

EASTERN REGIONAL HEALTH CARE COALITION



EMERGENCY PREPAREDNESS & RESPONSE PLAN

October 2022

Version 1.3

PROMULGATION

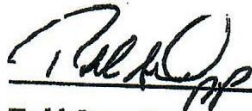
The Eastern Regional Health Care Coalition (ERHCC) issues this Coalition Preparedness & Response Plan in force and encompasses the area set forth within the Eastern Region as set for by the US Health and Human Services Assistant Secretary for Preparedness and Response (ASPR).



Peter Leyva - Chair



Clay Lammers - Co-Chair



Todd Opp - Secretary



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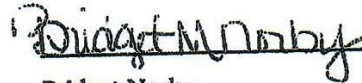
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SECTION I: PURPOSE, SCOPE, SITUATION, AND ASSUMPTIONS

1.1 Purpose

This Emergency Preparedness & Response Plan is a strategic level document intended to set the framework for operational and tactical response roles and activities in disaster and emergency situations. The purpose of this plan is to provide general guidance for preparation, response and recovery to all hazards and events that threaten the health care system that result in illness or injury to the population with the coalition boundaries. This plan will describe the parameters, abilities, and responsibilities of the Eastern Region Health Care Coalition (ERHCC) of Montana during emergencies and disasters. These elements involve preparedness planning, training, and exercises, as well as the operational and tactical response roles and activities in disaster and emergency situations. Strategic emergency preparedness and response planning serve to create policy objectives, establish priorities, and provide overall guidance for member organizations.

This plan intends to meet the emergency preparedness requirements put forth by the Montana Department of Public Health and Human Services (DPHHS) as an agent of the 2017-2022 Hospital Preparedness Program (HPP) – Public Health Emergency Preparedness (PHEP) Cooperative Agreement from the US Health and Human Service (HHS) Assistant Secretary for Preparedness and Response (ASPR) HPP.

This Framework incorporates the six Domains of the HPP/PHEP Preparedness and Response Capabilities national standards and the five National Preparedness Goal Capabilities (see below).

HPP/PHEP Domains	National Preparedness Goals
Community Resilience	Prevention
Incident Management	Protection
Information Management	Mitigation
Countermeasures and Mitigation	Response
Surge Management	Recovery
Biosurveillance	

1.2 Scope

The ERHCC provides guidance and information to coordinate support for coalition members, local emergency responders, tribal emergency responders, State agency partners, and volunteer organizations to address the delivery of public health and medical services and programs to assist Montanans threatened by potential or actual disasters.

This health care coalition, as a recipient of federal funding, is a dedicated partner to DPHHS in support of Emergency Support Function 8: Public Health & Medical Services (ESF-8). This ESF is a responsibility assigned to DPHHS by the 2016 Montana Emergency Response Framework (MERF), maintained and published by the Montana Department of Emergency Services (DES). Members of the ERHCC are agents of ESF-8 activities by the nature of their business.

This plan does not define or supplant any emergency operating procedures or responsibilities for any member agency or organization in the ERHCC. It is not a tactical plan or a field manual, nor does it provide Standard Operating Procedures (SOP). Rather, it is a framework for organization and provides decision-making parameters to use against unknown and unpredictable threats in an all-hazards planning and response environment. This plan intentionally does not provide specific or quantitative thresholds for activation or demobilization of organizational structures or processes described herein. Such determinations are situation-dependent and are left to incident management.

ESF-8 planning includes addressing medical needs associated with mental health, behavioral health, and substance abuse considerations of incident victims and response workers. Services also cover the medical needs of individuals classified as having access, functional, or special needs.

1.3 Situation

Montana is vulnerable to several hazards that might need assistance from both State and non-governmental organizations (NGOs). These hazards include but are not limited to, wildfires, earthquakes, floods, HazMat incidents, communicable disease outbreaks or other public health events, cyber-attacks, and severe weather. The 2015 Threat & Hazard Identification and Risk Assessment (THIRA) and the State Vulnerability Assessment (SVA), compiled by DES, outline the breadth of vulnerability to hazards endemic to Montana.

Individuals experiencing disasters or emergencies might encounter medical emergencies, face the spread of disease, or require mental and behavioral support to survive. Transient individuals, such as tourists, travelers, students, and the pre-disaster homeless, could be involved. Food and relief items could become scarce or compromised. Electronic medical records might be corrupted or suddenly become unavailable. A disaster could also adversely affect persons considered at-risk or having functional needs, including those with pre-existing disabilities, creating a need for medical care and public health support.

1.3.1 HEALTH CARE COALITION RISKS AND VULNERABILITIES

The ERHCC recommends each facility within the coalition conduct and maintain its own annual hazard vulnerability analysis (HVA). Coalition members should participate in or conduct a gap analysis to identify needs in preparation for disaster needs. This includes participating in local Emergency Management or DES THIRA efforts as part of a Local Emergency Management Committee (LEPC) or Tribal Emergency Response Council (TERC).

Collectively, the ERHCC will define, identify, and prioritize risks, in collaboration with DPHHS using data from these and other existing assessments for health care readiness purposes. The coalition determines any resource needs and gaps, identifies individuals who may require additional assistance, highlights training and exercise needs, and develops strategies to address preparedness and response priorities in the region. The ERHCC HVA is included in Appendix 3 of this document.

1.3.2 FUNCTIONAL NEED AND VULNERABLE POPULATIONS

The ERHCC will work within its ESF-8 responsibilities with its coalition partners and DPHHS to coordinate timely and appropriate support to organizations serving individuals with functional or special needs resulting from a disaster or emergency. Functional need populations are defined as people having access

or functional health (i.e., mental or medical) or physical (i.e., motor ability) needs beyond their capability to maintain on their own before, during, and after an incident. It also refers to the “at risk” or “special needs” populations described in the Pandemic and All-Hazards Preparedness Act, also known as PAHPA (PUBLIC LAW 109–417—DEC. 19, 2006), and in the National Response Framework (NRF) (2016).

The ERHCC conducts disaster planning and response activities considering the urgent circumstances of emergencies and the moral and legal obligations to meet the needs of individuals who have disabilities as defined by the Americans with Disabilities Act Amendments Act of 2008, P.L. 110-325.

People with disabilities and others with access and functional needs include individuals who are from diverse cultures, races, and nations of origin; individuals who do not read, have limited English proficiency, or are non-English speaking; people who have physical, sensory, behavioral, mental health, intellectual, developmental and cognitive disabilities; senior citizens with and without disabilities or other access and functional needs; children with and without disabilities or other access and functional needs and their parents and guardians; individuals who are economically or transportation-disadvantaged; women who are pregnant; individuals who have chronic medical conditions; and those with pharmacological dependency.

1.4 Assumptions

This plan assumes the following conditions for the purpose of designing responses in an all-hazard planning environment:

- A significant emergency, disaster, or public health event can happen at any time and have the potential to impact several health care organizations within the ERHCC
- A health care related disaster or emergency that exceeds the response capacities of a local or tribal organization will require broader assistance
- Not all health care coalition members will have current emergency operation plans to share with the coalition or with local emergency managers
- All hospitals will have emergency response plans they have properly exercised according to federal and state regulations
- Not all ERHCC members will have enough capacity to respond to an emergency as a sole entity
- ERHCC might be asked to provide leadership and coordination to perform emergency response and system recovery efforts for health care issues
- City, county and tribal emergency operation managers will need documents and resource lists that describe the relevant medical resources in their jurisdictions (e.g. local nursing homes, hospitals, quick response units, ambulance services, morgue locations, or mutual aid agreements for EMS and public health needs)
- Disruption in communications, electrical power, and transportation might adversely affect the availability of emergency medical services (EMS)

SECTION II: CONCEPT OF OPERATIONS

Tribal and local emergency managers coordinate the initial responses to serve the needs of emergency and disaster victims. When local resources and disaster coordination needs are exhausted, emergency

managers will request assistance through mutual aid contacts of neighboring health care facilities, then from the State. Local authorities retain responsibility for all response and recovery operations.

The ERHCC will conduct ESF-8 coordination operations through DPHHS PHEP/HPP in concert with both local emergency management and ESF-8 Partners. The ERHCC will integrate with the ESF-8 lead agency to ensure information is provided to local, state, and federal officials. Coordination and resource assistance for tribal and local emergency management is on an as-able basis.

The ERHCC and its members are collaborating partners, participating in information sharing, incident planning, strategy development, and resource management and coordination. The coalition serves as an integral component for medical mutual aid, providing a mechanism to provide surge operations and rapid distribution of aid when it is needed. The coalition supports and maintains tools and strategies for mutual systems, including professional volunteer recruitment and resource requests.

Membership consists of all facilities and agencies within:

Assisted Living Facility	Primary Care Specialists	Behavioral and Mental Health
Nursing Home	End Stage Renal Disease	Home Health
Skilled Nursing Facility	Rural Health Center	Hospice
Outpatient Surgical	Community Health Center	Academic Facilities
Tribal Health	VA Medical Facilities	DOD Health Facility
Therapy Centers	Foster Homes	Blood Banks
Pharmacies	Laboratories	Public Health
Emergency Management	Emergency Medical Services	

1.1 Implementation

Coalition response coordination activities begin when DPHHS, HPP, or any other ERHCC partner identifies an actual or impending emergency or disaster. Conditions that might lead to the implementation of this plan include, but are not limited to, the following conditional circumstances.

- Any substantive alert message requiring health care response via news media, social media, or notification from a planning partner, or an official local, state, or Federal entity about any of the following.
 - A natural disaster (e.g. widespread tornado or flooding)
 - A biological attack (e.g. anthrax dispersion)
 - A chemical attack or spill (e.g. train derailment that forces a community evacuation)
 - A biological disease outbreak (e.g. pandemic influenza)
 - A radiological threat or incident
 - A credible terrorist threat or actual terrorist incident
 - Or any other event that might result in a mass casualty event
- A request to activate or monitor by a Coalition member or partner (local Emergency Management, EMS, Long Term Care, Hospital, Local Public Health, etc.)
- Multi-jurisdictional incident or outbreak

- An incident in an area with few proximate resources, such as a low population county or a county without a hospital
- An incident large enough to require resource sharing, including
 - Strategic National Stockpile deployment
 - Epidemiologic investigation
 - Facility Evacuation

This plan is implemented upon approval by the ERHCC executive committee and carried forth by each document created in its support (See Response Plan Annexes, Appendices). This includes any preparative implementation of ESF-8 services for planning, mitigation, response or recovery.

1.2 Activation

Preparedness is always active. This plan is implemented upon approval by the ERHCC executive committee and carried forth by each component of the plan created in its support. During a response, the coalition coordinators will collaborate with DPHHS Emergency Preparedness Section and act as conduit of information to the membership. This includes any preparative implementation of ESF-8 services for planning, mitigation, response, or recovery.

1.3 Health Care Coalition Risks and Vulnerabilities

The ERHCC requires each facility within the coalition to conduct and maintain its own annual hazard vulnerability analysis (HVA). Additionally, coalition members should participate in or conduct a gap analysis to identify needs in preparation for disaster needs.

Collectively, the ERHCC will define, identify, and prioritize risks, in collaboration with DPHHS using data from these and other existing assessments for health care readiness purposes. The coalition can determine any resource needs and gaps, identify individuals who may require additional assistance, highlight training and exercise needs, and develop strategies to address preparedness and response priorities in the region.

1.3.1 FUNCTIONAL NEEDS AND VULNERABLE POPULATIONS

The ERHCC will work in its ESF-8 responsibilities with its coalition partners and DPHHS to coordinate timely and appropriate support to individuals with functional or special needs resulting from a disaster. Functional need populations are defined, for the purpose of ESF-8 response activities, as vulnerable or at-risk people having functional health needs beyond their capability to maintain during an emergency.

1.4 Functions

The ERHCC consults with its response partners and stakeholders to plan its operational functions for ESF-8 services. The coalition's function in preparation for emergency and disaster response and recovery is to provide technical and advisory support to local and tribal governments' emergency and disaster related health care planning needs. Planning takes an all-hazards approach in preparedness.

1.4.1 PREPAREDNESS CAPABILITIES

This preparedness plan follows the 2017-2022 Health Care Preparedness and Response Capabilities established by ASPR. The ERHCC is dedicated to supporting preparations for disasters and emergencies

that might impact Montana’s communities, strengthening our health and emergency response systems, and enhancing our nation’s health security. Preparedness planning strengthens the coalition’s health care delivery system to save lives during emergencies and disaster events that exceed the day-to-day capacity and capability of individual systems. The concept of operations for preparedness planning, therefore, must meet the principles outlined in the following capabilities.

