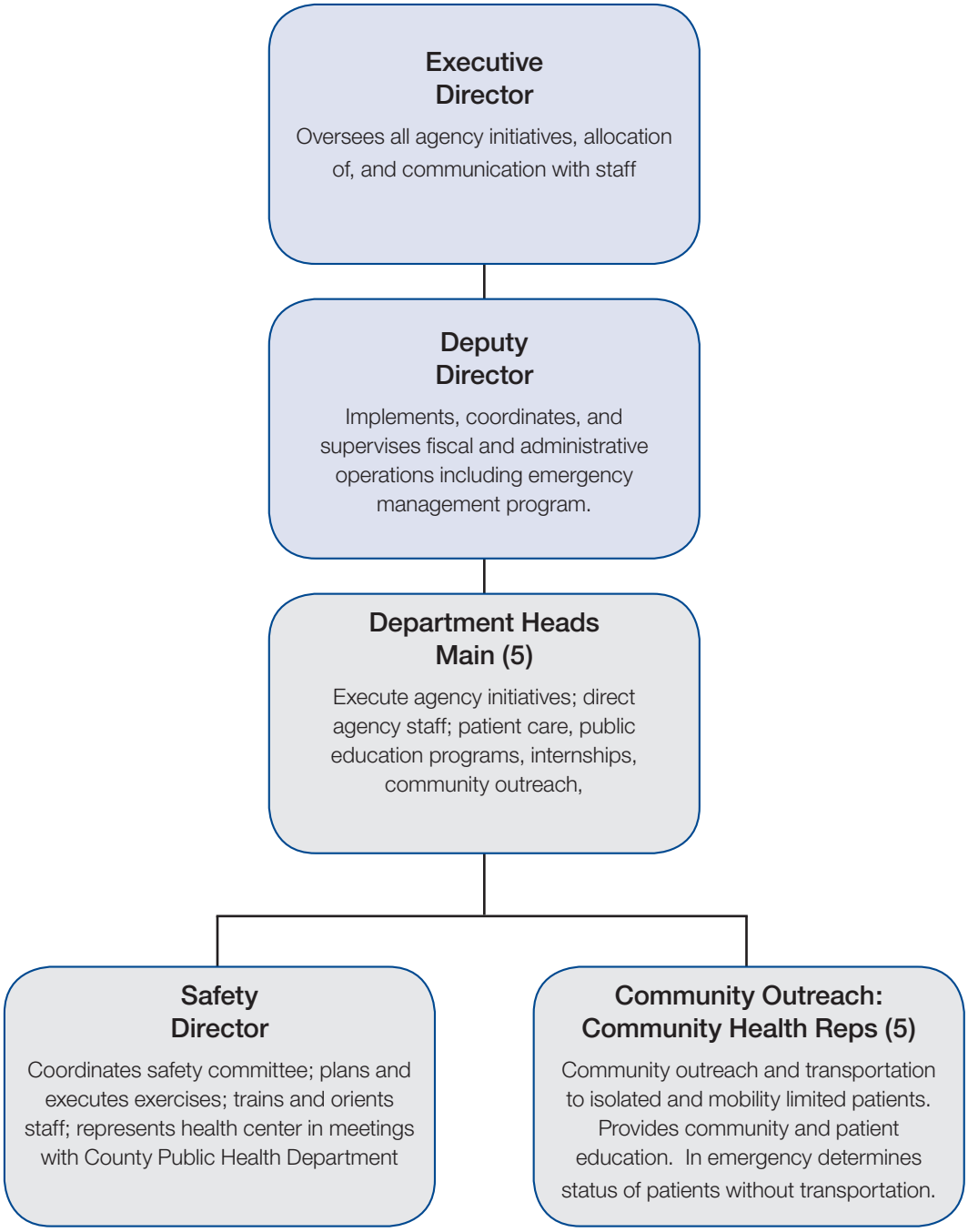
5-8. List the positions that would assume the authority of the key position if it became vacant unexpectedly, and any limitations the successor would have. (The same successors may be named for different key positions, but avoid designating the same position / individual as the first successor for several key positions.)

1. Essential Function	2. Critical Process or Service	3. Priority	4. Key Position(s)	5. Successors 1 & Limitations
Chronic Disease Management	Maintain effective management of patients with hypertension and diabetes	1	Physician CHRs (3)	Nurse Practitioner

Worksheet 3:

Current Organization Chart

Create a current agency chart for your practice. List the name of the position and the position's functions.
This should be a complete chart showing every practice position. The name of the individual in the position may be included.



Worksheet 4:

Alert Systems and Designated Assembly Areas

Worksheet 4 should be completed for each practice building.

1. List an evacuation or shelter-in-place system that is in place to alert building occupants to evacuate or shelter-in-place.
2. Describe the system listed in column 1.
3. Note how frequently the system is maintained.
4. Identify any back-up systems.
5. Identify designated assembly areas for employees evacuating a building in the event of an emergency. If a building has multiple designated assembly areas for different floors or sections of the building, note this in parentheses.

6-7. Identify two alternate assembly areas to be used in the event that designated area cannot be used.

Building: Main (_____)

1. Evacuation or Shelter-in-Place System	2. Description	3. Maintenance Frequency	4. Back-up Systems	5. Designated Assembly Area (Floor/ Section)	6. Alternate Assembly Area	7. Alternate Assembly Area
Telephone intercom system	Alert issued through telephone intercom to all telephones in health center	Yearly	Safety committee members designated to sweep staff and patient areas to ensure all patients, visitors and staff leave when required.	From south end of building, exit to parking lot across the street. From north end, cross street to Wal-Mart	Open field to west of building	High School gymnasium Church Circle

Worksheet 5:

Evacuation Team (EET) and Employee Contact List

Worksheet 5 should be completed for each practice building.

