

A P P E N D I X A

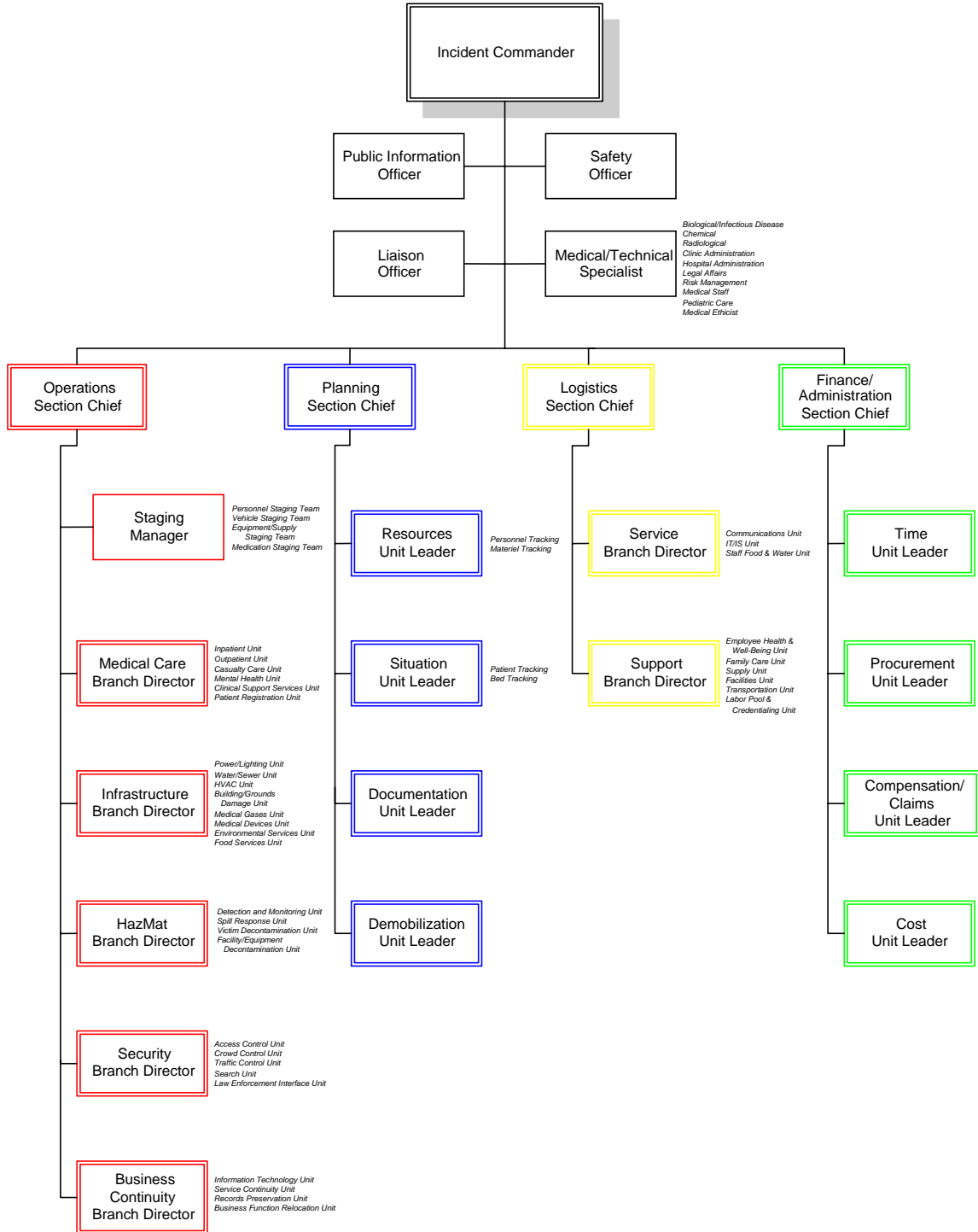
Incident Planning Considerations

- ❖ Hospitals should not plan or respond to emergencies in a vacuum. Successful integration with the local/tribal and state response community (public and private) starts with prevention, mitigation, and response planning; continues with training and exercises; and culminates in the actual response.
- ❖ Emergency management planning is continuous and must address regulatory standards and identified hazard vulnerabilities along with community response expectations and need.
- ❖ Regular training and exercising on incident management and emergency response procedures must be provided to ensure adequate staff preparation, competence, and confidence. The writing and publication of a comprehensive After Action Report is a vital means of ensuring all staff learn from training exercises and “live” incidents.
- ❖ Effective hospital planning with the community better ensures business continuity during and following an incident, regardless of its nature, complexity, or duration.
- ❖ Solicited and unsolicited volunteers will offer assistance; their utilization and support requirements should be addressed in the Emergency Operations Plan.
- ❖ The public expects a hospital to respond to an emergency situation in an appropriate, efficient, and timely manner, regardless of the nature of the incident.
- ❖ The public will seek healthcare assistance and safety regardless of the size of the hospital, services provided, or its operational status.
- ❖ Staff health and safety while meeting the hospital’s medical mission are the highest priorities in responding to any type of incident.
- ❖ Patient protection is essential and includes providing for their physical and emotional care, shelter, and appropriate situational information to properly inform and allay fear whenever possible.
- ❖ Providing for staff family support is vital to maintaining hospital operations and should be addressed in response planning.
- ❖ To be successful in managing any crisis or untoward situation, response practices must be scalable and flexible and adapted to meet the challenges posed by each incident.

- ❖ Victims may arrive with little or no warning. Information concerning hazardous materials or other chemical, biological, and/or radiation related incidents will not be immediately available.
- ❖ Not all patients with potential secondary contamination from a hazardous material will have been decontaminated prior to arriving at the hospital.
- ❖ A significant percentage of the persons seeking care will have experienced little or no exposure or harm but will still expect medical evaluation.
- ❖ Most victims will go to the hospital closest to the site where the incident occurred.
- ❖ Not all emergencies impacting a hospital will involve casualties but they will still require that effective incident management principles be used to mitigate the situation.
- ❖ Research has shown that disaster victims will come to the hospital via a variety of means and not simply by Emergency Medical Services. Self-referrals may account for more than 80% of those presenting for evaluation and treatment.
- ❖ Critical in helping prevent the hospital(s) from being overwhelmed by persons not requiring hospital evaluation and care will be:
 - The ability of other members of the healthcare system (physicians' offices, urgent care facilities, clinics, and pharmacies) to maintain or expand their daily service capability.
 - The effectiveness of a risk communication (including crisis communication) and a public education program before—not just during and after—an incident. The information provided should include appropriate guidance for all age groups and populations and be shared in a timely and effective manner.
 - The effective use of the media to convey information during and following an incident. The information provided to the public must include direction on what actions should and should not be taken, along with appropriate details about the incident and the actions being taken by the response community (including the hospital). Contradictory or confusing messages coming from different sources must be avoided. “One message many voices” must be the practice.

APPENDIX B

HICS Incident Management Team Chart



A P P E N D I X C

Using the Job Action Sheets

Purpose: To provide the user with a series of action options to consider when serving in a particular command role.

Use: The Hospital Incident Command System currently provides 78 Job Action Sheets (JASs) for addressing all types of hospital needs. However, in most cases only a portion of these positions will be necessary for a successful response. The items listed are minimum considerations for developing a JAS. A variety of other considerations may be included, based on hospital size, available resources, or response needs. Thus, each hospital can take the prepared JAS and use them as written, modify them as needed, or craft their own, unique JAS using the HICS model as a template.

Format: The key format considerations for each JAS are the same and include the following information:

- *Command Title* – the name of the position
- *Mission* – a brief statement summarizing the basic purpose of the job
- *Fundamental Information Box* – details information pertaining to who is assigned the position, where they are physically located, and basic contact information
- *Action Considerations* – suggested action steps listed by operational periods; the time periods are listed as:

Immediate	0–2 hours
Intermediate	2–12 hours
Extended	Beyond 12 hours
Demobilization/System Recovery	
- *Documents/Tools* – a listing of pertinent HICS forms this position is responsible for using, along with other tools that will help them fulfill their role and responsibilities

The JASs are designed to be customized, but hospitals are encouraged to maintain the prescribed format and terminology as a means of ensuring the standardization benefit of NIMS. Each hospital should look closely at the items listed in the Documents/Tools Section and make modifications appropriate for their facility and community. The format also allows for the JASs to be used to preliminarily document actions taken during the incident and assist in developing a chronology of events, problems encountered, and decisions made.