Capability 1 – Foundation for Health Care and Medical Readiness

The community’s health care organizations and other stakeholders—coordinated through a sustainable HCC—have strong relationships, identify hazards and risks, and prioritize and address gaps through planning, training, exercising, and managing resources.

Capability 2 – Health Care and Medical Response and Recovery Coordination

The ERHCC and DPHHS, plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.

Capability 3 – Continuity of Health Care Service Delivery

Health care organizations, with support from the ERHCC and DPHHS, provide uninterrupted and optimal medical care to all populations in the face of damaged or disabled health care infrastructures. The ERHCC and DPHHS provide training, education and resources during the planning process to ensure that organizations are prepared. Health care workers are well-trained, well-educated, and well-equipped to care for patients during emergencies. Simultaneous response and recovery operations result in a return to normal or, ideally, improved operations.

Capability 4 – Medical Surge

Health care organizations, including hospitals, EMS, and out-of-hospital providers deliver timely and efficient care to their patients even when the demand for health care services exceeds available supply. The ERHCC, in collaboration with DPHHS, coordinates information and available resources for its members to maintain conventional surge response. When an emergency overwhelms the coalition’s collective resources, it supports the health care delivery system’s transition to contingency and crisis surge response and promotes a timely return to conventional standards of care as soon as possible.

1.5 Operations

Montana DPHHS PHEP/HPP is not a responding organization to disasters, but rather a partner agency. The coalition provides technical and advisory support to local and tribal governments’ emergency and disaster related health care planning, response, and recovery needs. The ERHCC, led by the Executive Committee, consults among its response partners and stakeholders to plan its operational functions for ESF-8 services.

Coalition Response

The emergency response structure for the ERHCC emphasizes coordination and collaboration and is not a true unified command. It is an informative resource for the incident command established at the local or facility levels, which follow the principles of the National Incident Management System (NIMS). Rather, the structure resembles a multiagency coordination center, although in a decentralized format. These will

be managed virtually using either a Bridge Line or virtual platform established by either the DES Duty Officer (DO), DPHHS Duty Officer, or Coalition Coordinator.

Thresholds and Triggers

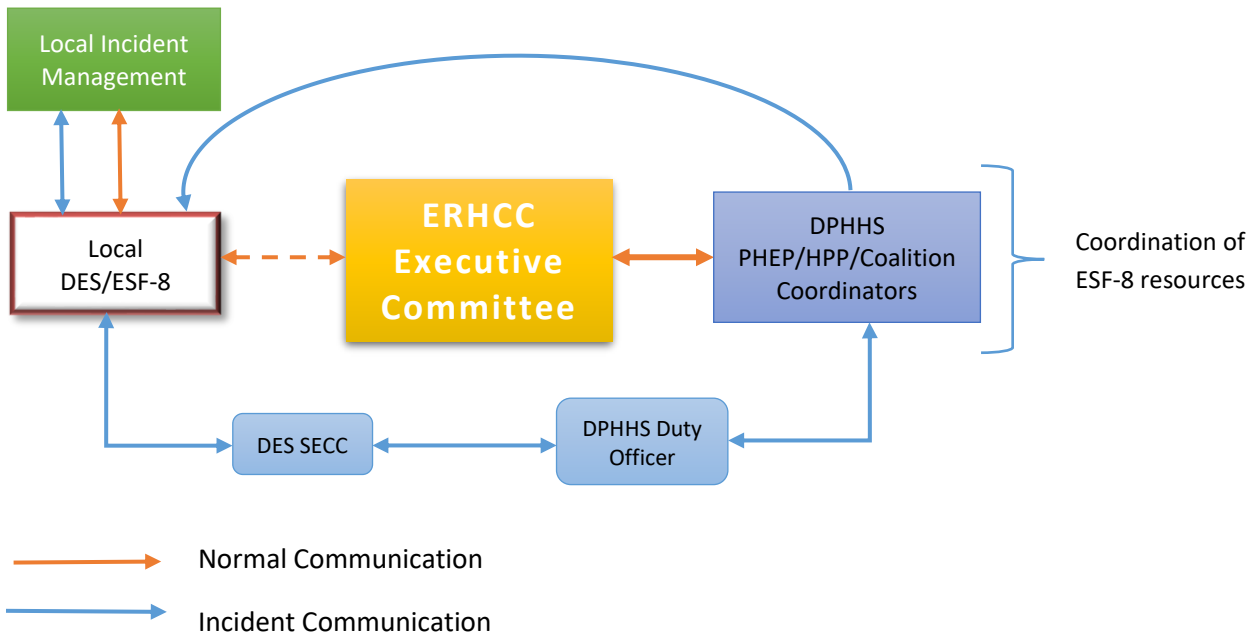
Coalition member facilities determine their own specific activation thresholds (or triggers). These triggers should cause an escalation of resource needs by the facility and necessitate a call for help. Coalition Coordinators will monitor data and information available, providing outreach to facilities as appropriate through coordination and collaboration with partners.

Incident Management and Coordination

Coalition member facilities will conduct their own response operations during an emergency, working within the parameters of NIMS and utilizing ICS. Participation in coalition response tier activities remain at information sharing, response advisory, and resource coordination. HPP and the ERHCC Executive Committee will provide as much assistance as possible to help members to return to pre-incident status.

Local incident managers work with local ESF-8 resource partners. If those resources are overwhelmed, requests are made to the State Emergency Coordination Center (SECC), operated by DES, and to PHEP/HPP through the DPHHS DO.

Figure 2: Incident Response Communication Flow



Notification will occur using the illustration in Figure 2.

The ERHCC Executive Committee will remain in an advisory role, connected remotely in an electronic virtual environment (internet, telephone, etc.) as needed. Executive Committee members have responsibilities to their own facilities’ response operations.

DPHHS is the State's ESF-8 coordinating agency and will collaborate with the ERHCC's Regional Coalition Coordinator to discuss regional plans, response activities, and resources appropriate to the localized incident.

During an emergency response involving the coalition, DPHHS PHEP/HPP will activate their response plans as appropriate and coordinate with the ERHCC Regional Coalition Coordinator to:

- Establish and maintain points of contact with jurisdictional authorities and other entities involved in the response for the incident
- Gather and share information with responding ESF-8 and local incident management partners
- Assist with NIMS compliance including incident management structure and development of IAPs as requested.

Information Sharing and Situational Awareness

The ERHCC Executive Committee and PHEP/HPP will exchange incident information as appropriate utilizing reliable, resilient, interoperable, and redundant information and communications systems. These systems may include EMResource, ImageTrend and other systems identified within the region. Member entities of the ERHCC will update statuses in EMResource for their respective facilities during an emergency.

EMResource contains essential elements of information (EEI) to allow PHEP/HPP and emergency managers to develop a common operating picture of response efforts. PHEP/HPP also provides this situational awareness to State DES.

General incident information exchange tools available to the ERHCC include, but are not limited to, the following (in no specific order).

- Internet Services
 - HPP Listserv
 - ERHCC Website
 - EMResource
 - eICS
- DES DO 24-hour contact
- DPHHS DO 24-hour contact
- Email and other distribution of all publications and communication from partner agencies
- Local Emergency Management/DES

Patient Tracking

Patient tracking is a facility level responsibility.

Resource Coordination

PHEP, HPP, and Coalition Coordinators will assist with resource coordination and management between partner organizations, particularly within the health care sector. This may include support and promotion of regional Personal Protective Equipment (PPE) procurement that could offer significant advantages in pricing and consistency.

Montana has a Health Care Mutual Aid agreement managed by HPP's contract with the Montana Hospital Association. Emergency Planners and Administrators or CEOs of health care agencies and organizations sign the document if they agree to provide mutual aid to another facility in need as capability allows.

- Language within the Montana Health Care Mutual Aid System (MHMAS) provides directions for requesting and receiving assistance as well as liability
- Facilities can call the DES DO to request access into the volunteer registry system if they are unable to obtain any other assistance
- Inventory of HPP/ERHCC funded equipment and capabilities will be maintained
- HPP/HCC maintain a limited PPE cache
- Pharmaceuticals are not cached

The ERHCC will collaborate with HPP recipients and DPHHS PHEP/HPP to manage staffing resources, including volunteers, within health care settings. This will include:

- Identifying situations that would require supplemental staffing;
- Developing rapid credential verification processes to facilitate emergency response;
- Identifying and addressing, to the extent possible, volunteer liability, licensure, workers compensation, scope of practice and third-party reimbursement issues; and
- Leveraging existing government and non-governmental volunteer registration programs, Emergency System for Advanced Registry of Volunteer Health Professionals (ESAR-VHP), to identify and staff health care roles during acute medical surge response events.

The CORES platform will be utilized for volunteers.

To improve regional readiness and response coordination, the ERHCC, in conjunction with DPHHS, will integrate strategies and tactics with the Regional Disaster Health Response System (RDHRS). The ERHCC and RDHRS will promote communications, information sharing, resource coordination, and operational response planning.

SECTION III: MEMBER ROLES & RESPONSIBILITIES

The ERHCC's member organizations must cooperate and collaborate in preparedness and response planning to sustain community resilience. This collaborative planning is also essential for immediate and effective coordination with other emergency response partners. Each of the partnering agency capabilities are affected by available resources and the size and scope of an incident. As such, response support is "as able." The coalition will assist member facilities in identifying National Incident Management System (NIMS) components in regard to preparedness and response considerations.

Every community has multiple organizations for contributing to preparedness activities. Collaboration at the Local Emergency Planning Committee (LEPC) or Tribal Emergency Planning Committee (TERC) is essential in the planning, response, and recovery activities of a coalition.

CORE ERHCC COALITION PARTNERS The following is a list of the core coalition partners and the primary roles those organizations or entities will fill in preparedness, response and recovery activities.

Disaster and Emergency Services

- Support and coordination to local emergency management

EMS

- Medical support and medical transportation

Hospitals

- Emergency department beds
- General medical, general surgical, and monitored beds
- Critical care beds
- Surgical intervention beds
- Clinical laboratory and radiology services
- Health care volunteer management
- Equipment and supplies
- Staffing
- Coordination of EMS transport

Public Health

- Coordinate and facilitate public health response and support to disasters and epidemics
- Provide information on diseases and illnesses through epidemiology and surveillance
- Participate or lead in risk communication and public information efforts with partners in a health care emergency, or for prevention of illness and promotion of healthy behaviors
- Support health care response operations through planning, logistics, and other incident management functions
- Provide emergency management expertise regarding public health and health care infrastructures
- Liaison with other state and local agencies with overlapping areas of response, including DPHHS/PHEP
- Coordinate procurement and distribution of health and medical equipment, medicine, and supplies
- Coordinate local public health service program delivery to assist those affected by the incident, emergency or disaster
- Serve as a response point for mental illness and/or substance abuse services to disaster survivors and responders
- Serve as a conduit to DPHHS Public Health Laboratory for specimen testing

DEVELOPMENT OF AN ALTERNATE CARE SYSTEM

In the event that the utilization of non-traditional settings and modalities for health care delivery may be required for a prolonged period of time, an alternate care system may be established. Public health agencies and emergency management organizations will have leadership roles with support from the ESF-8 lead agency and the Health Care Coalition. Key elements to be considered include:

- Establishment of telemedicine or virtual medicine capabilities
- Establishment of assessment and screening centers for early treatment

- Provision of medical care at shelters
- Assisting with the selection and operation of alternate care sites

SECTION IV: MAINTENANCE & REVIEW

The ERHCC formally reviews all components of this preparedness and response plan annually. This process allows the coalition to determine if it meets all essential factors, remains applicable, and affords the opportunity to update and change the plan as the coalition changes and grows.

Minor corrections, edits, updates, or adjustments in this document might occur on occasion without a formal review. Changes may also take place as part of improvement plans from exercise after action reports. All changes are tracked in a versioning method and in the Record of Change log.

EXERCISES

This plan or any of its components could be exercised separately or in conjunction with other exercises. Exercises will be used under simulated, but realistic, conditions to validate policies and procedures for responding to specific emergency situations and to identify deficiencies that need to be corrected.

Personnel participating in these exercises should be those who will make policy decisions or perform the operational procedures during an actual event (i.e. critical personnel). Exercises are conducted under no-fault pretenses.