This information is to be treated as sensitive and confidential and not to be used for other than emergency purposes.

1. Under "EET," list the members of the Emergency Evacuation Team (EET). Under "Employee Contact List," list all agency employees.
2. For EET members, designate the building floor or section for which that member of the EET is responsible. For all other employees, list the building floor or section on or in which he or she works.
3. For all employees (those listed under "EET," and those listed under "Employee Contact List"), provide the employees' e-mail addresses.
4. Likewise, their work, home, cell or pager phone numbers, and contact information of at least one emergency contact for each employee.

W: = Work # — H: = Home # — C/P = Cell/Pager # — E = Emergency Contact Information

Building: Main Clinic Facility

1. Employee Name, Title	2. Floor/Section	3. E-mail Address	4. Contact Information #
Emergency Evacuation Team			
	1.		**W:** **H:** **C/P:** **E:**
	2.		**W:** **H:** **C/P:** **E:**
Employee Contact List			
	1.		**W:** **H:** **C/P:** **E:**
	2.		**W:** **H:** **C/P:** **E:**
			W: **H:** **C/P:** **E:**

Worksheet 6:

Forming Family Support and Reconstitution Teams

1. List the employees who will be members of the Family Support or Reconstitution Teams.
2. Describe the roles and responsibilities of each member of each team.

	1. Name	2. Role / Responsibilities
Family Support Team		
Coordinator		Head the family support team. Contact team members to implement family support plan; facilitate implementation of family support plan
Team Member 1		
Team Member 2		
Team Member 3		
Reconstitution Team		
Coordinator		Oversee reconstitution. Determine when to implement reconstitution plan; ensure that building is structurally safe and meets local occupancy regulations; inform appropriate people that main facility is habitable and normal operations are able to be resumed at main office
Team Member 1		
Team Member 2		
Team Member 3		

Worksheet 7:

Counseling Services

1. Determine whether or not the practice will provide counseling services.
2. Designate who will provide the counseling services.
3. Provide a contact person for the service provider.
4. Provide contact information for the contact person.
5. Designate for whom counseling will be provided.
6. List the counseling services available from the service provider.

1. Counseling Provided?	2. Service Provider	3. Contact Person	4. Contact Information	5. Counseling for Whom?	6. Services Provided? Contract Y/N?
Yes	Feel Better Counseling Services		1234 Main St., Ste 201 1st City, 7th State 21210 W: (555)555-1234 awebman@work.com	Employees and their immediate family members Community Health Representatives Patients affected by disaster	Will provide both individual and group therapy sessions; specializes in all aspects of post-traumatic stress disorder (PTSD) Contract

Worksheet 8:

Delegations of Authority

1. List the authority to be delegated.
2. Designate whether the authority is "emergency" or "administrative."
3. List the position which has this authority during normal agency operations.
4. List the conditions that would trigger a delegation of the authority.
5. List the position or positions that will receive the authority if it must be delegated.
6. Indicate any rules that may exist for the delegation of authority.
7. Outline procedures for the delegation, including notifying relevant staff of the transfer of power.
8. Indicate any limitations on the duration, extent, and scope of the delegation.

	Medical Director	Executive Director
1. Authority (Function)	Oversee medical operations. Examine patients, prescribe medications, and provide medical advice.	Responsible for overall management of health center. Decision-making authority over expenditures and other commitments of resources and decision to remain open or evacuate facility. Can request resources from and provide resources in response to requests from other providers and county emergency officials. Reports to Board of Directors or other as designated by contract. Appoints Incident Commander for emergency events.
2. Type?	Emergency	Emergency
3. Position Holding Authority	Health Center Medical Director	Health Center Executive Director
4. Triggering Conditions	Medical Director or other full time clinic physician unavailable due to absence, injury or providing emergency care. Must be approved by Executive Director	Executive Director is incapacitated or unavailable.
5. Position(s) Receiving Authority	(1) Other full time clinic physician (2) Nurse Practitioner (3) Registered Nurse	(1) Assistant Executive Director (2) Finance Director (3) Medical Director
6. Rules	Individual possessing higher authority within the agency is not available	Remains acting until return of Executive Director or decision by Health Center governing body.
7. Procedures	Health Center Executive Director or Medical Director designates most experienced RN as clinic manager.	Assumes position when higher-ranking person is unavailable.
8. Limitations	May perform actions as permitted by license.	Has all authority of executive director.

Worksheet 9:

Records and Databases

1. List the critical processes and services that support essential functions.
2. List the vital records or databases necessary to perform each critical process or service.
3. List the vital records' or databases' form (paper or electronic) / category (emergency or legal) / type (static or dynamic).
4. If the vital record or database is in paper form, identify the record's or database's physical location.
   If the vital record or database is in electronic form, identify the file name and location(s) on a drive.
5. Identify the staff member(s) responsible for maintaining the vital record or database.
6. Identify the network or server that supports the vital record or database.
7. Identify the vital record's or database's Recovery Point Objective (RPO).
8. Prioritize the vital record or database – the shorter the RPO, the higher the priority.
9. Identify any unique risks to which the vital record or database may be susceptible.
10. List the current protection method(s) in place for the vital record or database.
11. In considering what additional measures should be performed to protect the vital record or database, answer the questions:
    Is offsite storage necessary? Should the file be stored in an alternative media? Is duplication necessary?

1. Critical Process or Service	Continued service to persons diagnosed with diabetes and hypertension	
2. Vital Record or Database	Patient records	
3. Form / Category / Type	Paper Electronic	
4. Location	Medical Director or other full time clinic physician unavailable due to absence, injury or providing emergency care. Must be approved by Executive Director	
5. Responsible Staff Member(s)	Medical Records Information Technology Manager	
6. Supporting Network or Server	TBD	
7. Maintenance Frequency	Weekly	
8. Recovery Point Objective (RPO)	1 day	
9. Priority	1	
10. Unique Risk	Must maintain secure storage of medical records	
11. Current Protection Method	Off-site pass word protected electronic records. Daily backup. Paper records in locked cabinets in locked file room	
12. Offsite storage? / Alternative Storage Media? / Duplication?	Off-site storage and daily backup of electronic records.	