When each JAS review is complete, it is recommended that one set be laminated and multiple paper copies duplicated for use and documentation during response. The JASs should be kept with the Incident Command identification (vest) for the position, along with needed administrative items such as pens and paper.

APPENDIX D

Using the HICS Forms

Purpose: To provide the incident management team with the documents needed to manage a response.

Use: Each form is designed for a particular purpose identified at the bottom of the form. Many of the documents are FEMA forms that have been modified to promote their use by hospitals; the FEMA ICS form numbers have been retained for forms. Other forms have been adapted from HEICS III or adopted from hospital best practices. It will be important that the information included on any form is legible and as complete as possible. Once the form is complete, it should be sent via the most immediate means possible (e-mail, fax, in person) to the designated recipient(s) indicated at the bottom of the page and as indicated on the instruction sheet that accompanies each form. Note that the forms can be printed with the instruction sheet on the reverse.

Available Forms: See the table below for a complete list of the twenty (20) forms that have been developed for HICS, who has responsibility for completing each form, and when the form is to be used.

NO.	NAME	RESPONSIBLE FOR COMPLETION	WHEN COMPLETED
201	Incident Briefing	Incident Commander	Prior to briefing in the current operational period.
202	Incident Objectives	Section Chiefs	Prior to briefing in the current operational period.
203	Organization Assignment List	Resources Unit Leader	At the start of the first operational period, prior to each subsequent operational period, and as additional positions are staffed.
204	Branch Assignment List	Branch Directors	At the start of each operational period.
205	Incident Communications Log (Internal and External)	Communications Unit Leader	Whenever possible prior to an event, at the start of each operational period, and as changes are made.
206	Staff Medical Plan	Support Branch Director	At the start of each operational period.
207	Incident Management Team Chart	Incident Commander	Whenever possible prior to an event, at the start of each operational period, and as changes are made.
213	Incident Message Form	All Positions	When intended Receiver is unavailable to speak with the sender or when a communication includes specific details which accuracy needs to be ensured.



NO.	NAME	RESPONSIBLE FOR COMPLETION	WHEN COMPLETED
214	Operational Log	Command Staff and General Staff	Continuously as a tool used to record major decisions (and critical details as needed) at all levels, from activation through demobilization.
251	Facility System Status Report	Infrastructure Branch Director	At start of operational period, as conditions change, or more frequently as indicated by the situation.
252	Section Personnel Time Sheet	Section Chiefs	Throughout activation.
253	Volunteer Staff Registration	Labor Pool & Credentialing Unit Leader	Throughout activation.
254	Disaster Victim/Patient Tracking Form	Patient Tracking Manager	Hourly and at end of each operational period, upon arrival of the first patient and until the disposition of the last.
255	Master Patient Evacuation Tracking Form	Patient Tracking Manager	As decisions are made and as information is determined concerning patient disposition during a hospital/facility evacuation.
256	Procurement Summary Report	Procurement Unit Leader	Prior to the end of the operational period and as procurements are completed.
257	Resource Accounting Record	Section Chiefs	Prior to the end of the operational period or as needed.
258	Hospital Resource Directory	Resources Unit Leader	Whenever possible prior to an event, at the start of each operational period, and as changes are made.
259	Hospital Casualty/Fatality Report	Patient Tracking Manager	Prior to briefing in the next operational period.
260	Patient Evacuation Tracking Form	Inpatient Unit Leader, Outpatient Unit Leader, and/or Casualty Care Unit Leader	As patients are identified for evacuation.
261	Incident Action Plan Safety Analysis	Safety Officer	Prior to safety briefing that is part of shift briefings conducted for all staff at the start of each operational period.

A P P E N D I X E

HEICS to HICS: Some Suggested Implementation Steps

The following are suggested steps for hospitals to consider when implementing the Hospital Incident Command System (HICS) into their facility.

A. Planning

1. Review your current Emergency Operation Plan (EOP)
 - a. Modify existing command structure to HICS incident management team design
 - b. Review NIMS compliance requirements (see NIMS Compliance Guidance for Hospitals) and insure EOP addresses the current required elements in prescribed time frame
2. Conduct a hazard vulnerability analysis (HVA) for your institution
 - a. Ensure that community response partners and local emergency management is incorporated into analysis
 - b. Codify planning and response priorities
 - c. Review with hospital leadership and subject matter experts for consensus
3. Using Incident Planning Guides (IPGs)
 - a. Review current EOP and accompanying annexes
 - b. Use the IPGs that pertain to the identified HVA threats and revise or write EOP annexes as needed
4. Review Job Action Sheets (JASs)
 - a. Convene subject matter experts and stakeholders from within the institution to review job action sheets; engage individuals/staff who would fill those roles in an event
 - b. Insure the JASs meet hospital need: revise content as necessary with details (e.g., correct telephone numbers)
 - c. Place own hospital logo on each JAS if desired
 - d. Laminate a copy of each JAS and place with appropriate incident command vest
 - e. Make copies and place in EOP



5. Review the HICS Forms noted on the JAS and included with the HICS materials
 - a. Make copies and place in your EOP
 - b. Place designated forms with appropriate incident command position materials
 - c. Load forms onto Hospital Command Center (HCC) computers

6. Review Incident Response Guides (IRGs)
 - a. Choose those consistent with HVA results
 - b. Make modifications consistent with hospital practice and local capabilities
 - c. Place own hospital logo on each IRG if desired
 - d. Make copies and place in EOP
 - e. Laminate copies and distribute to incident command kits if desired
 - f. Discuss chosen Incident Response Guides with neighboring hospitals, (sister hospitals), first responders, public safety and local emergency management to develop response consistency and standardized terminology

7. Prepare incident command kits
 - a. Create command vests for each position
 - With the vests consider:
 - Color designation for each vest according to Incident Management Team design
 - Appropriate incident command title on front and back in large letters readable in limited lighting
 - Front pockets to hold pens, paper, radio, and JAS
 - Place JAS in each appropriate incident command vest or on clipboard
 - Compile position clipboards with JAS, ICS forms, message forms, incident management team chart, phone directories
 - b. Place vests and clipboards with other command materials (pens, paper, designated forms, paperclips, flashlights, directories) into identified box(s) (pens, paper, designated forms, paperclips, flashlights, directories)
 - c. Lock cases and place in secure location
 - d. Develop master content inventory list
 - e. Perform periodic check of command kits for completeness

8. Develop mutual aid agreements
 - a. Other regional/state hospitals
 - b. police/fire/EMS
 - c. private sector EMS

9. Develop vendor agreements for acquisition of needed items during an emergency

10. Apply for available state/federal emergency preparedness funds
 - a. Document all expenses in accordance with accompanying award instruction

11. Develop public information/risk communication materials
 - a. Work with other hospitals and public health department to develop materials
 - b. Prepare advance copies of materials identified in the Emergency Operations Plan

12. Ensure the availability of resource inventory
 - a. Beds
 - b. Medications
 - c. Ventilators
 - d. Common medical equipment and supplies
 - e. Other items outlined in EOP

13. Purchase interoperable communication and information technology equipment

B. Training

1. Identify training needs for hospital personnel
 - a. Instruction for all staff
 - b. Instruction for incident command staff

2. Use accompanying training materials to review HICS principles
 - a. Present in classroom
 - b. Present using CD or internet format
 - c. In hospital newsletters, magazines

3. Prepare other identified training material appropriate for hospital and community response



4. Have designated personnel complete appropriate NIMS outlined education courses (found in NIMS Compliance Guidance for Hospitals)
 - a. Online from EMI (e.g. IS 100 - H, 200-H, and 700-H) at <http://training.fema.gov/EMIWeb/IS/>
 - b. From the local emergency management agency or other sponsoring organizations
 - c. Collaborate with other local or statewide hospitals to sponsor training
5. Send personnel to HICS implementation classes given locally, in the state or nationally