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Appendix 1 - Acronyms

ASPR – Assistant Secretary for Preparedness and Response

CAT – Coalition Assessment Tool

CDC – Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

DES – Montana State Disaster and Emergency Services

DHS – Department of Homeland Security

DO – Duty Officer

DOD – Department of Defense

DPHHS – Montana Department of Public Health & Human Services

EI – Essential Elements of Information

EMAC – Emergency Management Assistance Compact

EMS – Emergency Medical Services

EOC – Emergency Operations Center

EPA – Environmental Protection Agency

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

FEMA – Federal Emergency Management Agency

FRP – Federal Response Plan

HAN – Health Alert Network

HCC – Health Care Coalition

HCP – Health Care Personnel

HHS – US Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HPP – Health Care Preparedness Program

HVA – Hazard Vulnerability Analysis

IAP – Incident Action Plan

ICS – Incident Command System

IOM – Institute of Medicine
LEPC – Local Emergency Planning Committee
MCM – Medical Countermeasures
MERF – Montana Emergency Response Framework
MHA – Montana Hospital Association
MHMAS – Montana Health care Mutual Aid System
MOA – Memorandum of Agreement
MOU – Memorandum of Understanding
MRC – Medical Reserve Corp
MSMD – Medical Supplies Management and Distribution Plan
NGO – Non-Governmental Organization
NIMS – National Incident Management System
NRF – National Response Framework
OSHA – Occupational Safety and Health Administration
PAHPA – Preparedness All-Hazards Preparedness Act
PHEP – Public Health Emergency Preparedness
PHI – Protected Health Information
POD – Point of Dispensing
PPE – Personal Protective Equipment
QAD – Montana Quality Assurance Division
REC – Regional Emergency Coordination
SECC – State Emergency Coordination Center
SNS – Strategic National Stockpile
SOP – Standard Operating Procedure
ERHCC – Eastern Region Health Care Coalition
START – Simple Triage and Rapid Treatment
SVA – State Vulnerability Assessment
TERC – Tribal Emergency Response Council

THIRA – Threat and Hazard Identification and Risk Assessment

VA – Veteran’s Affairs

Appendix 2 – The Health Care Coalition

The Health Care Coalition (HCC) is described in detailed within the By-Laws. The HCC interacts at all levels as the Emergency Support Function (ESF-8).

Composition

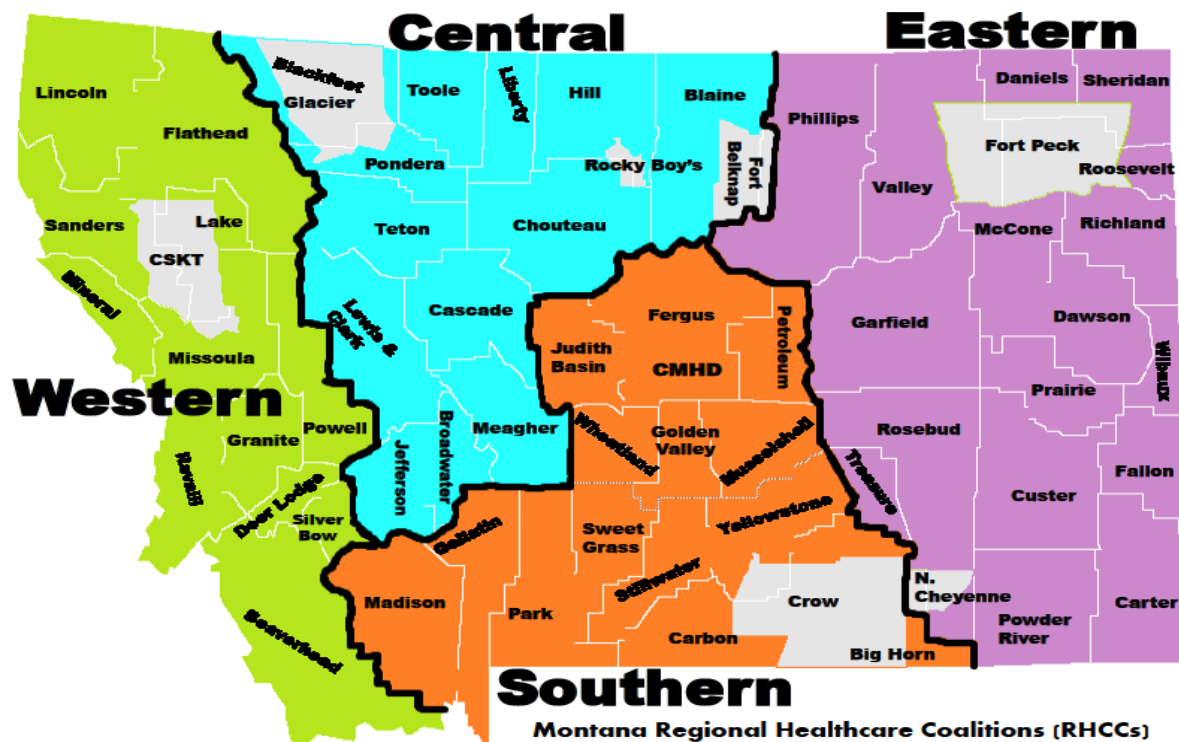
At a minimum; 2 hospitals, Emergency Medical Services (EMS), emergency management organizations, and public health agencies must be represented within each HCC.

Additional representation from the following is encouraged:

Assisted Living Facility	Primary Care Specialists	Behavioral and Mental Health
Nursing Home	End Stage Renal Disease	Home Health
Skilled Nursing Facility	Rural Health Center	Hospice
Outpatient Surgical	Community Health Center	Academic Facilities
Tribal Health	VA Medical Facility	DOD Health Facility
Therapy Centers	Foster Homes	

Regional Boundary

The Regional HCCs in Montana were initially established utilizing the preexisting boundaries established by the trauma referral patterns for patient care, but has since been revised as seen below:



Planning Considerations and Gap Analysis, Identification of Objectives

Major impact areas identified by US Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR) funding Opportunity.

Project Year 2019 (BP19-01) establishes the following as initiatives or priorities for an HCC through 2024:

- Medical Surge
- Patient Transportation
- Evacuation Planning
- Coordinating Medical Resources
- Health Surveillance
- Information Sharing
- Building Situational Awareness and Essential Elements of Information (EEI)
- Improved Alerting and Communication
- Finding Bed Availability (within EEI)
- Patient Tracking

A regional Hazard Vulnerability Assessment (HVA) will be accomplished. See Appendix 3 – The Eastern Regional HCC HVA.

Gaps will be identified through utilization of the ASPR Capability Assessment Tool (CAT). Coalition members are encouraged to include any topics relevant to the HCC. Upon completion of the aforementioned, a strategy will be established for short-, mid-, and long-term objectives to bridge gaps.

EOP

Member facilities will develop an Emergency Operations Plan describing procedures that staff will undertake to respond and recover from all hazards. It should provide guidance describing purpose and authority, situation and assumptions, Concept of Operations, Assignment of Roles and Responsibilities including the Incident Command System (ICS), authority and references; as well as procedures to follow during planned activities including communications plans, evacuation and shelter in-place plans, resources and assistance information, alternate care sites, public information officer, specific threat plans, continuity of operations, patient decontamination, to name a few.

Policies

Member facilities will develop emergency preparedness policy documents supporting the EOP. Examples of policies include: Hazard Vulnerability Analysis (HVA), use of NIMS, staff training, exercises, evaluation and improvement plans, notification of emergency or impending emergency, emergency codes, communications, staff call-back plans, notifying external authorities, resource requests, the media, Health Insurance Portability and Accountability Act (HIPAA) plans, Strategic National Stockpile, transporting patient plans, foodservice emergency planning, security plans, legal evidence and chain of custody plans, labor pool plans, staff health and safety plans, staff rest period plans, family care and support during an emergency plans, evacuation/shelter-in-place plans, facility role during 1135 Waiver, use of volunteers, credentialing/privileging of licensed independent providers during disasters, contaminated patients plans,

communication of threats/incidents plans, mail room security plans, infection prevention plans, use of POD (Point of Dispensing), Strategic National Stockpile, Essential Elements of Information (EEI).

All-Hazards Planning

Health care facilities are accomplishing all-hazards planning activities to support the conditions of participation for emergency preparedness provided by the Centers for Medicare and Medicaid Services (CMS).

Emergency Management Assistance Compact (EMAC) and Requests for Assistance

Requests for assistance begin at the local level within any State by the responding personnel to their County Emergency Management office. If the County Emergency Management office cannot fulfill the request for resources, it is routed to the Montana DES Office, even from another State.

The DES Office will forward health and medical requests to MT DPHHS PHEP (HPP) Office for fulfillment. MT DPHHS PHEP (HPP) Office will staff the request and either obtain the resources from another Regional Health Care Coalition facility or staff the request to ASPR or CDC Region 8. If a request is not within the purview of the DPHHS PHEP (HPP) Office, the request is sent back to DES for possible other agency EMAC coordination.

From time to time, requests for assistance from outside the state of Montana will be tasked. MT DES is the office of primary responsibility for staffing and delegating these requests. MT DPHHS PHEP (HPP) office will ask Montana facilities if they are able to fulfill and EMAC request. Results will be provided to DES.

Appendix 3 – The Eastern Regional HCC HVA

The ERHCC annually collects member organization HVAs and averages the input to determine the most likely risks and hazards.

Top Risks

Hazards are ranked according to vulnerability, which is the comparative significance of the threat based on probability, magnitude and mitigation.

Rank	Hazard	Incidents	Vulnerability	Preparedness
1	Supply Chain Shortage / Failure	1	84%	Low: 50 % Medium: 50 %
2	Patient Surge	2	81%	Medium: 50 % Low: 50 %
3	Transportation Failure	0	73%	Low: 50 % Medium: 50 %
4	Wildland Fire	5	73%	Medium: 50 % High: 50 %
5	Explosion	0	73%	Low
6	Acts of Intent	0	72%	Low
7	Infectious Disease Outbreak	1	71%	Medium: 50 % High: 50 %
8	Bomb Threat	0	70%	Low
9	Evacuation	0	70%	Medium: 50 % Low: 50 %
10	Hazmat Incident with Mass Casualties	0	70%	Medium: 50 % Low: 50 %
11	Mass Casualty Incident	0	69%	Medium
12	Drought	0	69%	Medium
13	Active Shooter	0	68%	Low
14	Communication / Telephony Failure	0	67%	Medium
15	HVAC Failure	0	67%	Medium
16	Radiation Exposure	1	67%	Low
17	Civil Unrest	0	67%	Low
18	Sewer Failure	1	66%	Medium
19	Dam Failure	0	66%	Medium: 50 % Low: 50 %
20	IT System Outage	0	65%	Low: 50 % Medium: 50 %
21	Tornado	1	64%	Medium
22	Hazmat Incident	0	63%	Medium
23	Workplace Violence / Threat	0	63%	Medium
24	Power Outage	0	61%	High: 50 % Medium: 50 %

25	Water Contamination	1	60%	Medium: 50 % High: 50 %
26	Gas / Emissions Leak	0	59%	Medium: 50 % Low: 50 %
27	Hostage Situation	0	59%	Low
28	External Flood	0	58%	Medium: 50 % Low: 50 %
29	Suicide	0	58%	Low: 50 % Medium: 50 %
30	Water Disruption	1	58%	High: 50 % Medium: 50 %
31	Earthquake	0	57%	Low
32	Natural Gas Disruption	0	57%	Low: 50 % Medium: 50 %
33	Generator Failure	0	56%	Medium
34	Internal Flood	0	56%	Medium
35	Suspicious Package / Substance	0	55%	Low
36	Inclement Weather	0	55%	High: 50 % Medium: 50 %
37	Temperature Extremes	0	55%	High: 50 % Medium: 50 %
38	Trauma	0	53%	High
39	Shelter in Place	0	53%	Medium
40	Fire	0	51%	High
41	Planned Power Outages	0	49%	High
42	Abduction	0	49%	Low
43	Building Move	0	48%	Low: 50 % Medium: 50 %
44	Forensic Admission	0	47%	Medium
45	Internal Fire	0	47%	High
46	VIP Situation	0	40%	Low: 50 % High: 50 %
47	Weapon	0	34%	Not Applicable: 50 % Low: 50 %
48	Epidemic	2	33%	Not Applicable: 50 % High: 50 %
49	Suspicious Odor	0	32%	Not Applicable: 50 % Medium: 50 %
50	Pandemic	1	31%	Not Applicable: 50 % High: 50 %
51	Natural Gas Failure	0	30%	Not Applicable: 50 % Medium: 50 %
52	Other Utility Failure	1	29%	Low: 50 % Not Applicable: 50 %

53	Chemical Exposure, External	0	28%	Not Applicable: 50 % Medium: 50 %
54	Landslide	0	27%	Not Applicable: 50 % Low: 50 %
55	Large Internal Spill	0	27%	Not Applicable: 50 % Low: 50 %
56	Other	0	27%	Low: 50 % Not Applicable: 50 %
57	Picketing	0	27%	Not Applicable: 50 % Low: 50 %
58	Strikes / Labor Action / Work Stoppage	0	27%	Not Applicable: 50 % Low: 50 %
59	Flood	0	24%	Not Applicable: 50 % Medium: 50 %
60	Seasonal Influenza	0	20%	Not Applicable: 50 % High: 50 %

Appendix 4 – Essential Elements of Information (EEI)

We use two methods to gather and share information. The Juvare EMResource website (See Appendix 4) and the HICS Form 251.