Worksheet 10:

Restoration and Recovery Resources

1. List the name(s) of the company the agency uses for record recovery and restoration.
2. Provide a contact person for the company.
3. Provide contact information for the contact person.
4. List the services provided by the company.

1. Company Name	2. Company Contact / Contact Information	3. Essential Function/ Activity Supported	4. Services/ Resources Provided	5. RTO Can Company Meet?	6. Alternative Providers or Strategy
The Paper People	Winston Crane 256 Barker Ave., First City, Seventh State 01011; Phone: (555)555-1369 Hours:8AM-10PM		Assessing and repairing, to the extent possible, the structural integrity of paper records		

Worksheet 11:

Vital Systems and Equipment

1. List the critical processes and services that support essential functions.
2. List the vital systems or equipment necessary to perform each critical process or service.
3. Briefly describe the vital system or equipment.
4. Provide the vital system or equipment's location.
5. Identify the staff member(s) responsible for maintaining the vital system or equipment.
6. Identify the Recovery Time Objective (RTO) for the vital system or equipment.
7. Prioritize the vital system or equipment – the shorter the RTO, the higher the priority.
8. Identify any unique risks or seasonal sensitivities to which the vital system or equipment may be susceptible.
9. List the current protection method(s) in place for the vital system or equipment.
10. List how frequently the vital system or equipment is maintained.
11. Provide any recommendations for additional protection methods for the vital system or equipment.

	Critical Process or Service 1A	Critical Process or Service 1B
1. Critical Process or Service)	Provide critical medications to patients	
2. Vital System or Equipment	Refrigeration for critical medications	
3. Description	Medications must be maintained at temperature below 40° F	
4. Location	Main health center site	
5. Responsible Staff Member(s)	Pharmacist – (Otis Redding) Facilities Manager – (Smokey Robinson)	
6. RTO	12 hours (as long as unit is not opened)	
7. Priority	1	
8. Unique Risks / Seasonal Sensitivity	Loss of critical medications	
9. Current Protection Method(s)	Refrigerator	
10. Maintenance Frequency	Annual	
11. Recommendations for Additional Protection Method(s) (if necessary)	Back-up Styrofoam ice chest. Off-site secure storage – local pharmacy or other secure facility with refrigeration.	

Worksheet 12:

Alternate Work Sites

1. List agency essential functions.
2. List the number of personnel needed to perform that essential function. Remember, this is the number of people that will need to be fed and provided for at the alternate facility.
3. Indicate what electricity requirements are needed to perform that essential function.
4. Indicate the communication requirements needed to perform that essential function.
5. Indicate the space requirements needed to perform that essential function.
6. Indicate whether lodging at the alternate work site will be necessary to perform that essential function, and if so, for how many.
7. Indicate what security requirements may be necessary to perform that essential function.
8. Indicate what secure storage requirements may be necessary to perform that essential function.
9. Considering the essential function requirements identified in columns 1-6, list viable alternate work sites.
10. Provide the alternate work site's address.
11. Indicate what transportation will be provided to the alternate work site, or if key personnel must provide their own transportation.
12. Identify the agreement the agency has in place allowing it to use the alternate work site following a COOP event.
13. Indicate the date this agreement was executed.
14. Indicate the cost to the agency for this agreement.
15. Provide any special notes that should be included regarding the alternate work site.

	Essential Function 1	Essential Function 2 – Clinic Example
1. Essential Function Name	Home Visits to Isolated Elders and Persons with Chronic Conditions	
2. # of Personnel	3 Community Health Representatives	
3. Electricity	Not required	
4. Communication	Phone, hand held radio	
5. Space	Not required	
6. Lodging	Not required	
7. Security	Personal and Health Center identification	
8. Secure Storage	Not required	
9. Alternate Work Site	Home of workers; home of patients	
10. Address	TBD	
11. Transportation	Personal vehicle; health center van	
12. Agreement	N/A	
13. Date Executed	N/A	
14. Cost	Normal salary + overtime	
15. Special Notes	List of priority clients maintained in secure location off-site	

Appendix B: Implementing Continuity of Operations Planning Worksheets

Worksheet 13:

Communications

1. List the current provider for each type of communication system (if applicable).
2. List the services provided by the current provider.
3. List any special services available from the current provider.
4. List at least one alternative provider who may provide the communication system should the current provider be unable to do so.
5. List an alternative mode of communication to the communication system.

Communication System	1. Current Provider	2. Services Provided	3. Special Services Available	4. Alternative Provider	5. Alternative Modes #1 & #2
Voice Lines	Verizon	Local and long distance service; voicemail	Emergency priority access to phone lines during times of limited service	PBX	1. Two-Way Radio 2. N/A
Fax Lines					1. 2.
Data Lines					1. 2.
Cell Phones					1. 2.
Pagers					1. 2.
E-mail					1. 2.
Internet Access					1. 2.
Instant Messaging					1. 2.
Personal Digital Assistants *(PDAs – e.g., Blackberry)*					1. 2.
Radio Communication Systems					1. 2.
TTY (Deaf Teletype)					1. 2.
Other					1. 2.

Worksheet 14:

Emergency Contact Information

1. Provide an emergency number that employees may call to learn about the emergency and the status of the practice.
2. Provide an emergency website that employees may check to learn about the emergency and the status of the practice.
3. Provide the phone number of the agency's State Emergency Operating Center.
4. List a contact with the practice's alternate work site(s), and his or her contact information.