C. Exercising

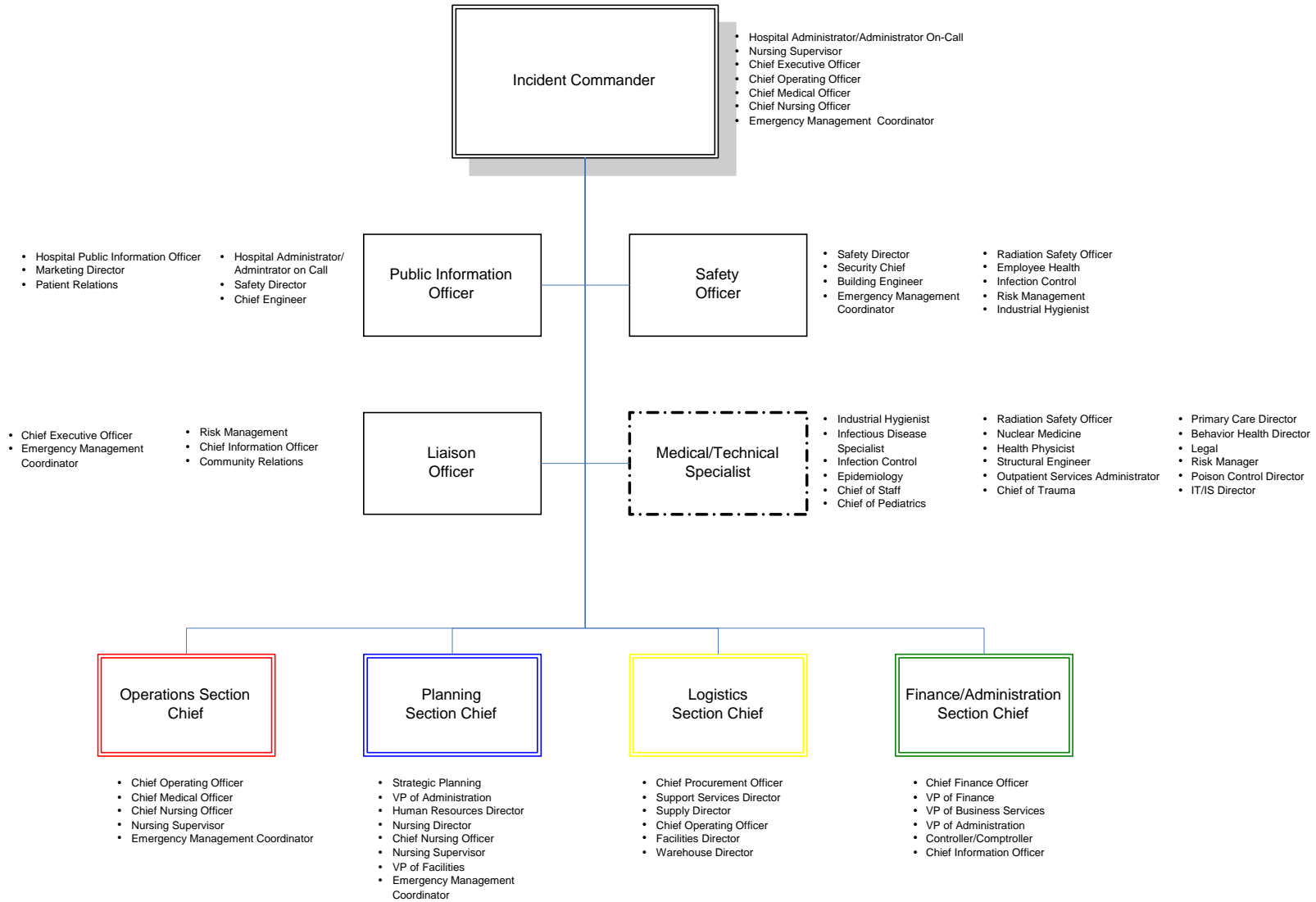
1. Review Hazard Vulnerability Analysis prioritized threats for scenario selection
 - a. Use accompanying HICS scenario-specific training materials
 - b. Revise scenario to fit local capabilities and needs
2. Develop needed exercise materials
3. Develop exercise evaluation tool
4. Work with local first responders, and emergency management in exercise design and execution
5. When appropriate, ensure that exercise design and execution complies with regulatory standards and grant funding guidelines
6. Publish an After Action Report (AAR) for all staff to read
7. Revise EOP and annexes to address needed corrective action and make staff aware of changes

A P P E N D I X F

Potential Candidates for HICS Command Positions

Purpose: The “Potential Candidates for HICS Positions” crosswalk (next page) provides suggestions for administrative positions commonly found in hospitals and their potential assigned roles in the Hospital Command Center (HCC), when activated. These suggestions are based on similarity to day-to-day position roles during the activation of the assigned role during operation of the HCC.

Use: The crosswalk is intended for pre-event planning and assignment of Hospital Command Center roles. By pre-assigning HCC assignments, the staff can be educated and exercised on their duties and scope of responsibility during an activation, and will be familiar with the associated Job Action Sheet before the event. It is recommended that each HCC Command position have not less than three to five persons pre-assigned to each role to allow for extended operations.



APPENDIX G

HEICS III to HICS Position Crosswalk

The table below compares HEICS III positions to the positions in the HICS incident management team structure. Note that as of the release of the HICS Guidebook, Job Action Sheets for the HEICS III positions will be accessible on the California Emergency Medical Services Web site, at www.emsa.ca.gov/dms2/heics_main.asp.

HEICS III Positions		HICS Positions	
Command	Incident Commander	Command	Incident Commander
Command	Public Information Officer	Command	Public Information Officer
Command	Safety and Security Officer	Command	Safety Officer
		Operations	Security Branch Director Access Control Unit Leader Crowd Control Unit Leader Traffic Control Unit Leader Search Unit Leader Law Enforcement Interface Unit Leader
Command	Liaison Officer	Command	Liaison Officer
		Command	Medical/Technical Specialist: Biological/Infectious Disease Chemical Radiological Clinic Administration Hospital Administration Legal Affairs Risk Management Medical Staff Pediatric Care Medical Ethicist
Logistics	Logistics Chief	Logistics	Logistics Section Chief
Logistics	Facility Unit Leader	Logistics	Facilities Unit Leader
Logistics	Damage Assessment and Control Officer	Operations	Buildings/Grounds Damage Unit Leader
Logistics	Sanitation Systems Officer	Operations	Water/Sewer Unit Leader
Logistics	Communications Unit Leader	Logistics	Communications Unit
		Logistics	IT/IS Unit
		Operations	Information Technology
Logistics	Transportation Unit Leader	Logistics	Transportation Unit Leader
Logistics	Materials Supply Unit Leader	Logistics	Supply Unit
		Planning	Materiel Tracking Manager
Logistics	Nutritional Supply Unit Leader	Logistics	Staff Food and Water Unit Leader
		Operations	Food Services



HEICS III Positions		HICS Positions	
Planning	Planning Chief	Planning	Planning Section Chief
		Planning	Resources Unit Leader Personnel Tracking Manager Materiel Tracking Manager
Planning	Situation Status Unit Leader	Planning	Situation Unit Leader
Planning	Labor Pool Unit Leader	Logistics	Labor Pool and Credentialing Unit Leader
Planning	Medical Staff Unit Leader		
Planning	Nursing Unit Leader		
Planning	Patient Tracking Officer	Planning	Patient Tracking Manager
		Planning	Bed Tracking Manager
Planning	Patient Information Officer		
		Planning	Documentation Unit Leader
		Planning	Demobilization Unit Leader
Finance	Finance Chief	Finance/Administration	Finance/Administration Section Chief
Finance	Time Unit Leader	Finance/Administration	Time Unit Leader
Finance	Procurement Unit Leader	Finance/Administration	Procurement Unit Leader
Finance	Claims Unit Leader	Finance/Administration	Compensation/Claims Unit Leader
Finance	Cost Unit Leader	Finance/Administration	Cost Unit Leader
Operations	Operations Chief	Operations	Operations Section Chief
Operations	Medical Care Director	Operations	Medical Care Branch Director
		Operations	Staging Manager Personnel Staging Team Leader Vehicle Staging Team Leader Equipment/Supply Staging Team Leader Medication Staging Team Leader
Operations	Medical Staff Director		
Operations	Inpatient Areas Supervisor	Operations	Inpatient Unit Leader
Operations	Surgical Services Unit Leader		
Operations	Maternal Child Unit Leader		
Operations	Critical Care Unit Leader		
Operations	General Nursing Care Unit Leader		
Operations	Out Patient Services Unit Leader	Operations	Outpatient Unit Leader
Operations	Treatment Areas Supervisor	Operations	Casualty Care Unit Leader
Operations	Triage Unit Leader		
Operations	Immediate Treatment Unit Leader		
Operations	Delayed Treatment Unit Leader		
Operations	Minor Treatment Unit Leader		
Operations	Discharge Unit Leader		
Operations	Morgue Unit Leader		
		Operations	Mental Health Unit Leader