1. Incident Name		2. Time Completed: (#) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____	
3. Name of Department / Unit Reporting Status Below		Contact Number:	
4. System	5. Status	6. Comments If not fully functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.	
Power Routine and emergency	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Lighting	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Water	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Sewage / Toilets	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Nurse Call System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Medical Gases / Oxygen	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
Communications IT systems, telephones, pagers	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A		
7. Remarks (Cracked walls, broken glass, falling light fixtures, etc.)			
8. Prepared by PRINT NAME: _____ SIGNATURE: _____ DATE/TIME: _____ FACILITY: _____			
1. Incident Name		2. Operational Period (#) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____	
3. Name of Facility / Building Reporting Status Below			
4. System	5. Status	6. Comments If not fully functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.	
COMMUNICATIONS			

Fax	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Information Technology System Email, registration, patient records, time card system	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Nurse Call System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Overhead Paging	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Paging System Code teams, standard paging	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Radio Equipment Facility handheld, 2-way radios, antennas	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Radio Equipment EMS, local health department, other external partner	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Radio Equipment Amateur radio	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Satellite Phones	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Telephone System Primary	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	

Telephone System Proprietary	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Telephone System Back-up	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Internet	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Video-Television Cable	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
INFRASTRUCTURE		
Campus Access Roadways, sidewalks, bridge	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Fire Detection System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Fire Suppression System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Food Preparation Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Ice Machines	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Laundry/Linen Service Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	

Structural Components Building integrity	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	(Note cracked walls, loose masonry, hanging light fixtures, broken windows)
PATIENT CARE		
Decontamination System Including containment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Digital Radiography System, Routine Diagnostics PACS, CT, MRI, other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Steam/Chemical Sterilizers	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Isolation Rooms Positive/negative air	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
SECURITY		
Facility Lockdown Systems Door/key card access	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Campus Security External panic alarms	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Campus Security Surveillance cameras	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Campus Security Traffic controls	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Campus Security Lighting	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	

Panic Alarms Internal and other reporting devices	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
UTILITIES		
Electrical Power Primary service	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Electrical Power Backup generator	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Fuel Storage	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	(Note amount on hand)
Sanitation Systems	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Water	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Natural Gas/Propane	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Air Compressor	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Hazardous Waste Containment System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Heating, Ventilation, and Air Conditioning (HVAC)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	

Oxygen	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	(Note bulk, H tanks, E tanks, Reserve supply status)
Medical Gases, Other	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	(Note reserve supply status)
Pneumatic Tube	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Steam Boiler	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Sump Pump	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Well Water System	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Vacuum (for patient use)	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Water Heater and Circulators	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
External Lighting	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
External Storage Equipment	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	

External Storage Vehicles	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
Parking Structures, Lots	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	(Power, panic alarms, access, egress, lighting)
Landing Zone Pads, lighting, fuel source	<input type="checkbox"/> Fully functional <input type="checkbox"/> Partially functional <input type="checkbox"/> Nonfunctional <input type="checkbox"/> N/A	
7. Remarks (Cracked walls, broken glass, falling light fixtures, etc.)		
8. Prepared by		
PRINT NAME: _____		SIGNATURE: _____
DATE/TIME: _____		FACILITY: _____

- PURPOSE:** The HICS 251-Facility System Status Report is used to record the status of various critical facility systems and infrastructure. The HICS 251 provides the Planning and Operations Sections with information about current and potential system failures or limitations that may affect incident response and recovery.
- ORIGINATION:** Completed by the Operations Section Infrastructure Branch Director with input from facility personnel.
- COPIES TO:** Delivered to the Situation Unit Leader, with copies to the Operations Section Chief, Business Continuity Branch Director, Planning Section Chief, Safety Officer, Liaison Officer, Materiel Tracking Managers, and the Documentation Unit Leader.
- NOTES:** The Infrastructure Branch conducts the survey and correlates results. Individual department managers may also be tasked to complete an assessment of their areas and provide the information to the Infrastructure Branch. If additional pages are needed, use a blank HICS 251 and repaginate as needed. Additions and deletions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
--------	-------	--------------

1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Name of Facility Reporting Status	Enter the name of the facility.
4	System	System type listed in form.
5	Status	<p>Fully functional: 100% operable with no limitations</p> <p>Partially functional: Operable or somewhat operable with limitations</p> <p>Nonfunctional: Out of commission</p> <p>N/A: Not applicable, do not have</p>
6	Comments	Comment on location, reason, and estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.
7	Remarks	Note any overall facility-wide assessments or future potential issues such as skilled staffing issues, fuel duration, plans for repairs, etc.
8	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

Appendix 5 – Information Sharing, Management and Situational Awareness

The HPP Office will share the following weekly or as needed:

MT CD Epi Weekly MMWR

MT DES SITREPs

MHA SITREPs

Health Alert Network (HAN) updates

MT DES Training and Exercise listing

The ERHCC will make changes to their infrastructure status (essential elements of information) utilizing the internet for the following applications:

Electronically via EMResource for bed availability and resource availability

EI in HICS 251 <https://montanahics251.com>

Juware

Provides a web-based platform for sharing information and disaster situations

<https://emresource.juware.com/EMSystem>

<https://eics.juware.com/web/home.aspx>

Appendix 6 – Communications Plan

DPHHS utilizes a Departmental Communications plan capable of creating telephone and internet stand-alone capability

Health care facilities will utilize internal communications planning for their organization. External to their organization, the local EOC will plan for communications requests through local Emergency Management to the State Emergency Coordination Center (SECC).

The SECC has capability of communicating with the DPHHS Department Operations Center where the HPP Program is housed.

Do not disclose Protected Health Information (PHI). Comply with requirements set forth by OSHA, EPA, CMS, HIPAA, and provider licenses.

Primary Communications

The primary communications are telephones and cellular telephones.

Secondary Communications

The secondary communications method is the internet using email as well as FAX.

Tertiary Communications

Tertiary communications are radios.

- Mutual Aid frequencies

- Amateur Radio (HAM)

Emergency Communications

Runners will be used as a last resort for essential communications.

Appendix 7 – Training

The ERHCC will develop, and update annually, a multi-year training and exercise plan (MYTEP) detailing the expected training opportunities and needs, as well as designating exercise events.

Below is the 2020 – 2024 MYTEP. Please note that all trainings are subject to availability and may change based on updated CAT and HVA responses. Coalition coordinators maintain an updated annual training and exercise plan.

FY2020-2021 (BP 2)

June 2020

- Quarterly RedCom EEI
- Pre-Event EEI
- RMRTS
- MEMSA
- Summer Institute

August 2020

- ICS 100
- PREP Summit
- Advanced Disaster Life Support (ADLS)
- PEDS Tabletop Exercises

September 2020

- Management of Aggressive Behaviors (MOAB)
- Executive Committee Meetings
- Surge Estimator Tool
- PEDS Tabletop Exercises

October 2020

- MEMSA
- Shakeout RedCom EEI
- Executive Committee Summit
- PEDS Tabletop Exercises

November 2020

- Advanced Burn Life Support (ABLS)
- Medical Countermeasures: Points of Dispensing (POD) (TEEX- MGT-319)

December 2020

- National Health care Coalition (HCC) Conference
- ICS 200
- PIO Training

January 2021

- Quarterly RedCom EEI

- AFN
- Basic Disaster Life Support (BDLS)
- ABLs
- Coalition Surge Test/HID Table Top

February 2021

- Coalition Surge Test/HID Table Top
- Cyber Security (TEEX-AWR-135 & 136)
- BDLS
- ABLs

March 2021

- Executive Committee Meeting
- Isolation & Quarantine for Rural Communities (RDPC MGT-433)

April 2021

- Quarterly RedCom EEI
- Disaster Management for Water and Wastewater Utilities (TEEX MGT-342 & 343)
- ABLs
- ADLS

May 2021

- Health Sector Emergency Preparedness (HSEP)
- PIO Training
- PHEP/HPP Regional Meetings

June 2021

- Executive Committee Meetings
- ICS 800

FY2021-2022 (BP 3)

July 2021

- Community Health care Planning & Response to Disasters (LSU-MGT-409)
- Pre-Event EEI
- Quarterly RedCom EEI
- Summer Institute

August 2021

- ICS 100
- PIO Training

September 2021

- Executive Committee Meetings
- HSEP

- Hazmat/First Responder Training

October 2021

- Executive Committee Summit
- Shakeout RedCom EEI
- MEMSA
- Community Health care Planning & Response to Disasters (LSU-MGT-409)

November 2021

- ABLIS

December 2021

- ICS 200
- Surge Estimator Tool
- HCC Conference

January 2022

- Quarterly RedCom EEI
- ABLIS
- BDLS
- Coalition Surge Test/Burn Annex

February 2022

- Coalition Surge Test/Burn Annex
- BDLS
- ABLIS
- ICS 700

March 2022

- Executive Committee Meetings
- Community Health care Planning & Response to Disasters (LSU-MGT-409)

April 2022

- Quarterly RedCom EEI
- ADLS
- ABLIS
- PIO Training
- Community Health care Planning & Response to Disasters (LSU-MGT-409)

May 2022

- Certified Health care Emergency Coordinator (CHEC)
- ICS 800
- PHEP/ HPP Regional Meetings

June 2022

- Executive Committee Meetings

FY2022-2023 (BP4)

July 2022

- Pre-Event EEI (waived)
- Summer Institute

August 2022

- Executive Committee Meeting

September 2022

- Executive Committee Summit
- Rocky Mountain Rural Trauma Symposium
- Montana Health Care Conference
- Montana Health Care Association Conference
- MACO

October 2022

- Surge Estimator Tool
- Shakeout RedCom EEI

November 2022

- ABLs
- Integrated Response to a CBRNE Incident (LSU-PER 219)

December 2022

- National Health care Coalition Preparedness Conference

January 2023

- Quarterly RedCom EEI
- ABLs
- Medical Response & Surge Exercise/Radiation Table Top

February 2023

- Medical Response & Surge Exercise/Radiation Table Top
- ABLs
- HERT

March 2023

- Executive Committee Meetings
- CHEC
- Regional Meeting
- Radiation Annex Draft Due

April 2023

- ABLs

- Quarterly RedCom EEI

May 2023

- PHEP/HPP Regional Meetings
- Cyber Security Course (TBD)

June 2023

FY 2023-2024 (BP 5)

July 2023

- Quarterly RedCom EEI
- Pre-Event EEI
- ICS 100
- Summer Institute

August 2023

- .

September 2023

- Executive Committee Meetings

October 2023

- Executive Committee Summit
- ICS 200
- Shakeout RedCom EEI
- MEMSA

November 2023

- ABLS

December 2023

- ICS 700
- HCC Conference

January 2024

- Quarterly RedCom EEI
- ABLS
- BDLS
- Coalition Surge Test/Chemical Table Top

February 2024

- Coalition Surge Test/Chemical Table Top
- ABLS
- BDLS

March 2024

- Executive Committee Meetings

April 2024

- Quarterly RedCom EEI
- ADLS
- ABLs

May 2024

- ICS 800
- PHEP/HPP Regional Meetings

June 2024

- Executive Committee Meetings

Appendix 8 – Exercise (Testing and Evaluation)

The ERHCC will develop, and update annually, a multi-year training and exercise plan detailing the expected training opportunities and needs, as well as designated exercise events.