1. Emergency Call-In Number	(555) 684-9652
2. Emergency Website	www.animalhealthCOOP.gov
3. County Emergency Operating Center	(555) 735-0946
4. County Public Health Department Emergency Contact Number	
5. Alternate Work Site Contacts	Aidan York 15 Easton Boulevard (555) 555-9364
Emergency Contacts	
6. Fire Department	911
7. Police Department	911
8. Ambulance/Emergency Medical Services	911
Non-Emergency Contacts	
9. Fire Department	(555) 555-9111
10. Police Department	555) 555-9114
11. Ambulance/Emergency Medical Services	(555) 555-9113

Worksheet 15:

Recall List

Note: Much of the information in this worksheet has already been gathered for Worksheet 5. It is a subset of that information and is organized differently for a different purpose. However, much of it may be taken directly from Worksheet 5.

1. In the cell marked "Director," enter the name of the agency's director or head. Under "COOP Team," enter the names of the COOP team members. Under "Key Personnel & Management," enter the names of the individuals that hold the key positions listed in Worksheet 2, column 4. Also list any individuals who are managers but do not hold key positions.
2. For all employees ("Director," those listed under "COOP Team," and those listed under "Key Personnel & Management"), provide the employees' e-mail addresses.
3. Likewise, their work, home and cell phone numbers.
5. Provide the contact information of at least one emergency contact for each employee.
6. Note the distance between the employee's residence and the main office, as well as the distance between the employee's residence and alternate work site(s).
7. Provide any additional relevant information that may affect the employee's availability following a COOP event, such as family or transportation considerations.

1. Employee Name	2. E-mail Address	3. Work Home Cell #	4. Emergency Contact Information	5. Distance from Main Office and Alternate Work Sites	6. Other
Director: Janice Doe	jdoe2@agency.gov	**W:** (555)962-8374 **H:** (555)224-9876 **C:** (555)772-8841	Chris Bob (uncle) (555)315-9080	Lives 20 miles from Main Office and 15 miles from Health Center	Single parent of 9 month old infant
Management Team					
Jamie Doe	jdoe17@agency.gov	**W:** (555)334-9825 **H:** (555)673-6392 **C:** (555)772-8842	Christine Doe (wife) (555)765-7862	Lives 30 miles from office and 40 miles from Health Center	Relies upon public transportation
		W: **H:** **C:**			
		W: **H:** **C:**			
Safety Team (Emergency Response Team)					
Luke Hyatt	lhyatt@agency.gov	**W:** (555)743-8888 **H:** (555)817-0905 **C:** (555)772-8854	Eleanor Hyatt (wife) (555)847-2736	Lives 2 miles from Main Office and 7 miles from Health Center	Shares car with wife
		W: **H:** **C:**			
		W: **H:** **C:**			

Worksheet 15:

Recall List

1. Employee Name	2. E-mail Address	3. Work Home Cell #	4. Emergency Contact Information	5. Distance from Main Office and Alternate Work Sites	6. Other
Essential Personnel – Triage/Treatment					
		W: H: C:			
		W: H: C:			
		W: H: C:			
Essential Personnel – Relocation Team					
		W: H: C:			
		W: H: C:			
		W: H: C:			
Essential Personnel – Alternate Site Treatment Team					
		W: H: C:			
		W: H: C:			
		W: H: C:			
		W: H: C:			

EMERGENCY PREPAREDNESS TOOLKIT
MOREHOUSE SCHOOL OF MEDICINE

Patient Resources

Create a Family Emergency Plan

Prepare a family emergency plan to be included in your home emergency supply kit. The family plan will list the name, date of birth, social security number, medical information and the work/ school locations for each family. It should also list the important contacts for the family such as doctors, veterinarians, medical insurance, and homeowners/rental insurance. The FEMA, Ready Campaign and the Ad Council have prepared a website to assist your family in developing a family emergency plan. The site and its tools can be found at http://ready.adcouncil.org/beprepared.

As part of your plan, families should also:

- *Identify meeting locations in case you are not able to return to your home or must evacuate quickly.* One meeting location should be within walking distance of your home. Another can be within your local area but not within walking distance of your home. A final location could be a friend or relative's home outside of your local area.
- *Identify an out-of-town contact.* It may be easier to make a long-distance phone call than to call locally, so make one person the out-of-town contact that all family members will contact in case of emergency.
- *Make sure every family member knows the out-of-town contact and their phone number.* Program that person as "ICE" (In Case of Emergency) in your phone. If you are in an accident, emergency personnel will often check your ICE listings in order to get a hold of someone you know. Make sure to tell your family and friends that you've listed them as emergency contacts.
- *Create emergency response cards for all of your family members and place copies in wallets, purse and backpacks.*
- *Teach all family members how to use text messaging.* Text messages can often work when cell phones are unable to be completed.
- *Subscribe to alert services.* Visit your local Office of Emergency Management and/or local government website to sign up for emails, newsletters and other alerts that will inform you of bad weather, road closings, local emergencies or other disasters.

You may also want to inquire about emergency plans at places where your family spends time: work, daycare and school. If no plans exist, consider volunteering to help create one. You will be better prepared to safely reunite your family and loved ones during an emergency if you think ahead and communicate with others in advance.

Prepare the Whole Family

After creating a plan, share the plan with your entire family. Talk with your family at an age appropriate level about potential emergencies and how your family has prepared. Show the family actions that have been taken to prepare your household and simple steps that can increase their safety.