HEICS III Positions		HICS Positions	
Operations	Ancillary Services Director	Operations	Clinical Support Services Unit Leader Pharmacy Services Diagnostic Radiology Services Laboratory Services Morgue Services Blood Donor Services Mental Health/Social Work
Operations	Laboratory Unit Leader		
Operations	Radiology Unit Leader		
Operations	Pharmacy Unit Leader		
Operations	Cardiopulmonary Unit Leader		
		Operations	Patient Registration Unit Leader
		Operations	Infrastructure Branch Director Power/Lighting Unit Leader Water/Sewer Unit Leader HVAC Unit Leader Building/Grounds Damage Unit Leader Medical Gases Unit Leader Medical Devices Unit Leader Environmental Services Unit Leader Food Services Unit Leader
		Operations	HazMat Branch Director Detection and Monitoring Unit Leader Spill Response Unit Leader Victim Decontamination Unit Leader Facility/Equipment Unit Leader
		Operations	Business Continuity Branch Director Information Technology Unit Leader Service Continuity Unit Leader Records Preservation Unit Leader Business Function Relocation Unit Leader
Operations	Human Services Director	Logistics	Support Branch Director
Operations	Staff Support Unit Leader	Logistics	Employee Health and Well-Being Unit Leader
Operations	Psychological Support Unit Leader		
Operations	Dependent Care Unit Leader	Logistics	Family Care Unit Leader

A P P E N D I X H

Working with the Scenarios, Incident Planning Guides, and Incident Response Guides

Purpose: HICS materials include a series of thirteen (13) internal and fourteen (14) external scenarios that hospitals may use to assist with their planning and training efforts.

Types: The external scenarios were devised by the Department of Homeland Security for use by state and local communities and represent a federal effort to promote integrated preparedness. The internal scenarios were developed by the National Work Group and intended to assist hospitals to prepare for fundamental problems such as utility failure, fires, and infant abductions. The scenario list is not all-inclusive. Hospitals are encouraged to use their Hazard Vulnerability Analysis to create their own scenarios, either individually or in collaboration with other facilities or response organizations. The scenarios include:

External Scenarios

- External Scenario 1: Nuclear Detonation—10-Kiloton Improvised Nuclear Device
- External Scenario 2: Biological Attack—Aerosol Anthrax
- External Scenario 3: Biological Disease Outbreak—Pandemic Influenza
- External Scenario 4: Biological Attack—Plague
- External Scenario 5: Chemical Attack—Blister Agent
- External Scenario 6: Chemical Attack—Toxic Industrial Chemicals
- External Scenario 7: Chemical Attack—Nerve Agent
- External Scenario 8: Chemical Attack—Chlorine Tank Explosion
- External Scenario 9: Natural Disaster—Major Earthquake
- External Scenario 10: Natural Disaster—Major Hurricane
- External Scenario 11: Radiological Attack—Radiological Dispersal Devices
- External Scenario 12: Explosives Attack—Bombing Using Improvised Explosive Device
- External Scenario 13: Biological Attack—Food Contamination
- External Scenario 15: Cyber Attack

External Scenario 14 was purposely omitted because of the limited application that a veterinary problem (foot and mouth disease) poses to hospital response and because the relative issues are addressed in the other biological scenarios.



Internal Scenarios

- Internal Scenario 1: Bomb Threat
- Internal Scenario 2: Evacuation, Complete or Partial Facility
- Internal Scenario 3: Fire
- Internal Scenario 4: Hazardous Material Spill
- Internal Scenario 5: Hospital Overload
- Internal Scenario 6: Hostage/Barricade
- Internal Scenario 7: Infant/Child Abduction
- Internal Scenario 8: Internal Flooding
- Internal Scenario 9: Loss of Heating/Ventilation/Air Conditioning (HVAC)
- Internal Scenario 10: Loss of Power
- Internal Scenario 11: Loss of Water
- Internal Scenario 12: Severe Weather
- Internal Scenario 13: Work Stoppage

Use: The hospital can use each scenario to assist in reviewing their EOP, build out questions or additional details to use during a facilitated discussion or table top exercise, or use as a basis for planning functional exercises.

APPENDIX I

NIMS Implementation Activities for Hospitals and Healthcare Systems

Organizational Adoption

Element 1 - Adoption of NIMS

Adopt the National Incident Management System (NIMS) at the organizational level for all appropriate departments and business units, as well as promote and encourage NIMS adoption by associations, utilities, partners and suppliers.

Association to NIMS

NIMS was developed as a comprehensive national approach to incident management, applicable at all jurisdictional levels and across functional disciplines, to further improve the effectiveness of emergency response providers and incident management organizations across a full spectrum of potential incidents and hazard scenarios. This national approach improves coordination and cooperation between public and private entities in a variety of domestic incident management activities.

NIMS uses a system approach to integrate the best of existing processes and methods into a unified national framework for incident management. This framework forms the basis for interoperability and compatibility that will in turn enable a diverse set of public and private organizations to conduct well-integrated and effective incident management operations.

Implementation Guidance

Hospitals and healthcare systems should work towards adopting NIMS throughout their organization. Hospital and healthcare systems should work towards full NIMS implementation through a phased in approach outlined in the cooperative agreement guidance issued by the National Bioterrorism Hospital Preparedness Program (NBHPP).

Implementation Example

The seventeen elements included in this document are addressed in the organization's emergency management program documentation.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>
4. HICS Implementation Manual



Command and Management

Element 2 - Incident Command System (ICS)

Manage all emergency incidents, exercises and preplanned (recurring/special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined in NIMS. ICS implementation must include consistent application of Incident Action Planning and Common Communication Plans.

Association to NIMS

ICS enables effective and efficient incident management via the integration of a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. ICS is structured to facilitate activities in five major functional areas: command, operations, planning, logistics, and finance administration. ICS is also flexible and scalable allowing for functional areas to be added as necessary and terminated when no longer necessary.

Prior to the events of September 11, 2001, ICS was primarily used for on-scene incidents by responders in the field. However, in the years since, hospitals have become integrated parts of the events of September 11, the 2005 hurricane seasons, impending Bird Flu epidemic, and daily incidents that produce multiple victims. Internally, hospitals often have events occur that benefit from the use of ICS. Such events include utility failure, VIP visits or admissions, hostage situations, fires, and patient evacuation, etc. Therefore, it is important that hospitals and healthcare systems exercise their own hospital policies and procedures that fit into an established incident command structure.

Implementation Guidance

Depending on the size and on-site capabilities of the hospital and healthcare system, the size and scope of ICS will vary. Hospitals and healthcare systems should implement an ICS that allows for the provision of safe and effective patient care and continuity of hospital operations regardless of the size of the hospital, size and type of incident, and/or limitations of resources, personnel and equipment.

The structure of a hospital ICS should be included in the Emergency Operations Plan (EOP) which will identify an Incident Commander and the appropriate departments/personnel to meet the following ICS areas—command staff, operations, planning, logistics, and/or finance needed to have an effective incident command structure. Once the ICS personnel are identified, subsequent training and exercises should be conducted to review the structure and ICS responsibilities designated to the hospital's and healthcare system's personnel.

Implementation Example

The organization's Emergency Operations Plan explains the use of ICS, particularly incident action planning and a common communication plan.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. IS-100, Introduction to Incident Command System
<http://www.training.fema.gov/emiweb/IS/is100.asp>
4. Training of Hospital Staff to Respond to a Mass Casualty Incident
<http://www.ahrq.gov/clinic/epcsums/hospmcsisum.pdf>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Command and Management

Element 3 - Multiagency Coordination System

Coordinates and supports emergency incident and event management through the development and use of integrated multiagency coordination systems (MACs). That is, develop and coordinate connectivity capability with Hospital Command Center (HCC) and local Incident Command Posts (ICPs), local 911 centers, local Emergency Operations Centers (EOCs), the state EOC and others as applicable.

Association to NIMS

A MAC is a combination of facilities, equipment, personnel, procedures and communications integrated into a common system with responsibility for coordinating and supporting incident management activities. In addition to hospital and healthcare systems, MACs can include the following entities:

- Local community/public health departments;
- Emergency medical services (EMS) (both private and public);
- Local 911 centers;
- Fire Departments;
- Hazardous materials response teams;
- Local and/or state emergency management;
- Local law enforcement offices/departments;
- Private physicians' offices, ambulatory care centers, urgent care centers, and/or community health centers.