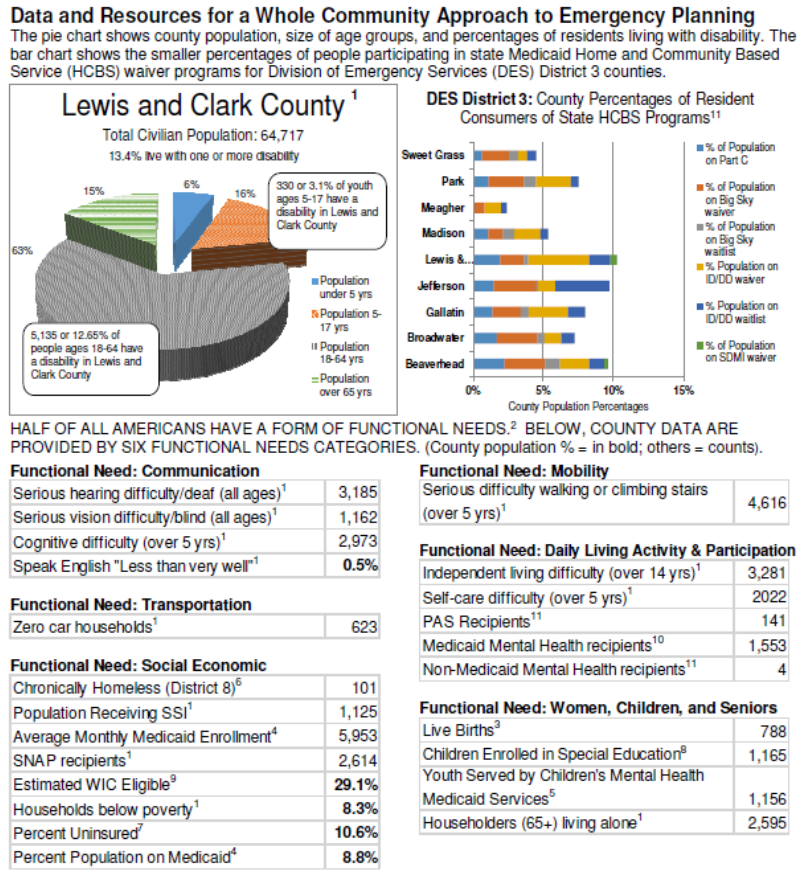
See the 2020 – 2024 MYTEP included in Appendix 7.

Appendix 9 – Access and Functional Needs Planning Considerations

County profile information can be access at the following website:

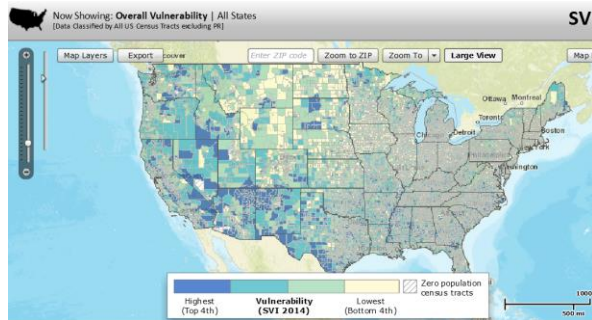
http://mtdh.ruralinstitute.umt.edu/?page_id=6292

Example:

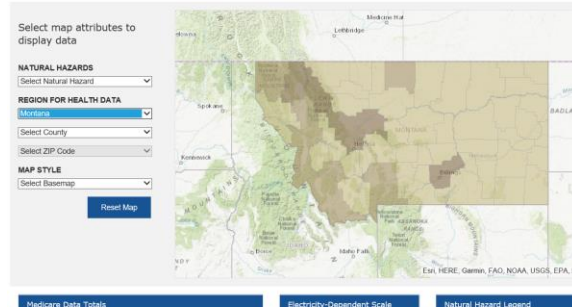


Data Sources. Please see appendix for a full listing of data sources and data definitions. For additional health

Social Vulnerability mapping can be obtained at: <https://svi.cc.gov/map.aspx>



Every 6 months MT DPHHS will receive in-depth emPOWER data updated by CMS from the US PHS Regional Emergency Coordination (REC). MT DPHHS HPP will forward this information to all Coalition membership to ensure facilities have the latest data for emergency planning activities at the local level. Generic emPOWER data can be obtained at <https://empowermap.hhs.gov/>.



Appendix 10 – Evacuation Planning Considerations

Facilities must have their own evacuation plan per the CMS Emergency Preparedness Rule. DPHHS, HPP and Regional Coalition Coordinators will work with local facilities to provide assistance and support during an evacuation and/or shelter-in-place scenario.

Appendix 11 – Mutual Aid

Montana Health care Mutual Aid System (MHMAS) provides agreement coverage for facilities to rely upon one another during a time of need as able.

MHMAS is the Emergency System for the Advance Registration of Volunteer Health Professionals for the state of Montana. MHMAS is a secure, web based online registration system used to register, verify and credential volunteer health care professionals BEFORE a major disaster or public health emergency occurs.

The registry can be found at <https://mhmas.org/>.

Appendix 12 – Protecting Responders

Incidents of varying scope and magnitude can happen, ranging from the more prevalent motor vehicle threats of exposure to fuels and oils and burning synthetics to a category A infectious disease. Once the facility has determined the likely threats to affect their staff, proper personal protective equipment should be identified, acquired, stocked, and trained.

Appendix 13 – 1135 Waiver Requests

Definition and Considerations

1135 During times of declared Public Health Emergency, under section 1135 of the Social Security Act, a temporary waiver of or modification to requirements of Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements may be enacted to ensure that sufficient health care items and services are available and that providers can then be reimbursed and exempted from sanctions. The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation

1135 waivers are determined by the Secretary of Health and Human Services and typically end no later than the termination of the emergency period, or 60 days from the date the waiver is originally published.

Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.

Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.

This function is carried out through the Quality and Assurance Division (QAD) at DPHHS.

Appendix 14 –Facility Closed Point of Dispensing (POD)

FREQUENTLY ASKED QUESTIONS

What is a Point of Dispensing (POD)?

A POD is a place where people get the medication that is sent in the Strategic National Stockpile (SNS).

What is a Closed POD?

A Closed POD is a location that is operated by a private or public organization that dispenses medication to a specific population which may include its employees, their families and clients. A Closed POD is not open to the public.

What is the Strategic National Stockpile (SNS)?

The SNS is a national stash of medical supplies and treatment owned by the Centers for Disease Control and Prevention (CDC). The SNS serves as a national supply of medications and medical supplies for emergency situations.

What is the responsibility of the local health department?

The local health department is responsible for dispensing the medications in the SNS to the citizens of this County within 48 hours of requesting the supplies.

What are the benefits of a Closed POD?

A Closed POD helps businesses ensure that their employees are protected and therefore able to continue working and/or return to work more quickly. The benefit to local health jurisdictions is that it reduces the number of people seeking medication at the public PODs.

What are the requirements for becoming a Closed POD?

Organizations with a significant number of employees or organizations that serve vulnerable populations are typically eligible to become Closed PODs. Public Health asks that you sign a Memorandum of Agreement prior to becoming a Closed POD.

How much is it going to cost?

Medication and training is free of charge.

Will there be training provided?

Yes. Training and exercise opportunities occur throughout the year. While there are currently no required trainings/exercises you will have the opportunity to participate in events as they arise.

When would we be asked to dispense medications at our own facility?

The only time Public Health would ask organizations to dispense medications would be if there is a great risk to the entire population of the local health jurisdiction and the preventative medications are needed to be taken immediately.

Who operates the Closed POD?

Your organization will operate the Closed POD with as much oversight from Public Health as possible.

Are medical personnel required?

Yes, to become a Closed Pod, you will need to have at least one medical personnel available to screen patients.

Will people be allowed to pick up medications for their families?

Yes, individuals attending the POD will be encouraged to pick up medications for their families.

How will the medication be packaged?

The medication will be packaged for individual use and will be taken orally. Drug information sheets will be provided with the medication.

Who needs to take the medication?

Assuming this is a major public health emergency the entire population of the local health jurisdiction will need to take the medication.

Is it possible that our organization will need to operate a Closed POD after-hours, during the weekend, or on a holiday?

Yes, public health emergencies can occur at any time. It is essential that your organization be prepared to operate a POD during non-working hours since health will be at risk if medications are delayed.

Is this legal?

Yes, it is legal. Public health officials depend on volunteers to assist during an emergency. Participating as a Closed POD is a voluntary program.

Appendix 15 - CHEMPACK Host Facilities

Medical Materials Assets (excerpt for DPHHS MCM Plan)

Medical Materials Assets

CHEMPACK Host Facilities			
All numbers are 406 area code			
Location & Cache	Address	Primary 24/7 Pharmacy Contact	Alternate 24/7 Emergency Contact
Billings Fire Dept. Station #5 <i>CHEMPACK</i>	605 S. 24 th Street W Billings, 59102	657-3000 (Fire Dispatch) Ask for On-Duty HazMat Battalion Chief	657-3000 (Fire Dispatch) Ask for On-Duty HazMat Battalion Chief
Frances Mahon Deaconess Hospital <i>CHEMPACK</i>	621 3 rd St Glasgow, 59230	228-3500 (Main Number) Ask for Pharmacy	228-3500 (Main Number) Ask for Maintenance on Call
Benefis Health Care <i>CHEMPACK</i>	1101 26 th St. South Great Falls, 59405	455-5430 Ask for Pharmacist in-Charge	455-5000 Ask for Security
Kalispell Regional Medical Center <i>CHEMPACK</i>	310 Sunnyview Ln Kalispell, 59901	752-5111 (Main Number) Ask for Pharmacist in-Charge	752-5111 Ask for House Supervisor
St. Patrick Hospital <i>CHEMPACK</i>	500 W. Broadway Missoula, 59806	329-0321 Ask for Pharmacist Lead	329-0321 Ask for Pharmacist
St. Peter's Health <i>CHEMPACK</i>	2475 E. Broadway Helena, 59601	444-2350 Ask for Pharmacist on Call	442-2480 Ask for Security Supervisor
Bozeman Deaconess Hospital <i>CHEMPACK</i>	915 Highland Blvd. Bozeman, 59715	414-1050 Ask for Pharmacist on Duty	525-5000 Ask for House Supervisor

CHEMPACK Cache	
Cache Owner	Centers for Disease Control and Prevention
Cache Purpose	Rapid provision of chemical nerve antidote
Authorized to Request	Any hospital or appropriate jurisdictional authority
Request Channel	Directly to host hospital
Intended Use	Rapid treatment of multiple victims that are potentially exposed to large nerve agent chemical release
Target Population	Individuals potentially exposed to nerve agent chemicals due to a chemical release
Transportation	Preplanned and coordinated by requesting entity
Chain of Custody	Chain of custody will be maintained and tracked – forms are with the CHEMPACK Container
Patient Tracking	All individuals receiving cache medications should be documented and tracked
Reporting Requirements	Report CHEMPACK activation as soon as reasonably possible to DPHHS DOC
Charging/Billing	Cache assets should not be charged to the patient/recipient
Restrictions	The Container may not be opened unless a public health emergency is perceived to exist and is beyond the local capacity to respond

- DPHHS and CDC authorize breaking the CHEMPACK container seal and using the packaged products only when the competent authority, in coordination with an incident commander at the scene, determines that an accidental or intentional nerve agent release and:
 - ✓ The material is medically necessary to save lives
 - ✓ Is beyond local emergency medical response capabilities
 - ✓ Has put multiple lives at risk.
- A component requesting authority is defined as public health, DES, hospital, EMS, or other medical professional or any organization identified and trained by the local public health jurisdiction.
- Accessing CHEMPACK assets should be initiated when a nerve agent release involving multiple victims is suspected. The transportation or use of CHEMPACK assets to the scene should not be delayed while waiting for a confirmation of exposure.
- Opening a CHEMPACK container will result in the loss of that CHEMPACK asset for future use. There is no funding for restocking. The CHEMPACK is sustained through the CDC’s CHEMPACK sustainment program.

CHEMPACK Contents*

EMS Configuration for up to 454 Casualties

Medication ¹	NDC #	Unit Pack	Cases	QTY
Mark 1 auto-injector	6505-01-174-9919	240	5	1200
Atropine Sulfate 0.4mg/ml 20ml	63323-234-20	100	1	100
Pralidoxime 1gm inj 20ml	60977-141-01	276	1	276
Atropen 0.5 mg	11704-104-01	144	1	144
Atropen 1.0 mg	11704-104-01	144	1	144
Diazepam 5mg/ml auto-injector	6505-01-274-0951	150	2	300
Diazepam 5mg/ml vial, 10ml*	0409-3213-12	50	1	50
Sterile water for injection (SWFI) 20cc	0409-4887-20	100	2	200

¹ Some medications within the CHEMPACK do not provide a medication name on case the label. To confirm the medication the NDC number must be checked.