- *Create emergency response cards for each member of the family.* For children or vulnerable adults include his/her full name, nicknames, address, phone number, responsible adult's phone numbers and out of state contact.
- *Point out the home emergency supply kit and go bags to the whole family.*
- *Share the neighborhood meeting place.*
- *Practice your evacuation routes and Stop, Drop & Roll drills.*
- *Make sure all family members know who the out-of-town contact is and how to call this person to let them know where they are.*
- *Teach children basic personal information and parents' full names in case they become separated from a parent or guardian.*
- *Teach children to dial their home telephone number and Emergency 9-1-1.*

Determine Your Risk

Investigate your community to determine what types of emergencies/disasters are most likely to occur in your community and make sure your emergency plans consider all types. Consider both climate as well as the landmarks (i.e. streams, train tracks, high-rise buildings, valleys, etc.) in your area. Learn what methods might alert you to an emergency. Your family might hear a siren, get a telephone call from a local alert system or hear an emergency radio and TV broadcast.

Deciding to Stay or Go

For any emergency/disaster, the first decision for your family is to stay where you are or evacuate. In creating a plan for your family, you should prepare for both leaving and staying in your community. Most often, the information provided by local authorities on evacuation plans are based on the best information they have available and should be headed. Use your common sense and the information on hand, including this sheet, to determine the danger (i.e. lack of food, damage to physical structure, power outages) to your family and "worst case scenarios" should you choose to stay after an evacuation has been ordered. You should continue to watch TV, listen to the radio and check the Internet for new information as it becomes available. You may also want to inquire about emergency plans at places where your family spends time: work, daycare and school. If no plans exist, consider volunteering to help create one. You will be better prepared to safely reunite your family and loved ones during an emergency if you think ahead and communicate with others in advance.

Personal Preparedness Checklist

In the event of an emergency, utilities and usual services, such as running water, electricity and gas, may be unavailable. Experts recommend that your family should be prepared for at least three days. Store your home emergency supply kit in an easy to access location in your home. Put the contents in a large, watertight container that you can easily move.

This list was adapted from *Survival: How Being Prepared can Keep You & Your Family Safe* by Lt. General Russel L. Honoré, US Army (Ret).

Recommended Items to Include in Home Emergency Supply Kit

Water

Plan at least one gallon of water per person per day for at least three days.Children, nursing mothers and ill will need more. Store the water in containers that will not break or decompose.

Food

Include at least a three-day supply of non-perishable food for all members of the family (including infants or others on special diets). Consider high-protein and ready to eat foods that don't require refrigeration, preparation, cooking or little/no water. Make sure to include a can-opener if canned foods are included. Examples– packaged milk and juices, granola bars, peanut butter & crackers, canned meats and fruits.

Clothing & Basic Supplies

Include at least one complete change of clothing per person with a long sleeve shirt, long pants and sturdy shoes. Update the clothing to reflect the current time of year and sizes of family members.

- Go Bag for each member of the family*
- Personal hygiene items including toilet paper, feminine supplies, hand sanitizer, soap, toothbrushes and toothpaste
- Diapers
- Denture needs
- Hats & Gloves
- Rain gear
- Warm blankets or sleeping bags for each person
- Moist towelettes or baby wipes, garbage bags and plastic ties for personal sanitation

First Aid & Medical Supplies

- Extra Prescription Drugs & Glasses or Copies of Prescriptions
- List of all currently prescribed medications for all family members with the name of the medication, dosage, frequency and the prescribing doctors name.
- First aid kit
  - —Bandages in various sizes
  - —Antiseptic Wipes
  - —Germicidal Hand Wipes
  - — Cold Pack
  - — Sterile Dressings & Gauze Pads
  - — Tweezers
  - — Adhesive Tape
  - — Scissors
  - — First Aid Manual
  - — Antibacterial ointment
  - — Medical Grade Non-Latex Gloves
- Nonprescription Drugs (Adult, Infant & Children Strengths)
  - —Aspirin or nonaspirin pain reliever
  - —Antacid
  - — Antidiarrhea medication
  - — Laxative

Personal Preparedness Checklist continued

Tools & Supplies

- Cell phones and chargers
- Cash or traveler's checks and change
- Matches in a waterproof container
- Wrench or pliers to turn off utilities
- Duct Tape
- Flashlight and extra batteries
- Fire Extinguisher
- Whistle to signal for help
- Insect Repellent
- Plastic Sheeting
- Mess Kits, or paper cups, plates & plastic utensils
- Battery-powered or hand crank radio and a NOAA Weather Radio with tone alert and extra batteries
- Any communication devices (landline phones, wireless laptops, walkie-talkies, GPS devices, text messaging devices, portable radio, etc)
- Household chlorine bleach and medicine dropper – When diluted nine parts water to one part bleach, bleach can be used as a disinfectant. Or in an emergency, you can use it to treat water by using 16 drops of regular household liquid bleach per gallon of water. Do not use scented, color safe or bleaches with added cleaners.

Other Items

Copies of important family documents in a waterproof, portable container
- — Driver's license or identification card, passports, social security cards
- — Birth and death certificates
- — Insurance policies
- — Bank account numbers, credit card numbers and companies
- — School records, transcripts, diploma and degrees
- — Important telephone numbers

- Local maps
- Books, games, puzzles or other activities for children
- Permanent marker, paper and pencil
- Portable music or video device

*Go-bag

The following items should be put together in a backpack or other easy to carry bag in case of a quick evacuation. Prepare one Go-bag for each family members and make sure the bag has an I.D. tag.

- Some water and food
- Toothbrush and toothpaste
- Copy of health insurance and identification cards
- Any special needs items for children and seniors.
- Extra keys to your house and vehicle
- Prescription medications and first aid supplies
- List of emergency point-of -contact phone numbers
- Sturdy shoes, a change of clothes, and a warm hat
- List of allergies to any drug (especially antibiotics) or food
- Emergency cash in small denominations and quarters for phone calls
- Extra prescription eye glasses, hearing aid or other vital personal items
- For children, include a family picture and favorite toy or game to help calm them.