The primary functions of multiagency coordination systems are to:

- Support incident management policies and priorities;
- Facilitate logistics support and resource tracking;
- Provide information regarding resource allocation decisions to incident management personnel in concert with incident management priorities;
- Coordinate incident related information; and
- Coordinate interagency and intergovernmental issues regarding incident management policies, priorities, and strategies.

Implementation Guidance

MAC relationships should be defined prior to an incident to address the potential emergency needs and areas of priority:

- Personnel staffing, roles, and authority
- Decontamination of patients, personnel, and/or equipment etc.
- Equipment and supplies
- Security
- Ancillary Services

Once MAC relationships have been established, hospitals and healthcare systems should participate in collaborative planning sessions, resulting in exercises and training that should be conducted among the agencies to test and validate facilities, equipment, personnel, procedures and integrated communications.

Implementation Example

The organization's Emergency Operations Plan demonstrates the management and coordination connection between the HCC and other similar external centers multi-agency coordination system entities (i.e., local EOC, public health, EMS, law enforcement, and others as appropriate).

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Command and Management

Element 4 - Public Information System

Implements processes and/or plans to communicate timely accurate information through a Joint Information System (JIS) and Joint Information Center (JIC).

Association to NIMS

Public Information Systems establish a system and protocol for providing timely and accurate information to the public during crisis or emergency situations. This system includes “many voices” and creates “one message” that is sent out to the public. During an event, a hospital or healthcare system would assign a Public Information Officer (PIO) or Public Affairs Representative/Spokesperson to handle:

- Media and public inquiries;
- Emergency public information and warnings;
- Rumor monitoring and response;
- Media monitoring; and
- Other functions required for coordinating, clearing with appropriate authorities, and disseminating accurate and timely information related to the incident, particularly regarding information on public health and safety and protection.

A Public Information System is comprised of a Joint Information System (JIS) and a Joint Information Center (JIC). The JIS provides an organized, integrated, and coordinated mechanism to ensure delivery of understandable, timely, accurate, and consistent information to the public in a crisis. The JIC is a physical location where public information professionals from organizations involved in incident management activities can co-locate to perform critical emergency information, crisis communications, and public affairs functions. A hospital PIO or Public Affairs Representative/Spokesperson can be located at a hospital’s command center, local EOC and/or the JIC.

Implementation Guidance

A hospital should identify at least one PIO or Public Affairs Representative/Spokesperson (dependent on the size of the hospital or healthcare system) that is responsible for media and public information as it pertains to an event that involves the hospital. The designated PIO or Public Affairs Representative/Spokesperson should establish working relationships, prior to an incident occurring, with local media outlets, emergency management, law enforcement, public health, emergency medical services, etc.

Implementation Example

The organization’s Emergency Operation Plan explains the management and coordination of public information with healthcare partners and jurisdictional authorities such as local public health, EMS, emergency management and others as appropriate.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-702 National Incident Management System – Public Information Systems
<http://www.training.fema.gov/EMIWeb/IS/is702.asp>
5. IS-242 Effective Communication <http://www.training.fema.gov/EMIWeb/PDS/>



6. G-290 Basic Public Information Officer Course (EMI and State Emergency Management Agencies) – Please contact your state emergency management office for available course dates.
7. B-966 Advanced Public Information Officers Course: Health Departments and Hospitals (Noble Training Center) <http://training.fema.gov/EMIWeb/NTC/>
8. CDC Risk Communications Training <http://www.bt.cdc.gov/erc/training.asp>
9. Emergency Management (EM) Principles and Practices for Healthcare Systems <http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Planning

Element 5 – NIMS Implementation Tracking

Hospitals and healthcare systems will track NIMS implementation annually as part of the organization's emergency management program.

Association to NIMS

Within NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning, training and exercises, personnel qualifications and certification, equipment certification and publication management. In order to implement NIMS, all activities must be met and maintained by a hospital or healthcare system. A NIMS implementation designee is typically identified to implement and track NIMS implementation.

Depending on the size of the hospital, duties of the NIMS implementation designee can be included into another job position (i.e. hospital administrator, safety officer, department manager) and does not necessarily need to be a separate, stand alone position. The NIMS implementation designee should have a working knowledge of emergency management, hospital operations, and hospital command center operations. A working relationship with local emergency management can provide assistance and guidance in these areas.

Implementation Guidance

It is the sole responsibility of the hospital and healthcare system to self-certify that it is NIMS compliant. Hospital and healthcare systems should designate a NIMS implementation designee to implement annual activities and track NIMS implementation. This designee should have a working knowledge of the emergency management life cycle (i.e. Preparedness, Prevention, Mitigation, Response, and Recovery) as well as the daily and emergency operations procedures and protocols of the hospital or healthcare system.

Implementation Example

NIMS organizational adoption, command and management, preparedness planning, training, exercises, resource management, and communication and information management activities will be tracked from year to year with a goal of improving overall emergency management capability.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-1 Emergency Manager: An Orientation to the Position
<http://www.training.fema.gov/EMIWeb/IS/is1.asp>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshq/page.cfm?pg=122>

Preparedness Planning

Element 6 – Preparedness Funding

Develop and implement a system to coordinate appropriate hospital preparedness funding to employ NIMS across the organization.

Association to NIMS

Preparedness funding enhances a hospital's and health care systems ability to prepare for and respond to bioterrorism and public health emergencies. The preparedness funding monies can assist the hospital or health care system to further achieve training, equipment, or planning. The Health Resources and Services Administration (HRSA), National Bioterrorism Hospital Preparedness Program (NBHPP) requires hospitals to be NIMS compliant.

Implementation Guidance

Hospitals and healthcare systems should establish a working relationship with their state Department of Health and state hospital associations to identify activities to obtain and appropriately allocate preparedness funding. Hospitals and healthcare systems should also develop a proactive process to seek other federal funding to support preparedness that takes advantage of developing interoperability training with their local and regional multi-disciplinary partners that enhances the Unified Command aspects of NIMS. Assistance with developing such funding should be coordinated with the assistance of each state's Hospital Association and Emergency Management Authority.

Implementation Example

The organization's emergency management program documentation includes information on local, state, and federal preparedness grants that have been received and deliverables to be achieved. Documentation demonstrates that preparedness grants received by the organization meet any regional, state, or local funding commitments.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. HRSA <http://www.hrsa.gov>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Planning

Element 7 – Revise and Update Plans

Revise and update plans [i.e. Emergency Operations Plan (EOPs)] and standard operating procedures (SOPs) to incorporate NIMS components, principles and policies, to include planning, training, response, exercises, equipment, evaluation, and corrective actions.

Association to NIMS

Plans describe how personnel, equipment, and other resources will support incident management activities. In addition, they describe the process and schedule for identifying and meeting training needs; the process and schedule for developing, conducting, and elevating exercises and correcting identified deficiencies, arrangements for procuring or obtaining required incident management resources through mutual-aid mechanisms and vendors/suppliers; and evaluates hazards that the hospital or healthcare system is most likely to face. EOPs describe organizational structures, roles and responsibilities, policies, and protocols for providing emergency support. EOPs also facilitate response and recovery activities, drive decisions on prevention and mitigation efforts or risk based preparedness measures for specific hazards. SOPs are a reference document that details the procedures for performing a single function or a number of independent functions.

Implementation Guidance

Hospitals and healthcare systems should update emergency plans to establish the necessary policies and procedures to achieve preparedness and respond to and recovery from an incident. Once updated, plans should be exercised and reviewed to determine and measure functional capability. Plan reviews should be conducted annually and/or after every event or incident to identify future updates that may be needed.

Implementation Example

The organization's emergency management program work plan reflects status of any revisions to EOPs such as training materials, response procedures, exercise procedures, equipment changes and/or purchases, evaluation and corrective processes.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS – 235 Emergency Planning <http://www.training.fema.gov/EMIWeb/IS/is235.asp>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>

Preparedness Planning

Element 8 – Mutual-Aid Agreements

Participate in and promote interagency mutual-aid agreements, to include agreements with public and private sector and/or nongovernmental organizations.

Association to NIMS

Mutual-aid is a legal agreement between two or more entities in which they agree to assist one another when their respective resources cannot meet demands. A Memorandums of Understanding (MOU) and/or Agreement (MOA) are voluntary commitment exercised at the discretion of the participating entities based on incident specific needs and available resources to meet demands.