Appendix 16 – HPP PPE Cache

The Health care Preparedness Program maintains a PPE cache that may be shared across multiple health care organizations in an emergency. This cache may provide resources necessary to protect responders, employees, and their families from hazards during response and recovery operations.

The cache is maintained and rotated by Concordance, a medical equipment and supply company, under contract through the Montana Hospital Association (MHA). The quantity of the cache and manufacturers of the supplies may vary as the cache is rotated through the system. There are different methods or conditions under which this cache may be deployed.

HPP PPE Cache	
Cache Owner	DPHHS, Hospital Preparedness Program
Cache Purpose	To provide rapid access to Personal Protective Equipment during a public health emergency and hospital surge situations when normal supply chains are inadequate
Authorized to Request	Hospital authorized individuals
Intended Use	Provision of PPE due to shortages during hospital surge events
Target Population	Health care workers and first responders
Charging/Billing	Cache assets are not to be charged to patients
Restrictions	Cache requests are for immediate use and cannot be stockpiled

Appendix 17 – Health care Coalition Cache

Purpose

The purpose of this document is to provide guidance on the processes for requesting personal protective equipment (PPE) held by the Regional Health care Coalitions. The purpose of the cache is to assist all health care entities as able. All PPE issued from The Regional HPP Cache are intended for emergency response, not for daily usage.

Personal protective equipment (PPE) is used every day by health care personnel (HCP) to protect themselves, patients, and others when providing care. PPE helps protect HCP from many hazards encountered in health care facilities. Facilities should ensure they have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care.

The greatly increased need for PPE caused by highly infectious disease outbreaks or other health care emergencies may cause PPE shortages, posing a tremendous challenge to the U.S. health care system. Health care facilities that may have difficulty accessing the needed PPE may have to identify alternate ways to provide patient care.

Surge capacity refers to the ability to manage a sudden increase in patient volume that would severely challenge or exceed the present capacity of a facility. While there are no commonly accepted measurements or triggers to distinguish surge capacity from daily patient care capacity, surge capacity is a useful framework to approach a decreased supply of PPE during a highly infectious disease outbreak. To help health care facilities plan and optimize the use of PPE, CDC has developed a [Personal Protective Equipment \(PPE\) Burn Rate Calculator](#).

As PPE availability returns to normal, health care facilities should promptly resume standard practices.

(Optimizing Supply of PPE and Other Equipment during Shortages, 2020)

Policy

The Montana Regional Health care Coalitions have procured Medical Grade PPE. All PPE issued from The Regional HPP Cache is intended for emergency response, not for daily usage. Caches will be maintained in a climate-controlled setting to ensure quality of the product. The cache will be managed by Vendor Managed Inventory (VMI).

Procedure

In order for a health care entity to request PPE from the Regional Health care Coalition Cache, the following steps must be taken:

1. Facility has implemented PPE conservation strategies, as identified by the CDC, to safely extend supplies of existing PPE

2. Facility has exhausted all other means of commercial procurement before requesting cache inventory
3. Facility has utilized mutual aid agreements with surrounding facilities to obtain PPE
4. Facility has completed a request to local DES
 - a. Request will be routed to State DES if additional support is needed
5. If all avenues have been exhausted, facility will complete a request to the Regional Health care Coalition

If a request is received by the Regional Health care Coalition, the request will be reviewed by a subcommittee of the respective Coalition Executive Committee and HPP staff. The Coalition maintains the authority to issue PPE in amounts less than request in order to maintain appropriate supply for additional requests that may be received. If a request is granted PPE will be shipped by Concordance costs covered by HPP as able. Once the HPP cache is depleted, it is gone.

Appendix 18 – Supply Chain

Facilities are responsible for maintaining their own supply chain plans and policies. Coalition may be able to assist with PPE on occasion but supplies needed outside of that scope will be the responsibility of the facility. Coalitions will share information on supply chain disruption, alternate sources, etc. as the information becomes available. The process for requesting additional supplies includes exercising Mutual Aid agreements as the first step. If unable to obtain the needed supplies, the facility should reach out to local Emergency Management offices who will then submit the request to the appropriate agencies for fulfillment.

Appendix 19 - Resources and References

Center for Domestic Preparedness. (n.d.). Retrieved August 26, 2020, from <https://cdp.dhs.gov/>

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Annex 1 – Crisis Standards of Care Concept of Operations

Section I: Purpose, Goals, Scope and Assumptions

Purpose

This document provides guidance for the continued delivery of essential health services during a pervasive or catastrophic event where the ability to provide conventional standards of care is compromised. The guidance is focused towards hospitals providing acute care services. These guidelines build upon and rely on the substantial infrastructure related to Department of Homeland Security Emergency Support Function #8 capacity and capabilities for public health and the health care system. Based on all-hazards planning and the use of National Incident Management System for response activities, state and local public health, and health care organizations form an integrated framework of essential health services in a crisis care environment.

Goals

- Provide ethical and legal framework for implementing crisis standards of care
- Emphasize processes for:
 - Notifying Montana Department of Public Health and Human Services (DPHHS) and Disaster and Emergency Services of a pervasive or catastrophic event
 - Requesting Declarations of a State of Emergency or a State of Disaster, including the provision authorizing the practice of disaster medicine
- Provide guidance for using the Hospital Incident Command System (HICS) for crisis management within health care facilities
- Assist health care facilities in determining appropriate and feasible levels of health care during crises
- Provide guidance for consistent and equitable triage and health care during pervasive or catastrophic events
- Assist health care facilities in encouraging public use of self-triage and self-care using the media
- Provide guidance for establishing plans to offer palliative health care, behavioral health services, and mental health treatment during a crisis, see attachment E for more information.

Scope

A defined ethical framework shall serve as the basis for guidelines on equitable health care resource allocation. This framework includes the following duties:

- **Duty to Plan:** health care facilities have a duty to plan for catastrophic events, including for delivery of health care along the continuum from conventional to crisis response
- **Duty to Care:** patients shall not be abandoned if not prioritized for acute or specialized health care; all possible palliative and supportive health care shall be provided for those not qualifying for acute or specialized health care
- **Duty to Steward Resources:** health care providers should balance the obligations of saving the greatest number of lives versus caring for each patient; decisions on using scarce resources should balance the likelihood for patient survival

- **Duty of Fairness:** ethical policies do not require all persons receive identical treatment, but do require differences in treatment be based on appropriate differences among patients. Policies should account for the needs of the most at-risk and support equitable distribution of scarce goods and resources. Particular attention in disaster plans is required for those with vulnerabilities and specific needs requiring accommodation during disasters.
- **Duty to Educate:** Each health care facility has a responsibility for community education concerning what to expect when an event occurs that overwhelms resources and requires a crisis standards of care response

Assumptions

- Adopting crisis standards of care is based on the best available evidence, including but not limited to the following potential sources of information:
 - Community partners (e.g., public health agencies, area hospitals and clinics, health care providers, community members)
 - Broad-based clinical care committee
 - *Montana Crisis Standards of Care Guidelines for Hospitals*
- Implementing crisis standards of care involves acknowledging existing licensing requirements, regulatory issues, changing scientific information, and an ethical framework used during decision-making
- Changing of Federal or state regulations, professional license requirements, and facility license requirements might occur during an event

Section II: Roles & Responsibilities

Governor/Federal Partners

Federal assistance is available to supplement the resources of State, local, voluntary agencies in major disasters. Some forms of Federal assistance could be available without a Presidential declaration. Others would become available only following a declaration by the President at the request of the State's Governor. FEMA uses the Federal Response Plan (FRP) to coordinate the government response to disasters or emergencies. The FRP describes the mechanisms by which the Federal government mobilizes resources and conducts activities to augment State and local response efforts. Local and State responders are fully committed as they attempt to respond to a major disaster. Local first responders work closely with voluntary agencies; the Mayor or County Executive activates the local EOC. Upon a request from the local executives, the Governor activates the STATE EOC, declares a State Emergency or disaster, and activates the State Emergency Operations Plan.

The Governor has the duty, when necessary, to formally declare a disaster or emergency either before, during, or after an event. The request process for declaring a State Disaster or Emergency must be routed through local Emergency Management to the State Disaster Emergency Services. Local principle executive officers of a political subdivision may be issue emergency proclamations or disasters declaration as well.

Health care Facility Executive Officer

The health care facility's Executive Officer or designated representative has primary responsibility for activating and implementing crisis standards of care procedures. The Executive Officer should have the following duties:

- Following consultation with a broad-based clinical care committee and other applicable partners, determine if the event and available resources necessitate activating crisis standards of care for the health care facility
- Serve or designate a representative to serve as the health care facility's Incident Commander
- Determine when the health care facility should resume conventional standards care

Hospital Command Staff

Hospital command staff should have the following duties:

- Undergo training in the crisis standards of care plan components and response
- Understand their role and the roles of response partners
- Be well-versed in incident action planning during long-term events
- Have access to appropriate resources (e.g., job aids) to guide decision-making
- Serve as the interface for resource requests and acquisition with local, state, and tribal jurisdictions
- Understand policies for patient transfer and diversion, including the process for sheltering, relocating, and evacuating patients
- Understand the process for rapid facility and incident assessment to gain situational awareness
- Understand how the health care facility interfaces with local, state, and Federal public health agencies

Montana DPHHS

- Assist health care facilities with situational awareness regarding local and regional available resources
- Distribute health alert messages to local health departments
- Submit official requests to the Centers for Disease Control and Prevention for Strategic National Stockpile assets
- Coordinate Crisis Standards of Care Development Task Group meetings, coordinate development of *Crisis Standards of Care Guidelines for Hospitals*, and maintain the Guidelines.
- Monitor health impacts and coordinate with local, state, and federal partners to address impacts.

Montana Hospital Association (MHA)

- Assist health care facilities with mutual aid requests for health care workers through the Montana Health care Mutual Aid System (MHMAS)
- Assist health care facilities with other mutual aid requests

Local Health Jurisdiction

- Coordinate with State and hospitals based on situation needs.

- Plan for Strategic National Stockpile (SNS) deployment which is the nation’s largest supply of potentially life-saving pharmaceuticals and medical supplies for use in a public health emergency. The stockpile ensures the right medicines and supplies are available when and where needed to save lives.
- Refer to the IOM Guidance, Chapter 5, and also on page 6 of this document under Responsibilities of Public Health Department.
- IOM Reference Guide http://www.iom.edu/~media/Files/Report%20Files/2012/Crisis-Standards-of-Care/CSC_SponsorGuide.docx).
- Part of Emergency Support Function #8. Public Health and Medical Services provides the mechanism for coordinated Federal assistance to supplement State, tribal, and local resources in response to a public health and medical disaster, potential or actual incidents requiring a coordinated Federal response, and/or during a developing potential health and medical emergency. ESF#8 provides the following supplemental assistance to State, tribal, and local governments in the following core functional areas:
 - Assessment of public health/medical needs
 - Health surveillance
 - Medical care personnel
 - Health/medical/veterinary equipment and supplies
 - Patient evacuation
 - Patient care
 - Safety and security of drugs, biologics and medical devices
 - Blood and blood products
 - Food and safety and security
 - Agriculture safety and security
 - All-hazard public health and medical consultation, technical assistance, and support
 - Behavioral health care
 - Vector control
 - Potable waste/wastewater and solid waste disposal
 - Mass fatality management, victim identification, and decontaminating remains
 - Veterinary medical support
- Contribute to the decision-making process for declaring a disaster, and in collaboration with the Department of Homeland Security (DHS), mobilizes and deploys ESF-8 personnel to support national or regional teams to assess public health and medical needs, including the needs of at-risk population groups. HHS in coordination with supporting departments and agencies, enhances existing surveillance systems to monitor the health of the general and medical needs population; carries out field studies and investigations; monitors injury and disease patterns and potential disease outbreaks, blood and blood product biovigilance, and blood supply levels; and provides technical assistance and consultations on disease and injury prevention and precautions.