Additional Suggested Resources

Honore', R.L. & Martz, R. (2009). *Survival: How Being Prepared can Keep You & Your Family Safe. New York, NY: Atria Books.*

Ready.gov Get a Kit offered by: ready.gov – http://www.ready.gov/america/getakit/index.html

Emergency Preparedness & You offered by the Centers for Disease Control and Prevention – http://www.bt.cdc.gov/preparedness/

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Household Information Sheet

Home Address:	
Home Phone Number:	Nearest Cross Streets:
Emergency Contact Name:	Phone Number:
Out-of-Town Contact Name:	Phone Number:
Out-of-Neighborhood Meeting Place:	

Fill out the following for each member of your household and keep it up to date. Consider putting recent pictures to assist with identification.

A	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
B	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
C	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
D	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		
E	Full Name:	Physical Description:	
	Date of Birth:	SS#:	Cell Phone:
	Allergies & Medical Conditions:		

Work/School Locations

	Name	Address	Phone Number
A			
B			
C			
D			
E			

Personal Resources Contact Information

	Name	Phone Number	Policy Number
Physician			
Pediatrician			
Pharmacy			
Dentist			
Church			
Medical Insurance Company			
Medical Insurance Company			
Homeowners/Renters Insurance			
Auto Insurance			
Veterinarian			
Medical Supply Company			

Utility Companies

	Name	Phone Number	Account Number
Electrical Service Provider			
Gas Service Provider			
Water Service Provider			
Phone Service Provider			

Local Emergency Contacts

Emergency Police, Fire & Ambulance: **911**

Non-Emergency Police: _____

Local Government Alert Website: _____

Local Emergency Management Agency Office: _____

Information Sources

Local Radio Stations: _____ TV Stations: _____

FEMA Ready.gov – A resource to assist in preparing your family. www.ready.gov

American Red Cross Safe & Well Website
After a disaster, register to let your family and friends know that you are safe and well or to check the safety of family members.
https://safeandwell.communityos.org

Emergency Preparedness & You - Centers for Disease Control and Prevention (CDC) and the American Red Cross have teamed up to answer common questions and provide step-by-step guidance you can take now to protect you and your loved ones. http://www.bt.cdc.gov/preparedness/

Wallet Emergency Response Card

Name:

DOB:

Local Emergency Contacts:

Name	Phone

Out-of-state Contact/Phone:

Name	Phone

Health Information

Physician:

Phone:

Chronic Conditions & Allergies

Pharmacy:

Phone:

Medications:

Name	Dosage	Frequency

TO PREPARE FOR AN EMERGENCY

- Keep your emergency contacts and medication lists correct and up-to-date.
- Keep emergency supplies in your car, including comfortable shoes, water, food and warm clothes.
- Designate an out-of-state contact to relay family emergency information.

Wallet Emergency Response Card

Name:

DOB:

Local Emergency Contacts:

Name	Phone

Out-of-state Contact/Phone:

Name	Phone

Health Information

Physician:

Phone:

Chronic Conditions & Allergies

Pharmacy:

Phone:

Medications:

Name	Dosage	Frequency

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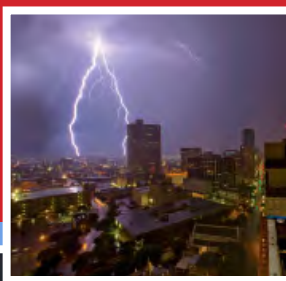
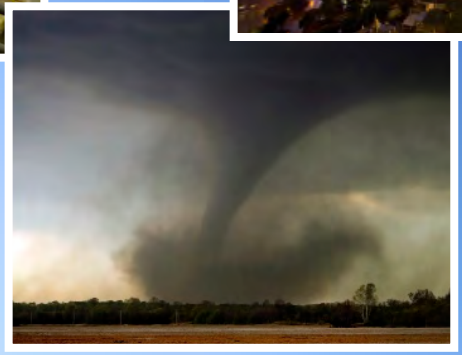
Appendix & Supplemental Documents





EMERGENCY PREPAREDNESS TOOLKIT
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The National Incident Management System (NIMS)

The National Incident Management System (NIMS)

As you develop practice specific practice responses for emergencies, you will be most impacted by the National Incident Management System (NIMS) guidelines as found in the National Response Framework. NIMS provides the template for the management of incidents and will guide how a practice participates in recovery efforts from preparedness though to ongoing management and maintenance.

NIMS is based upon Incident Command Structure and was formalized by Homeland Security Presidential Directive 5 following September 11, 2011 to develop a comprehensive, national approach to incident management that provides the template for how to respond to incidents. It is applicable for all levels of government, the private sector, and nongovernmental agencies. Similar to Incident Command System (http://www.fema.gov/emergency/nims/IncidentCommandSystem.shtm), NIMS can be scaled for any size incident and event; it is not solely related to emergency response efforts.

NIMS is:

- A core set of doctrine, concepts, principles, terminology and organizational processes for all hazards.
- Essential principles for a common operating picture and communications interoperability.
- Standardized resource management procedures for coordination among different jurisdictions and organizations.

NIMS' five key areas of focus to form a comprehensive incident management system are:

- *Preparedness* – NIMS preparedness requires the partnership of all levels of government, private sector and non-governmental organizations. NIMS preparedness encompasses an ongoing cycle of planning, organizing, training, equipping, exercising, evaluating and taking correction action.
- *Communications and Information Management* – NIMS prompts the use of flexible communications and information systems. It builds on the concepts of interoperability, reliability, scalability, and portability.
- *Resource Management* – NIMS describes standardized resource management practices such as typing, inventorying, organizing and tracking for the effective sharing and integration of critical resources across jurisdictions.
- *Command and Management* – NIMS enables effective and efficient incident management and coordination by providing a flexible, standardized structure with three key organizational concepts, the Incident Command System, Multiagency Coordination Systems, and Public Information.
- *Ongoing Management and Maintenance* – The FEMA National Integration Center's Incident Management Systems Integration (IMSI) Division provides strategic direction, oversight, and coordination of NIMS.