Examples of Mutual-Aid agreements include:

- Direct One-on-One Mutual-Aid: resources are obtained from local entities.
- State Coordinated Mutual-Aid: once local and Direct One-on-One Mutual-Aid resources have been exhausted, hospitals or healthcare systems can coordinate with local emergency management who can request additional resources through the state emergency management agency.
- Interstate Mutual-Aid: once State Coordinated Mutual-Aid resources have been exhausted, state emergency management can activate Emergency Mutual Aid Compact (EMAC). EMAC is more readily available since conditions for providing assistance have been established prior to an event.

Mutual-aid agreements can be established between participating hospitals' or healthcare systems, private sector and nongovernmental organizations to supply personnel, equipment, supplies, facilities, services (i.e. decontamination, laboratory testing), etc.

The mutual-aid system is not a replacement for any individual hospital's or healthcare system's emergency planning; rather, it is meant as a supplement that will augment a hospital's or healthcare system's capabilities.

Implementation Guidance

Hospitals and healthcare systems should establish mutual-aid agreements with neighboring hospitals and/or healthcare systems, public health departments, hazardous materials response teams, local fire department, local law enforcement, area pharmacies, and/or medical supply vendors. Established mutual-aid agreements should be shared with local emergency management prior to an incident occurring.

Implementation Example

The organization's emergency management program documentation includes information supporting any hospital mutual aid agreements.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. Emergency Management Assistance Compact (EMAC) <http://www.emacweb.org/>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Training

Element 9 – IS-700 NIMS

Complete *IS-700: NIMS: An Introduction*

Association to NIMS

NIMS provides a consistent nationwide template to enable all levels of government, private sector, and nongovernmental organizations to work together during domestic incidents. NIMS represents a core set of doctrine, concepts, principles, terminology, and organizational processes to enable effective, efficient, and collaborative incident management at all levels. NIMS also addresses emergency prevention, preparedness, response, recovery, and mitigation programs and activities. These areas are used by all response entities and encourage collaborative working relationships with each other.

Implementation Guidance

IS-700 NIMS: An Introduction should be completed by the hospital personnel that would have a leadership role in emergency preparedness, incident management, and/or emergency response during an incident. Personnel designated to fulfill ICS roles (i.e. hospital emergency manager, hospital administration, department heads) should complete IS-700 or equivalent, though additional participants may include the following hospital and healthcare systems staff:

- physicians;
- nursing;
- ancillary,
- materials/resource management;
- security/safety;
- laboratory;
- radiology; and/or
- inter-facility transport.

Implementing a phased-approach methodology would allow employees to complete the training without causing a time constraint burden on the hospital. One approach may be to include IS-700 in semi-annual or yearly competencies or as part of employee evaluation to achieve training for all identified hospital personnel. IS-700 can be taken on-line at <http://www.training.fema.gov/EMIWeb/IS/is700.asp> or in the classroom setting when taught by a qualified instructor. The actual timeframe and method of completing this course is left to the discretion of the hospital.

A hospital or healthcare system should maintain one overall record of completion for employees as well as documentation in the employee's personal file.

Implementation Example

The organization's emergency management program training records track completion of IS-700 or equivalent by personnel who are likely to assume an incident command position described in the hospital's emergency management plan.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-700 Course <http://www.training.fema.gov/EMIWeb/IS/is700.asp>
5. NIMS Training Requirements http://www.fema.gov/pdf/emergency/nims/06_training.pdf
6. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Training

Element 10 – IS-800.A NRP

Complete *IS-800.A: NRP: An Introduction*

Association to NIMS

The National Response Plan (NRP) integrates Federal government domestic prevention, preparedness, response, and recovery plans into a single, all-discipline, all-hazards plan. The NRP provides structure and mechanisms for national-level policy and operational direction for Federal support to state, local, and tribal incident managers and for exercising direct Federal authorities and responsibilities as appropriate under the law. Understanding of the NRP, provides understanding of incident management at all levels of government, private industry and nongovernmental agencies

Implementation Guidance

IS-800.A: National Response Plan (NRP): An Introduction should be completed by personnel whose primary responsibility is emergency management within a hospital or healthcare system.

Implementing a phased-approach methodology would allow employees to complete the training without causing a time constraint burden on the hospital. One approach is to incorporate IS-800 into semi-annual or annual competencies or a part of employee evaluation to achieve training for identified hospital personnel whose primary responsibility is emergency management. IS-800 can be completed on-line at <http://www.training.fema.gov/EMIWeb/IS/is800a.asp> or in the classroom setting when taught by a qualified instructor. The actual timeframe and method of completing this course is left to the discretion of the hospital.

A hospital or healthcare system should maintain one overall record of training completion for all identified ICS employees.

Implementation Example

The organization's emergency preparedness program training records track completion of IS-800.A or equivalent by individual(s) responsible for the hospital's emergency management program.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. National Response Plan http://www.dhs.gov/interweb/assetlibrary/NRP_FullText.pdf
5. IS-800 National Response Plan (NRP) and Introduction
<http://www.training.fema.gov/EMIWeb/IS/is800a.asp>
6. NIMS Training Requirements http://www.fema.gov/pdf/emergency/nims/06_training.pdf
7. NRP – Notice of Change
http://www.fema.gov/pdf/emergency/nims/notice_change_nrp.pdf
8. Quick Reference Guide for the National Response Plan (changes made as of June 2006)
http://www.fema.gov/pdf/emergency/nims/ref_guide_nrp.pdf
9. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>

Preparedness Training

Element 11 – ICS 100 and 200

Complete *ICS 100* and *ICS 200* Training or equivalent courses

Association to NIMS

Incident management organizations and personnel at all levels of government and within the private-sector and nongovernmental organizations, must be appropriately trained to improve all-hazards incident management capability nationwide. ICS provides the foundation of response and recovery personnel structure to effectively manage the incident. ICS is applicable to first responders up to supervisory personnel. The various functions to manage an incident are streamlined through the ICS structure.

Implementation Guidance

ICS-100 Introduction to ICS or equivalent should be completed by the hospital personnel that would have a direct role in emergency preparedness, incident management, and/or emergency response during an incident. Personnel designated to fulfill ICS roles (i.e. hospital emergency manager, hospital administration, department heads) should complete IS-100 or equivalent, though additional participants may include the following hospital and healthcare systems staffs:

- physicians;
- nursing;
- ancillary,
- materials/resource management;
- security/safety;
- laboratory;
- radiology; and/or
- inter-facility transport.

ICS-200 ICS for Single Resources and Initial Action Incidents or equivalent should be completed by personnel whose primary responsibility is emergency management, to include (at a minimum) middle management within a hospital or healthcare system. Middle management may refer to physicians, department managers, unit leaders, charge nurses, and any staff (i.e. hospital administration) that would have a role in an emergency operations center (hospital, local, or state).

Implementing a phased-approach methodology would allow employees to complete the training without causing a time constraint burden on the hospital. One approach may be to incorporate ICS-100 and ICS-200 or equivalent courses into semi-annual or annual competencies, or as part of employee evaluation to achieve training for all hospital personnel. IS-100 and 200 can be taken on-line at <http://www.training.fema.gov/EMIWeb/IS/is100.asp> and IS-200 <http://www.training.fema.gov/EMIWeb/IS/is200.asp> or in the classroom setting when taught by a qualified instructor. The actual timeframe and method of completing these courses is left to the discretion of the hospital.

A hospital or healthcare system should maintain one overall record of completion for all employees as well as documentation in the employee's personal file.



Implementation Example

The organization's emergency preparedness program training records track completion of the ICS-100 and ICS-200 or equivalent courses by personnel who will have primary responsibility as part of emergency management.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-100 <http://www.training.fema.gov/EMIWeb/IS/is100.asp>
5. IS-200 <http://www.training.fema.gov/EMIWeb/IS/is200.asp>
6. NIMS Training Requirements http://www.fema.gov/pdf/emergency/nims/06_training.pdf
7. Incident Command System Instructor Guidelines
<http://www.fema.gov/pdf/emergency/nims/ICSInstructorGdl0106.pdf>
8. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>

Preparedness Exercises

Element 12 – Training and Exercises

Incorporate NIMS/ICS into internal and external local, regional, and state emergency management training and exercises.