Eastern Region Health Care Coalitions

The ERHCC will collaborate with DPHHS PHEP/HPP to assist with:

- Integration with state-level efforts
- Management of crisis conditions through regional coordination, including resource sharing and patient distribution
- Management of information and policy decisions with the assistance of coalition partners during a protracted event
- Management of resource requests and scarce resource allocation decisions when the demand cannot currently be met
- Support EMS agency planning for indicators, triggers, and response strategies during crisis conditions
- Support hospital planning for indicators, triggers and response strategies during crisis conditions
- Transition to contingency care by requesting resources or moving patients to other facilities
- Integration of crisis care/crisis standards of care into exercises.

Section III: Concept of Operations

Indicators and Triggers for Initiating Crisis Standards of Care

The Institute of Medicine's *Crisis Standards of Care: A Toolkit for Indicators and Triggers* defines indicators as "...measures or predictors of changes in demand and/or resource availability" and triggers as, "...decision points". The Institute of Medicine's toolkit encourages health care facilities not to rely upon concrete indicators and triggers, but instead maintain flexibility when initiating crisis standards of care. Examples of potential triggers include but are not limited to the following:

- Activation of local or regional surge plans
- Exhaustion of maximum surge capacity
- State or local Emergency Operations Center activation for an event that involves patient surge
- Exacerbating factor during an event (e.g., severe weather)
- Disruption of essential services or critical infrastructure
- Insufficient human or material resources, or patient care space availability

Legal Authority

Formal declaration of a disaster or emergency by the Governor will provide authority to medical practitioners for practicing disaster medicine, waiving certain statutory restrictions, and triggering liability protections (Montana Code Annotated Sec. 10-3-302 through -303). A declaration request from local government to the Governor may occur before, during, or after an event.

Command and Control

Hospitals should use the Hospital Incident Command System to integrate with other local, regional, state, and federal agencies. The use of the Hospital Incident Command System requires regular education and testing to ensure efficient use during events.

Progressing from Conventional to Contingency to Crisis Standards of Care

The availability of resources during a disaster will influence the standards of care practiced by health care providers. Health care facilities will have to consider standards of care and resource availability on a

continuum based upon the situation (**Attachments A and B**). Health care facilities should consider the implications of progressing from conventional to contingency to crisis standards of care (**Attachment C**).

Triage

Health care facilities might need to modify standard triage practices during a disaster. Simple triage and rapid treatment (START) is one triage method used by first responders to rapidly classify victims during a mass casualty incident based on the severity of injury. See **Attachment D** for a full description of START and a triage algorithm for use during a disaster.

Communication Systems

Montana facilities should have a well-developed communications annex in their emergency operations plan describing the means for information sharing with staff, patients, and other regional facilities and agencies. The facilities should have redundant ability to communicate with:

- Local emergency management system
- Local emergency operations center
- Local, state, and tribal health multiagency coordination center (as applicable)
- Other area hospitals and facilities

Facilities should have 24/7 capability to receive health alerts and other local, state, and Federal health communications, and a process for rapidly analyzing those communications and developing or modifying policy accordingly.

Public Information

Each health care facility has a responsibility for community education concerning what to expect when an event occurs that overwhelms resources and requires a crisis standards of care response. This education should encompass the following:

- Redefining public expectations
- Offering psychological and ethical support services for responders and community members
- Establishing guidelines and protocols related to palliative care
- Establishing relationships with media and public health agencies to enhance public understanding regarding the limitations of the health care system during a large-scale event

Facilities along with their local health departments should use the Institute of Medicine's document titled, *Crisis Standards of Care in disasters and pandemics: A Community Conversation*, to engage their communities (see http://www.iom.edu/~media/Files/Report%20Files/2012/Crisis-Standards-of-Care/CSC_SponsorGuide.docx).

Below are the responsibilities of the State Public Health Department:

- Providing oversight of and/or support to local health departments, depending on whether the structure is centralized or decentralized:
- Overseeing EMS agencies;
- Regulating laboratories
- Licensing health care practitioners
- Regulating health care
- Monitoring the health status of the population

- Providing prevention services (e.g., HIV, injury control, tobacco control);
- Conducting disease surveillance and control
- Overseeing maternal and child health services and medical assistance programs;
- Implementing health care reforms;
- Providing and regulating mental health services; and
- Collaborating on grants and programs with federal partners (e.g., Department of Health and Human Services)

State health departments are actively engaged in public health emergencies preparedness (CDC,2010; TFAH,2010) For example, often in collaboration with other state agencies, they

- Administer Public Health Emergency Preparedness (CDC.2011a) and Hospital Preparedness Program (ASPR, 2012) cooperative agreements that HHS provides for state, local, and hospital preparedness;
- Participate in state-level management of emergencies (e.g., as the state’s lead ESF-8 agency) (MEMA,2009);
- Develop pandemic, medical surge, and other emergency response plans (e.g., mass fatality management and hospital evacuation);
- Coordinate state and local components of federal response programs (e.g. Cities Readiness Initiative for mass dispensing of antimicrobials following and anthrax attack (CDC,2011b);
- Develop and participate in multidisciplinary emergency planning workgroups (Garrett et al.,2011);
- Plan for the allocation and prioritization of scarce resources (e.g. Vaccines and ventilators) during responses (Garrett et al.,2011);
- Coordinate registration and credentialing systems for health care volunteers (e.g., Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP]) and health care response teams (e.g., Medical Reserve Corps [MRC]);
- Manage stockpiles of medical countermeasures (e.g. Antivirals) and other material;
- Identify and develop plans for alternate care sites; and
- Establish health care emergency communications systems (ASPR, 2011a).

Facilities should have the following:

- *Robust public information infrastructure* — a strong public information infrastructure is vital during implementation of crisis standards of care, activation of alternate care sites, and other similar activities with substantial community impact. Such extraordinary measures require an active and consistent system of communication among command staff, response agencies, health care facilities, and the community. It is important an internal public information officer assist in drafting appropriate messaging for internal and external dissemination.
- *Representation and participation in local or regional joint information system* — the joint information system brings together resources from multiple response organizations to share information and present a consistent message to the public. The joint information center is the physical location where public information officers from separate organizations gather to

perform this task and work within local, regional, state, or tribal infrastructure to assist in implementing or becoming a part of the joint information system. Size and complexity of the joint information system will vary based upon the size of facilities, communities, and counties.

Release of Protected Health Information

Health care providers covered by the Health care Insurance Portability and Accountability Act (HIPAA), in general, may share protected health information (PHI) to assist in patient care and disaster relief efforts. Information relevant to the following areas may be shared:

- Treatment — health care providers may share PHI as necessary to provide treatment, including sharing PHI with other health care providers, referring patients for treatment, and coordinating patient care. Health care providers may share PHI to the extent necessary to seek payment for these health care services.
- Notification:
 - Health care providers may share PHI as necessary to identify, locate, and notify family members, guardians, or other persons responsible for the patient’s care. The health care provider should obtain written permission from patients, when possible; however, if the patient is incapacitated or not available, health care providers may share PHI if doing so is in the patient’s best interest.
 - When necessary, the facility may notify police, news media, or public to the extent necessary to help locate, identify, or notify family members and others regarding the location and condition of the patient. Health care providers do not need to obtain the patient’s permission to share PHI with disaster relief organizations (e.g., American Red Cross) as doing so would interfere with the organization’s ability to respond to the emergency.
- Imminent Danger — health care providers may share PHI with persons able to prevent or lessen a serious and imminent threat to the health and safety of a person or the public, consistent with applicable law and the health care provider’s standards of ethical conduct.
- Facility Directory — health care facilities maintaining a directory of patients may tell inquiring persons whether a patient is at the facility, location within the facility, and general condition.
- Third party communications — during a large-scale event, it will be necessary to communicate PHI to third parties, such as other hospitals, state health department, and law enforcement, in accordance with applicable laws and regulations.

Note: consideration of the release of PHI is often complicated, but health care facilities can reference the following link to assist in making PHI release decisions:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/decisiontoolintro.html>

This tool does not address other Federal, state, or local confidentiality laws that might apply in specific circumstances. Because this tool focuses on issues relevant to emergency preparedness, this tool does not present all uses and disclosures permitted by HIPAA, nor does it discuss all requirements. For further clarification, please consult the health care facility’s Privacy Officer or other appropriate professional.

Palliative Care

During disasters when resources are scarce, the task of providing palliative care can be shifted to those without prior health care experience. Palliative care services provided should not exclude management of pain or psychosocial, spiritual, or emotional needs. Palliative care will likely require a multidisciplinary and coordinated response. If palliative care is offered at an alternate care site, transportation between primary care and mortuary sites must be considered and prioritized. Health care facilities should:

- Plan accordingly for the delivery of palliative care, including staff education, allocating appropriate space, and ensuring adequate inventory of supplies
- Provide each patient with pain and symptom management, as resources allow

Behavioral Health

Disasters can negatively affect the mental and behavioral health of both patients and health care staff, and other responders. Existing mental health conditions (e.g., anxiety disorder, schizophrenia) can be worsened during an emergency and the onset of other mental health conditions (e.g., post-traumatic stress disorder) can occur. The mental health of certain vulnerable populations (e.g., children, elderly) can also be affected. Patients might require mental health treatment services during or after a disaster event. Health care facilities should consider the following mental and behavioral health elements:

- *Occupational Mental and Behavioral Health*
 - Health care facility has a personal resilience plan for health care workers including triage and referral to a continuum of evidence-based mental health treatment
 - Health care providers understand employee resilience plan, including sources of employee mental health support
 - Health care providers are trained in anticipating typical stress reactions, developing a personalized resilience plan, and identifying coping resources
 - Health care facility has non-mental health personnel trained in basic psychological first aid and psychological triage, and assigns a role to mental health operations within HICS
- *Public Mental and Behavioral Health*
 - Health care facility provides crisis standards of care-specific coping information and resources to patients, family members, and staff, including “neighbor-to-neighbor, family-to-family” psychological first aid
 - Health care facility plans for triage-driven management of psychological casualties, including participation in local or regional plans for mental health incident management
 - Health care facility participates in development of risk communications that includes a behavioral health component for patients, their families, and health care workers
 - Health care facility participates in a local gap analysis and develops an action plan to build key local disaster mental health and spiritual care capacities

Vulnerable Populations and Patients Requiring Special Care

Patient groups requiring special consideration should be identified, and to the extent possible, resources to address their needs purchased or stockpiled proportional to the facility’s role in the community. The facility should understand the local, regional, state, or tribal plans and available resources for specific populations. These populations include but are not limited to the following:

- Children
- Elderly
- Burn patients
- Patients requiring airborne isolation
- Patients requiring decontamination
- Patients with functional limitations
- Patients requiring dialysis

Strategic National Stockpile

The Strategic National Stockpile (SNS), maintained by the Centers for Disease Control and Prevention, provides access to medical supplies, pharmaceuticals, and equipment during public health emergencies and other disaster events. Each state is responsible for maintaining plans and procedures for requesting, receiving, and distributing SNS resources during an event. DPHHS is the designated agency responsible for creating, maintaining, and exercising the plan known as the Medical Supplies Management and Distribution Plan (MSMD).

Local health jurisdictions are responsible for maintaining plans to request and receive SNS assets. Health care facilities should maintain procedures, in collaboration with local health jurisdictions and emergency management, to provide situational awareness regarding the event’s impact on the delivery of health care and the need for additional resources. Information and requests for resources should follow the local communications channels, moving from the facility through the local emergency operations center, and then to the State Emergency Coordination Center for action. Requests for resources require pre-planning from the facility. Procedures to identify the types and amounts of resources needed should be in place along with plans to receive those resources.

Planning and Training

A plan for staff education should be in place to familiarize all personnel with at least the following:

- Crisis standards of care triggers
- HICS implementation
- Standards of care continuum
- Facility plans for human and physical resources based upon crisis status
- Community resources and partners
- Mental health support services available for staff and families

Health care facilities should take the following actions:

- Regularly train and exercise Hospital Command Staff in activation of the continuum of care, including use of surge spaces and staffing
- Regularly perform training and exercises with key staff, including those on a clinical care committee and potential triage team members
- Address collective bargaining issues, if applicable
- Consider staff behavioral health issues
- Ensure Federal Resources (e.g., National Disaster Medical Services, Disaster Medical Assistance Teams, Veteran’s Administration) are reviewed and considered

- Provide staff with just-in-time training

Volunteer Management

Montana Health care Mutual Aid System (MHMAS) volunteers will follow the state protocol for requesting the activation of the MHMAS System. The health care facility should determine whether unaffiliated and spontaneous volunteers (those not deployed through MHMAS, state, or Federal system) will be used. If not, those volunteers should be directed away from the scene and given instructions for registering with MHMAS, thereby allowing timely verification of credentials.