For further regarding NIMS, please consult: http://www.fema.gov/nims.

There are several different levels of NIMS trainings based on your role during an incident. Please consult the FEMA Emergency Management Institute to learn more about the specific needs for your anticipated role at: http://training.fema.gov/is/nims.asp.

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The Planning Process

The Planning Process

Step One: Form a Planning Team

The planning team should be comprised of representatives from different areas and functions of the practice. Key members should be the clinic or practice manager, chief medical officer or other medical designee, and representative from the front desk staff. For larger practices or clinics, other members included are public information officers, representatives from human resources, a representative from the security staff, a representative from social services staff, and representatives from any other agencies leasing/ sharing space within the facility (i.e. local public health, WIC agency). Finally, if possible, it is suggested to include a patient representative on the planning committee to help bring the patient's perspective = to the plan.

Step Two: Assess the Hazards & Risks

The most basic preparation for risk management involves identifying the threats to a practice. State and local emergency management agencies are required by FEMA regulations to complete comprehensive local hazards for their communities. To receive the most accurate and complete information to assist in the development of your plan, contact your local emergency management agency to receive a copy of their comprehensive plan. This information will assist you in providing an assessment of the natural hazards, technological hazards, and human-caused hazards for your area.

Consider using a hazard assessment tool and facility checklist such as those found in the templates and resources section of this guide to evaluate your onsite risks and mitigation abilities.

Step Three: Determine Goals & Objectives

The goals and objectives of a plan support the plan's purpose (or mission). The goals are broad statements that respond to the problems identified during the hazard and risk assessment. The success of the goals is determined after the responses are complete and the major priorities have been met. Objectives are more specific actions that are carried out during the response. These are the actions that will help ensure the goals are met.

Step Four: Plan Development

The planning team should identify all the resources (physical, staffing, informational) needed for the successful implementation of the goals in different emergency scenarios. During this step, the planning team can develop a list of resources needed and compare the list of needed resources with available resources. Special attention should be provided for the resource needs of patients who receive services from the site (i.e. pharmacy refills, durable medical equipment.) The list should also include informational needs that will help develop the plan and deadlines for collecting information.

All the information collected to this point should be used in creating a draft of a plan. The planning team, or a subcommittee, should take responsibility for developing a fully-completed, rough draft of the basic plan. Make sure to provide the plan and its documents in alternate formats (i.e. pdf, Word documents, .jpeg) and locations (i.e. main location, satellite locations, office email address) for ease of use by different audiences.

Once the final draft of the plan has been completed, the plan should be presented and formally adopted by the senior leadership of the practice or clinic. Copies should be provided for all satellite locations and departments.

Step Five: Plan Implementation

After developing the plan, it should be formally disseminated and mangers should be required to train their staff so they have the knowledge, skills and abilities needed to perform tasks identified in the plan. Staff should also be briefed on the change of command and communications policies for their site. Ideally, the site will conduct exercises using the plan to determine areas of weaknesses and strength. The plan should be revised based upon the outcomes of the exercises.

Planning is an ongoing effort and the plans should be reviewed on a regular schedule. Plan updates should be done after major incidents, changes in staff, changes in local hazards or the enactment of new laws.

EMERGENCY PREPAREDNESS TOOLKIT
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Practice Communications

Practice Communications

Here are some points to consider when developing a communications plan for your practice in the aftermath of an event.

- *Designate three people who have the authority to share messages and act as a spokesperson for your practice.* Consider having the spokesperson complete an online crisis communication course.
- *Share only the information you know to be true.*
- *Use your voicemail system, social media sites and websites to provide an update on the status of your practice.* Advise patients on when you anticipate reopening, the locations where you know they can receive assistance, and a method by which they can reach a provider for your practice. If you cannot provide a reopening date or a provider to contact, advise patients of this information.
- *Use your communication systems to direct patients to reputable sources of information.* Consider directing patients to a local chapter of the Red Cross, cdc.gov and local news sources to learn more about medical treatment options.
- *Send the practice information update to your list of local news stations.* Find out deadlines in advance and meet the deadline when sending out information.
- *Create short messages.* Provide all relevant information in less than 30 total words if possible.
- *After an event, review the communications strategy and share any areas that can be improved.*

Additional Resources

Crisis and Emergency Risk Communication training course offered by the Centers for Disease Control and Prevention – http://emergency.cdc.gov/cerc/CERConline/index.html

Natural Disaster Public Service Announcements (PSAs) and Podcasts offered by the Centers for Disease Control and Prevention – http://www.bt.cdc.gov/disasters/psa/

Emergency Communications Toolkit offered by Washington State Department of Health – http://www.doh.wa.gov/phepr/toolkit/

Media Contact List

	Email/Website	Telephone	Notes
Media – Television (ABC Network)			
Media – Television (NBC Network)			
Media – Television (CBS Network)			
Media – Television (FOX Network)			
Media – Television (PBS Network)			
Media – Television (Local Network)			
Media – Radio			
Media – Radio			
Media – Radio			
Media – Radio			
Media – Radio			
Media – Newspaper			
Media – Newspaper			
Media – Newspaper			
Media-Website			
Other Numbers			

EMERGENCY PREPAREDNESS TOOLKIT
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Partnerships and Building Connections

Partnerships and Building Connections

Past experiences have shown that during a disaster or an event, the resources needed to rebuild a community may come from unexpected sources. An example might be the culinary students at a technical college preparing meals for medical teams located at a town hall using the propane provided by a home improvement store. While none of these would appear to be traditional partners in emergency recovery efforts, they all provide an important service. Making these connections in advance is critical for easing the recovery and rebuilding efforts of a community.