Association to NIMS

Incident management organizations and personnel at all levels of government and within the private sector and nongovernmental organizations must be appropriately trained to improve all-hazards incident management capability nationwide. All agencies involved in incident management must participate in realistic multidisciplinary and multijurisdictional exercises to improve integration and interoperability. This type of training ensures that personnel at all jurisdictional levels and across disciplines can function effectively together during an incident.

Implementation Guidance

Hospitals and healthcare systems should include NIMS and ICS policies and practices into internal and external training and exercises. During trainings and exercises, plans should be reviewed to ensure hospital and healthcare systems staff competency and proper execution of roles and responsibilities during an event.

Implementation Example

The organization's emergency management program training and exercise documentation reflects the use of NIMS/ICS.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Exercises

Element 13 – All-Hazard Exercise Program

Participate in an all-hazard exercise program based on NIMS that involves responders from multiple disciplines, multiple agencies and organizations.

Association to NIMS

Incident management organizations and personnel at all levels of government, as well as within the private sector and nongovernmental organizations, should be appropriately trained to improve all-hazards incident management capability nationwide. All agencies involved in incident management should participate in realistic multidisciplinary and multijurisdictional exercises to improve integration and interoperability. This type of training ensures that personnel at all jurisdictional levels and across disciplines can function effectively together during an incident.

Hospital and healthcare systems can conduct drills and exercises to achieve and evaluate proficiency. Drills provide instruction and/or training for personnel on particular roles, responsibilities, plans, and/or equipment. The building blocks that make up the various exercises available can be referred to as the “crawl-walk-run” approach once drills have been conducted. The “crawl-walk-run” approach is accomplished by the following:

- Tabletop (*crawl*) allows participants to move through a scenario based on discussions regarding the coordination of plans and procedures with other departments or agencies.
- Functional Exercise (*walk*) allows participants to work through plans and procedures in a real-time scenario, typically based in an operations center environment. The exercise pace can be increased or decreased depending on participants ability to work through their plans and procedures.
- Full-scale Exercise (*run*) requires participants to move people and apparatus while working through plans and procedures in real-time.

Implementation Guidance

Hospitals and healthcare systems should participate in local, regional, and/or state multi-discipline and multi-agency exercises twice per year to every 2 years (dependent on the type of drill or exercise to be held). Exercise activities should address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of casualties through the hospital system, resource management, security procedures, specialty lab testing, and/or site/facility safety. Exercises can be conducted through drills, tabletop, functional, and/or full-scale exercises.

It is strongly encouraged that personnel conducting drills or helping to plan exercises should have the experience and documented training to facilitate these events. Such exercise design and evaluation training is available from federal and state emergency management agencies. Additionally, a system to provide a critical evaluation process for use in every exercise, drill and actual event in which the hospital or healthcare system would participate is strongly encouraged. Such evaluations should provide both quantitative and qualitative data / information upon which to define a process for improvement in future drills, exercises or actual events. The ability to identify both strengths and areas for improvement is critical to effective drill and exercise management over time and helps to strengthen Element 14– Corrective Actions.

Implementation Example

The organization's emergency management program training and exercise documentation reflects the organization's participation in exercises with various external entities.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Preparedness Exercises

Element 14 – Corrective Actions

Hospitals and healthcare systems will incorporate corrective actions into preparedness and response plans and procedures.

Association to NIMS

Corrective action plans are designed to implement or enhance procedures that are based on lessons learned from actual incidents or from training and exercises. Corrective actions make up the improvement plan for identified issues, such as those identified in a After Action Report (AAR), that require action to be taken by a person or group by a particular date in order to correct the issue.

Implementation Guidance

After a hospital or healthcare system has participated in a drill or exercise, a corrective action report should be created. In the corrective action report, the following points should be addressed for each identified issue:

- The identified action to correct the issue or deficiency,
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action should be incorporated into plans and procedures once completed.

Implementation Example

The organization's emergency management program documentation reflects a corrective action process.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshq/page.cfm?pg=122>

Resource Management

Element 15 – Response Inventory

Maintain an inventory of organizational response assets.

Association to NIMS

Resource management involves coordinating and overseeing the application of tools, processes, and systems that provide incident managers with timely and appropriate resources during an incident. Resources include personnel, teams, facilities, equipment, and supplies. Resource inventory is maintained throughout the emergency management life cycle (prevention, preparedness, response, recovery, mitigation) so that a hospital is prepared for and able to support the event. During the response and recovery phase supplies and equipment may be needed from other hospitals or retail stores. Memorandums of Agreement (MOA) and Memorandums of Understanding (MOU) should be established during pre-incident times.

By standardizing the procedures, methodologies, and functions involved in these processes, the NIMS ensures that resources move quickly and efficiently to support managers and emergency responders. When they are established, multiagency coordination entities may also prioritize and coordinate resource allocation and distribution during incidents.

Implementation Guidance

Supplies and equipment (i.e., personal protective equipment (PPE), patient care supplies, generator) that will be used in excess during an incident response should be determined (based on amount of staff, potential patients, usage time, etc.), ordered, and stocked on-site or elsewhere prior to an incident. Healthcare systems should stock additional supplies at a warehouse and/or throughout their hospitals to maintain necessary supplies that during an incident that will exceed normal par levels. These supplies or response assets should be maintained in a record of inventory whether on paper or in a database.

For items whose usage would exceed par levels as a result of a large scale incident or items that for which expiration would be an issue (i.e., additional antibiotics, vaccines, PPE, etc.), an MOU or MOA should be developed to expedite receipt of items when needed. Plans should reference the MOU or MOA information to include the following:

- Contact information of who the agreement is with;
- Types or actual supplies or equipment to be provided;
- Mobilization method and receipt of resources;
- Tracking and reporting of resources;
- Recovery of resources; and
- Reimbursement of resources.

Implementation Example

The organization's emergency management program documentation includes a resource inventory (i.e., medical/surgical supplies, pharmaceuticals, personal protective equipment, staffing, etc.).



References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-703 – NIMS Resource Management
<http://www.training.fema.gov/EMIWeb/IS/is703.asp>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>

Resource Management

Element 16 – Resource Acquisition

To the extent permissible by law, ensure that relevant national standards and guidance to achieve equipment, communication, and data interoperability are incorporated into acquisition programs.

Association to NIMS

In order for a common operating system to exist, equipment, communications and data interoperability must be standardized and understood by all. Hospitals and healthcare systems should be able to directly communicate with each other via phone, computer, and/or radio. An event may disable one or more communication methods, resulting in limited communication resources. The coordination and usage of common equipment and data sources allows for communications to still function when infrastructure (i.e. phone lines, computer lines) has been impacted.

Information technology, phone, and radio communications allow for information to be relayed and coordinated in real-time.

Implementation Guidance

To the extent possible, hospital and healthcare systems should work to establish common equipment, communications, and data interoperability resources with other local hospitals, emergency medical services (EMS), public health, and emergency management that will be used during incident response.

Implementation Example

The organization's emergency management program documentation includes emphasis on the interoperability of response equipment, communications, and data systems with external entities.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. IS-703 – NIMS Resource Management
<http://www.training.fema.gov/EMIWeb/IS/is703.asp>
5. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>



Communication and Information Management

Element 17 – Standard and Consistent Terminology

Apply standardized and consistent terminology, including the establishment of plain English communication standards across the public safety sector.

Association to NIMS

Effective communications, information management, and information and intelligence sharing (i.e. biological event) are critical aspects of domestic incident management. To establish and maintain a common operating picture and ensuring accessibility and interoperability are principle goals of communications and information management. When operating in a multidiscipline and multijurisdictional incident common language among entities will alleviate confusion and miscommunications.

Implementation Guidance

Hospitals and healthcare systems should establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plain language should be addressed in plans as well as written into training and tested during drills and exercises.

The use of plain English does not prohibit the use of in-house hospital emergency codes to communicate within the facility. When communicating with entities outside the hospital, plain language should be used in place of internal specific emergency codes (e.g. Dr. Red is internal to a hospital, if a hospital was reporting a fire to the incident commander they would simply state that they have a fire or if a hospital is establishing lock down they would not use there internal emergency code terminology to notify outside resources but simply state that they are on lock down.)

Implementation Example

The organization's emergency management program documentation reflects an emphasis on the use of plain English by staff during emergencies.