Recovery

Recovery will likely involve progressive restoration of services as issues resolve and resources become available. The same ethical framework for implementing crisis standards of care applies to the restoration of conventional standards of care. Health care facilities should take the following actions during the recovery phase:

- Communicate through the incident command structure.
- Refer to the facility's emergency operation plan for guidance
- Conduct debriefing sessions for critical evaluation of actions taken during the event
- Create after-action reports using data gathered during debriefings
- Maintain accurate records

Section IV: Maintenance

The *Crisis Standards of Care Development Task Group* will review these procedures annually to ensure currency and accuracy. The person assigned responsibility for maintaining these procedures will propose substantial edits and procedural changes to the entire Task Group. The review is for advisory purposes to determine whether the procedures herein remain appropriate to the goals. Goals of the review include:

- Ensure overall plan accuracy and readiness
- Address and resolve policy, methodology, and technical issues
- Coordinate with related plans, procedures, and protocols

Minor corrections, edits, updates, or adjustments in this document do not need reviewed by the Task Group; however, those changes, should be recorded in the 'Record of Change Log' and the version of the document changed accordingly.

Section V: Additional Information

In September 2021, Montana Department of Public Health & Human Services released a Scarce Resource Management & Crisis Care Guidance document in response to the 2020 – 2021 COVID-19 pandemic emergency. Links to this document are included below. These documents may be used in conjunction with this Annex to provide guidance for the continued delivery of essential health services during a pervasive or catastrophic event where the ability to provide conventional standards of care is compromised.

Front Matter:

<https://dphhs.mt.gov/publichealth/cdepi/diseases/CoronavirusMT/MontanaCrisisCareGuidanceFrontMatter.pdf>

Overview & Materials:

<https://dphhs.mt.gov/publichealth/cdepi/diseases/CoronavirusMT/MontanaCrisisCareGuidanceOverviewMaterials.pdf>

Section V: Attachments

Attachment A

Progression from Conventional to Contingency to Crisis Care

Standards of Care Continuum			
	Conventional	Contingency	Crisis
Standards of Care	Usual	Functionally equivalent	Sufficient for resources available
Space	Usual inpatient and outpatient spaces and beds	Adapted patient care areas (e.g., post-anesthesia care units, day surgery areas)	Use of non-patient areas for patient care (e.g., classrooms, lobbies)
Staff	Usual staff — consider augmenting staff or using cross-trained staff	Changes in staffing including ratios, shift duration, duties, or use of equivalent staff from another institution	Use of staff not normally trained for certain skills or positions (e.g., use of subspecialty providers in acute care clinics)
Supplies	Usual or normally substituted supplies	Adapted supplies (e.g., conserving oxygen use, using transport ventilators for longer-term ventilation)	Re-use or re-allocate (resource triage) supplies

Attachment B

Progression of Care Continuum

Minimal Contingency Actions

- Initiate more stringent admission criteria
- Conduct early discharges
- Eliminate linen changes, bed-baths, and similar nursing care duties
- Increase shift length
- Increase slightly patient-to-health care provider ratio
- Eliminate dietary preferences
- Limit post-mortem nursing care
- Restrict hospital access
- Initiate cohorting
- Consider implementing Montana Health care Mutual Aid System (MHMAS)

Moderate Contingency Actions

- Perform acute care onsite at long-term care facilities
- Use of clinical judgment might replace certain laboratory and radiological diagnostics
- Implement disaster/emergency clinical privileges for health care providers
- Increase moderately patient-to-health care provider ratio
- Recruit health care providers (e.g., retired)
- Increase care provided by family members
- Decrease frequency of vital signs
- Change palliative care practices
- Change charting practices

Crisis Actions

- Expand markedly the clinical privileges for health care providers
- Increase substantially patient-to-provider ratio
- Use volunteers for some patient care
- Use family to administer medications
- Do not perform cardiopulmonary resuscitations
- Use of clinical judgment might replace certain laboratory and radiological diagnostics
- Modify informed consent requirements
- Conduct minimal charting

Attachment C

Implications of the Care Capacity Continuum for Resources

	Low risk, low impact	Moderate risk, moderate impact	High risk, high impact
Space	Expand hours and use procedural spaces for out-of-hospital care (e.g., surgery and procedure center recovery areas)	Use operative spaces for inpatient care	Use cot-based care in flat space areas
	Use post-anesthesia care unit areas for inpatient capacity	Use alternate care sites to divert outpatients (e.g., influenza centers)	Change admission criteria substantially (e.g., no admission for cardiac rule-outs if no ECG changes and normal troponin)
Staff	Change documentation requirements	Change staffing patterns, hours, or supervision	Provide just-in-time training to staff for providing lower-impact interventions and overall patient care (e.g., inhaler administration, change of burn dressings) so specialty staff can concentrate on higher-impact interventions (e.g. ventilator management, burn debridement)
	Delegate non-clinical duties (e.g., meal serving) to non-clinical staff	Change frequency of clinical assessments (e.g., vital signs based on clinical changes)	
Supplies	Implement conservation strategies (e.g., restrict oxygen use to those with hypoxia)	Adapt medications or supplies to the event (e.g., use of BiPAP or selected anesthesia machines as ventilators)	Reuse products requiring high-level disinfection or sterilization (e.g. eastern lines, ventilator circuits)
	Recommend substitute medication classes where possible	Reuse otherwise disposable products that can easily be cleaned or disinfected (e.g., cervical collars, tourniquets)	Reallocate medications or supplies to those who will derive the greatest benefit or make the least demand on resources

Attachment D

Triage

Triage System — START Triage

Simple triage and rapid treatment (START) is a triage method used by first responders to classify rapidly victims during a mass casualty incident based on the severity of injury.

Triage Classifications

First responders using START evaluate victims and assign them to one of four categories:

1. Immediate (red)
2. Delayed (yellow)
3. Walking wounded/minor (green)
4. Deceased/expectant (black)

The colors correspond to triage tags used by some agencies to express each victim's status. Tags are not necessary if patients can be sorted physically into separate designated areas.

Responders arriving to the scene of a mass casualty incident might first identify the ambulatory patients by asking any victim who is able to walk to relocate to a certain area. Non-ambulatory patients are then evaluated. The only medical intervention used before declaring a patient deceased is an attempt to open the airway. Any patient who is not breathing after this attempt is classified as **deceased** and given a black tag. No further interventions or therapies are attempted on deceased patients until all other patients have been treated. Patients who are breathing and have any of the following conditions are classified as **immediate**:

1. Respiratory rate >30 per minute
2. Unresponsive (unable to follow commands)
3. Capillary Refill >2 seconds

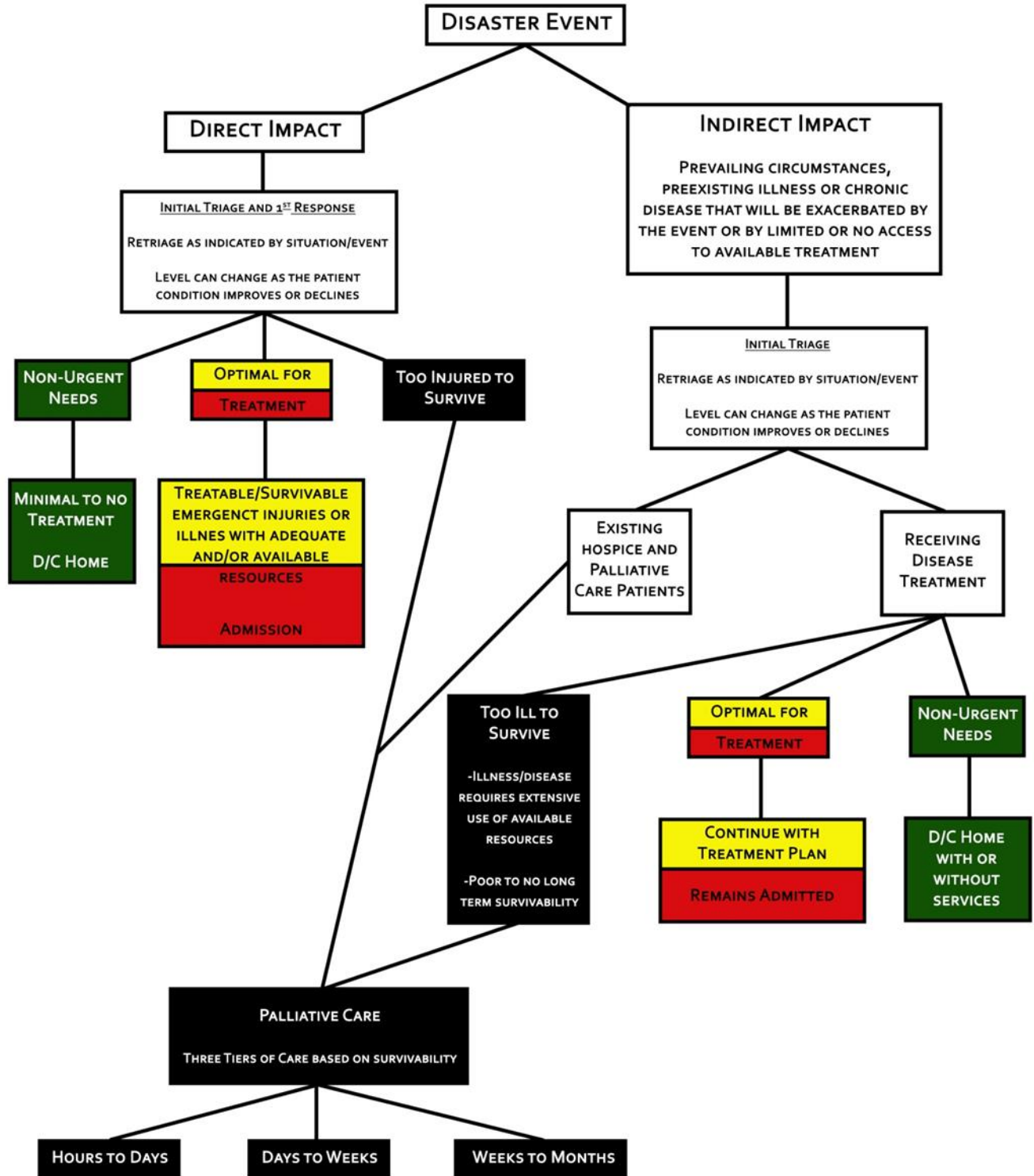
All other patients are classified as **delayed**.

Pediatric Patient Modifications

START has been modified to provide treatment for children. One modification is JumpSTART. Several simple modifications have been made to the adult version. The primary modification, for use with pediatric patients, is to change the "normal" respiratory rate. JumpSTART assigns the **immediate** classification based on respiratory rate if the child's respiration is <15 or >45 breaths per minute. Another change is in the apneic pediatric patient; a patient with a pulse is given 5 breaths. If breathing resumes the patient is classified and tagged as **immediate**. If the patient does not resume breathing, the patient is classified and tagged as **deceased**. Determining whether the patient is pediatric or adult is accomplished quickly by checking for underarm hair development on boys and breast bud or any breast development on girls. The presence of these secondary sex characteristics should be used to classify the patient as an adult for the purposes of triage. For patients whom the age is known, patients aged ≥8 years are considered adults for the purposes of triage.

Attachment E

Guidance for establishing plans to offer palliative health care



Attachment F

Glossary

Acute care — pattern of health care in which a patient is treated for a brief but severe episode of illness, for the sequelae of an accident or other trauma, or during recovery from surgery. Acute care is usually delivered in a hospital by specialized personnel using complex and sophisticated technical equipment and materials, and involves intensive or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.

Memorandum of agreement (MOA) and memorandum of understanding (MOU) — MOAs and MOUs are similar and typically used to preliminarily memorialize an agreement between parties with a complete agreement anticipated to follow. To the extent the terms of the agreement are sufficiently specific and either party has relied on such terms, the MOA or MOU will be enforceable. However, MOAs and MOUs do not carry the weight of a formal contract entered into by the parties.

Palliative care — palliative care is care delivered to improve the quality of life of patients with serious or life-threatening disease, such as cancer. The goal of palliative care is to prevent or treat, as early as possible, the symptoms and side effects of the disease and its treatment, in addition to the related psychological, social, and spiritual problems. The goal is not to cure. Palliative care is also called comfort care, supportive care, and symptom management.

Specialized or specialty care — **broad** specialty care is health care provided by physicians whose training focused primarily in a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.