- *Determine and recruit local partners. Attend local chamber of commerce or business association meetings to determine who the partners in your community are. Reach out to organizations within a half-mile radius of your office.* Share your emergency plans and ask about theirs. See if there are areas of overlap where resources can be shared in case of emergency. Compile all partners into one listing and include listing in emergency plan materials (Click to access: Community Partner Contact List).
- *Share preparedness promotion with community organizations.* Community organizations can help prepare their members in advance by distributing information about household preparedness.
- *Ask community organizations to share information in the event of an emergency.* Local organizations can provide announcements and updates to the community from a trusted and credible source. They can also refer patients, who need assistance with mental health or other referrals, to your center.
- *Use the community organizations to build a resource list.* Community organizations may have access to non-medical resources, such as housing assistance or food assistance that your patients may need after an event.
- *Consider developing a Memorandum of Understanding (MOU) to guide the partnerships.* The purpose of the MOU is to establish a working relationship between two or more parties, indicating a common line of action. It is not considered a legal commitment but provides guidelines for how organizations are willing to assist each other. (Click to access: Emergency Management MOU Template)
- *Determine who should be involved in the MOU.* While only certain organizations (i.e. providers and clinics that provide direct patient care) should be considered as direct partners in the MOU, consider identifying other stakeholders that should be informed and may assist in other ways.
- *Build support and a consensus for the MOU from the management of all stakeholders.* Share the draft MOU internally to determine any areas that need clarification or revision from the perspective of providers and staff.
- *The MOU should be as concise as possible.* Guidelines and procedures should be developed separately but become part of the MOU, by reference, when approved.
- *The MOU should include a reimbursement provision.* Reimbursement shall not duplicate any state or federal assistance available.

Additional Resources

- *Working with Your Community: Preparing for Emergency Response* – Published by Community Health Care Association of New York State (CHCANYS). This document shares best practices and guidelines for creating partnerships with different agencies in your community. (Click to access: http://www.mpca.net/Client/MPCA/Files/CHCANYSEP_WorkingWithYourCommunity.pdf
- *SAFECOME, Writing Guide for a Memorandum of Understanding* – Published by US Department of Homeland Security. This document provides direction on how to write a Memorandum of Understanding between two agencies. http://www.safecomprogram.gov/library/Lists/Library/Attachments/145/MOU.pdf

Emergency Management Memorandum of Understanding Template

Emergency Management Memorandum of Understanding Template

Emergency Management Memorandum of Understanding (MOU) between _____ (Medical Practice) and (Partner) _____ which calls for both authorities to establish and maintain a coordinated program for enhancing Emergency Management

WHEREAS, _____ (Medical Practice) and (Partner) _____ are subject to danger and damage anytime from flooding, tornadoes, high winds, lightning, hazardous material incidents and other acts of nature or terrorism; and

WHEREAS, _____ (Medical Practice) and (Partner) _____ propose this Emergency Management Memorandum of Understanding (MOU) to establish a formal working Mutual-Aid relationship between (Partner) _____ and the _____ (Medical Practice) in support of Emergency Management planning, response and recovery programs; and

WHEREAS, (Partner) _____ and _____ (Medical Practice) have established emergency response plans to reduce the loss of life and property and protect citizens from all types of hazards through a comprehensive, risk-based, all-hazards emergency management program of mitigation, preparedness, response and recovery; and

WHEREAS, in light of their respective common goals to reduce the loss of life and property from natural or man-made emergencies or disasters, _____ (Medical Practice) and (Partner) _____ recognize the need to maintain a strong coordination at a level that ensures efficient use of all available resources, consistent with the principles of each entity; and

WHEREAS, _____ (Medical Practice) and (Partner) _____ agree to encourage, coordinate, promote, and support an ongoing relationship between both entities and to hold periodic partnership meetings to focus on, but not limited to, identifying and assessing an all-hazards approach and associated risks, particularly as they relate to _____ (Medical Practice) and (Partner) _____; and

WHEREAS, _____ (Medical Practice) and (Partner) _____ would benefit from the development and adoption of this MOU; and

WHEREAS, both parties agree, but not limited to the following:

- *Cooperate in all areas of mutual interest as it relates to Emergency Management: sharing data, information, planning, response, recovery, and other operational support programs;*
- *Enhance and maximize both Emergency Management program capabilities of both participants for the purpose of protecting the public health and safety, the (Medical Practice) environment, and to preserve and safeguard property;*
- *In the event of an emergency or disaster declared by the jurisdiction, provide a rapid coordinated and effective response with full utilization of all resources of both participant jurisdictions, including any resources on hand or available that are essential to the safety, care and welfare of those impacted.*
- *Each jurisdiction shall appoint an individual representative to serve as a point of contact for matters relevant to this MOU.*
- *This MOU becomes effective on the date of execution and shall remain in effect unless terminated, by written notification, by either jurisdiction to the other.*
- *This MOU may be amended by written mutual agreement.*

WHEREAS, _____ (Medical Practice) has considered this Multi-Jurisdictional MOU and has determined that it is in the best interest of the (Medical Practice) to approve such an MOU,

NOW, THEREFORE, BY THESE PRESENTS BE IT HEREBY CONFIRMED BY THE _____ (MEDICAL PRACTICE) IN _____ THAT (Partner) _____ and the _____ (Medical Practice) Memorandum of Understanding (herein referred to as the "Emergency Management MOU") therein is hereby approved and that upon adoption of the MOU by (Partner) _____ and all previous versions are hereby abrogated.

EXECUTED THIS _____ DAY OF _____ 20__.

_____

Name, (Executive Director/Owner/Responsible Party)

_____ (Medical Practice)

_____

Name, (Executive Director/Owner/Responsible Party)

_____ (Partner).

Morehouse School of Medicine
720 Westview Drive SW
Atlanta, GA 30310-1495