References

1. National Incident Management System (NIMS)
<http://www.dhs.gov/interweb/assetlibrary/NIMS-90-web.pdf>
2. HSPD-5 <http://www.whitehouse.gov/news/releases/2003/02/20030228-9.html>
3. HSPD-8 <http://www.fas.org/irp/offdocs/nspd/hspd-8.html>
4. Emergency Management (EM) Principles and Practices for Healthcare Systems
<http://www1.va.gov/emshg/page.cfm?pg=122>

A P P E N D I X J

Recommended Resources

Guidance from Governmental Agencies and Professional Associations

A number of federal agencies have provided emergency preparedness guidance to hospitals in recent years. *NOTE: Web addresses were correct as of this Guidebook's publication date.*

- Agency for Healthcare Research and Quality (AHRQ) – www.ahrq.gov/
 - Provides guidance on bioterrorism and other public health emergencies. Recent documents include “Evaluation of Hospital Disaster Drills: A Module Based Approach.”
- Agency for Toxic Substance and Disease Registry (ATSDR) – www.atsdr.cdc.gov
 - Provides toxic substance data and hazardous material response-preparedness guidance.
- Centers for Disease Control and Prevention (CDC) – www.bt.cdc.gov
 - Provides a variety of online and print materials on CBRNE and other disaster and public health emergency related topics.
- Environmental Protection Agency (EPA) – www.epa.gov
 - Provides compliance guidance on a number of environmental protection topics along with a variety of educational materials.
- Federal Emergency Management Agency (FEMA) – www.training.fema.gov/emiweb
 - Provides preparedness information in addition to online and classroom training.
- Health Resources and Services Administration (HRSA) – www.hrsa.gov
 - Manages several funding efforts related to terrorism preparedness, including the National Bioterrorism Hospital Preparedness Program, and publishes best practices documents.
- Occupational Safety and Health Administration (OSHA) – www.osha.gov
 - Publishes guidance on a variety of topics, including Personal Protective Equipment (PPE) and respirator use. Recent documents include “Best Practices for Hospital Based First Receivers from MCI Incidents Involving Release of Hazardous Substances.”
- Veteran’s Affairs Administration – www.va.gov
 - Publishes guidance primarily for VA hospitals but helpful also to private and public hospitals.

Several nongovernmental agencies also provide guidance and educational materials on emergency preparedness for hospitals and healthcare facilities.

- American Hospital Association (AHA) – www.aha.org
 - Publishes planning and response lessons-learned guidance from member facilities and others.



- American Society of Healthcare Engineering (ASHE) – Publishes planning, response, lessons-learned, guidance, regulatory advisories, and educational materials – www.ashe.org
- American Society for Testing and Materials (ASTM) – www.astm.org/
 - Produces voluntary response standards for a variety of responders, including hospitals. See WK4344, “Standard Guide for Hospital Preparedness.”
- Joint Commission for Healthcare Organizations (JCAHO) – www.icafo.org
 - Writes guidelines for emergency preparedness and periodically provides educational materials and planning guides.
- National Fire Protection Association (NFPA) – www.nfpa.org
 - Writes guidance on a wide range of topics, including “Standard 99 Healthcare Facilities” and “Standard 1600 Disaster/Emergency Management and Business Continuity.”

In addition, a number of collaborative agencies provide guidance and educational materials on emergency preparedness for hospitals and healthcare facilities specific to the weapons of mass destructive environment that are of interest to civilian healthcare entities.

- Armed Forces Radiobiology Research Institute (AFRRI) – <http://www.afri.usuhs.mil/>
 - A national resource for radiation biology research in the world that collaborates with other governmental facilities, academic institutions, and civilian laboratories in the United States and other countries whose findings have broad military and civilian applications.
- Chemical Stockpile Emergency Preparedness Program (CSEPP) - <http://www.cma.army.mil/csepp.aspx>
 - The Chemical Stockpile Emergency Preparedness Program (CSEPP) works closely with communities around the nation to enhance emergency plans and provide chemical accident response equipment and warning systems.
- Radiation Emergency Assistance Center/Training Site (REAC/TS) - <http://www.orau.gov/reacts/index.htm>
 - Provides a 24-hour emergency response program at the Oak Ridge Institute for Science and Education, REACTS trains, consults, or assists in the response to all types of radiation accidents or incidents. The Center's specially trained team of physicians, nurses, health physicists, radiobiologists, and emergency coordinators is prepared around-the-clock to provide assistance on the local, national, or international level.
- United States Army Medical Research Institute of Infectious Diseases (USAMRIID) - <http://www.usamriid.army.mil/>
 - Conducts basic and applied research on biological threats to create medical solutions to protect the war fighter and collaborates with the CDC regarding research specific to biological threats.

- United States Army Medical Research Institute of Chemical Defense (USAMRICD) - <http://chemdef.apgea.army.mil/>
 - Provides support for discovering and developing medical countermeasures for chemical agent exposures.

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2. Centers for Disease Control and Prevention (1999). Framework for Program Evaluation in Public Health. *MMWR* September 17, 1999. vol.48.No. RR-11
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Web Sites

1. <http://www.aha.org> – American Hospital Association Web page
2. <http://www.atsdr.cdc.gov> – Agency for Toxic Substances and Disease Registry
3. <http://www.bt.cdc.gov> – CDC Bioterrorism – emergency preparedness Web page w/ numerous helpful links
4. <http://www.cdc.gov> – CDC general page
5. <http://www.dhs.gov> – Department of Homeland Security
6. <http://www.hhs.gov/disasters> – Department of Health and Human Services Web page on disaster topics
7. <http://www.llis.gov> – Lessons Learned and Information Sharing Web site with after action reports, lessons learned and drill evaluations for disaster management and preparedness.
8. <http://www.fema.gov/EMI> – Emergency Management Institute

A P P E N D I X K

HEICS IV Project Organization

Given the impact that the Hospital Incident Command System (HICS) is anticipated to have on hospital preparedness and response activities nationwide if not internationally, it was decided that four distinct groups would play a vital role in the project.

The National Work Group

The National Work Group consisted of twenty persons from across the United States with a variety of hospital-based backgrounds and experiences. Their responsibility was to identify through facilitated discussion the core content for HICS and to approve the critical details to be included in each part of the HICS products. The work group members attended six meetings, ranging from two to three days, and participated in multiple teleconferences.

Persons interested in working on the project were sought from around the nation. More than eighty individuals submitted an application for consideration. A selection committee carefully chose the twenty persons invited to participate. All of these individuals have the needed mix of professional backgrounds, professional experience, and familiarization with HEICS III and NIMS to effectively meet the project's objectives. In addition, they come from different geographic areas of the United States and represent hospitals of all sizes and service delivery models. Only personnel with hospital or direct healthcare system affiliation were selected to participate, and all have had responsibility for emergency preparedness in their facilities.

Ex Officio Members

Representatives from seven federal agencies and national organizations that have a stake in the project were given the opportunity to participate with the National Work Group in meetings and to review and comment on all draft documents. Ex officio members included personnel from the American Hospital Association (AHA), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Society for Healthcare Engineering (ASHE), NIMS Integration Center (NIC), Emergency Management Institute (EMI), Department of Health and Human Services, and Health Resources and Services Administration.

The Secondary Review Group

To complement the expertise of the National Work Group, individuals were given the opportunity to apply to serve on the Secondary Review Group. More than 70 persons submitted an application and were selected to participate. The members of this group possess a variety of backgrounds and include not only experienced



hospital personnel but also public safety and public health officials, consultants, and medical industry vendors.

The Secondary Work Group's role was to review selected draft materials developed by the national group and share comments and suggestions via a formal evaluation tool. Their input was sought at three separate times during Phase I of the project as well as in Phase II. This group's input was invaluable in clarifying specific viewpoints and reinforcing others.

Contract Support Team

Representatives from the National Healthcare Continuity Management of Kaiser Permanente in California and from the ER One Institute at the Washington Hospital Center in Washington, D.C., were selected by EMSA to provide support for all phases of the contract. Their responsibilities included:

- Overall project coordination
- Planning and facilitating the National Work Group meetings
- Drafting project-related materials for the work group to review
- Coordinating the Secondary Review Group feedback process
- Maintaining project records
- Providing a production-ready copy of project materials to California EMSA in accordance with timeline agreements

The Contract Support Team met multiple times each week to coordinate the various aspects of the project work. In addition, regular meetings were held with EMSA's Chief of Disaster Medical Services and Coordinator of Bioterrorism Preparedness to update them on the progress being made and to receive needed guidance and direction.

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