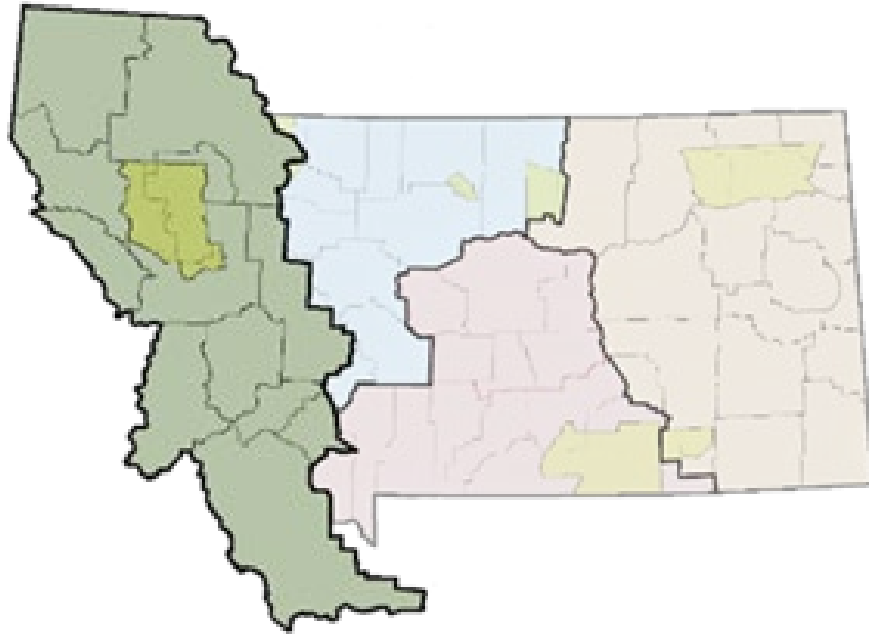


MONTANA'S WESTERN HEALTH CARE COALITION



PREPAREDNESS & RESPONSE PLAN

June 2025
Version 2.1

PROMULGATION

The Western Health Care Coalition (WHCC) issues this Coalition Preparedness & Response Plan in force and encompasses the area set forth within the WHCC as set for by the US Health and Human Services Administration of Strategic Preparedness and Response (ASPR).

Western Montana Health Care Coalition (WMHCC)
Memo for Record

To: File

From: Gary Zimmerman, Readiness & Response Specialist

Date: June 20, 2025

Subject: Executive Committee Approval of the WMHCC Preparedness & Response Plan

This memorandum serves as official documentation that the Western Montana Health Care Coalition Executive Committee reviewed and approved the **WMHCC Preparedness & Response Plan** during its regular meeting held on **June 18, 2025**.

The approval was granted by consensus of the Executive Committee members in attendance and is recorded in the official meeting minutes maintained by the Coalition.

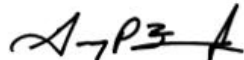
This memo serves in lieu of individual member signatures on the plan's promulgation page.

Approved:

Western Montana Health Care Coalition Executive Committee Meeting

Date: June 18, 2025

Reference: Executive Committee Meeting Minutes



Gary Zimmerman, Readiness & Response Specialist
Western Montana Health Care Coalition

TABLE OF CONTENTS

PROMULGATION	2
Record of Review	3
Record of Change	4
Record of Distribution	5
Section I: Purpose, Scope, Situation, and Assumptions	9
1.1 Purpose	9
1.2 Scope	9
1.3 Situation	10
1.3.1 Health care Coalition Risks and Vulnerabilities.....	10
1.3.2 Functional Need and Vulnerable Populations	11
1.4 Assumptions.....	11
Section II: Concept of Operations	12
1.1 Implementation	12
1.2 Activation	13
1.4 Functions.....	13
1.4.1 Preparedness Capabilities.....	13
1.5 Operations	14
Section III: Member Roles & Responsibilities	16
Development OF AN ALTERNATE CARE SYSTEM	17
Section IV: Maintenance & Review	17
Exercises.....	17
Appendices	19
Appendix 1 – Acronyms	20
Appendix 2 – The Health Care Coalition	23
Appendix 3 – The Western Health Care CiakutuibC HVA	26
Appendix 4 – Information Sharing, Management and Situational Awareness.....	28
Appendix 5 – Communications Plan	29
Appendix 6– Training and Exercise Plan	30
Appendix 7 – Access and Functional Needs Planning Considerations.....	Error! Bookmark not defined.
Appendix 8 – Evacuation Planning Considerations.....	33
Appendix 9 – Volunteer Coordination	34
Appendix 10 –Responders Safety and Health.....	35
Appendix 11 – 1135 Waiver Requests	36
Appendix 12 – Facility Closed Point of Dispensing (POD).....	37

Appendix 13 – CHEMPACK Host Facilities.....	39
Appendix 14 – Supply Chain.....	42
Appendix 15 – Coalition Coordination Plan for Surge Incidents.....	43
Appendix 16 – Resources and References.....	45
Annexes.....	46

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. This plan will describe the parameters, abilities, and responsibilities of the Western Health Care Coalition (CRHCC) of Montana during emergencies and disasters. These elements involve preparedness planning, training, and exercise, as well as the operational and tactical response roles and activities in disaster and emergency situations. Strategic emergency preparedness and response planning serves to create policy objectives, establish priorities, and provide overall guidance for member organizations.

The intent of this plan is 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 – Public Health Emergency Preparedness (PHEP) Cooperative Agreement from the US Health and Human Service (HHS) Administration of Strategic Preparedness and Response (ASPR) Hospital Preparedness Program (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

Community Resilience
Incident Management
Information Management
Countermeasures and Mitigation
Surge Management
Biosurveillance

National Preparedness Goals

Prevention
Protection
Mitigation
Response
Recovery

1.2 Scope

The HCC 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 2025 Montana Emergency Response Framework (MERF), maintained and published by the Montana Division of Disaster and Emergency Services (DES). Members of the HCC are agents of ESF-8 activities by the nature of their business.

HCC roles within the ESF-8 response structure include the following:

- Serve as a reference point for health care-related resources.
- Advise or connect advisors to local emergency managers regarding health care needs during disaster response operations.
- Maintain health care situational awareness during disaster and emergency responses.
- Share information between health care entities, DPHHS, and ESF8 partners.

This plan does not define or supplant any emergency operating procedures or responsibilities for any member agency or organization in the HCC. It is not a tactical plan or 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 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 (NGO). These hazards include, but are not limited to, wildfires, earthquakes, floods, HazMat incidents, communicable disease outbreak 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, outlines 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 HCC encourages each facility within the coalition to 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 HCC 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, provides information on populations who may require additional assistance, highlights training and exercise needs, and develops strategies to address preparedness and response priorities in the WHCC. The CRHCC HVA is included in Appendix 3 of this document.

1.3.2 FUNCTIONAL NEED AND VULNERABLE POPULATIONS

The HCC 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.

The HCC 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 HCC
- 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 HCC members will have enough capacity to respond to an emergency as a sole entity
- HCC 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 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 neighbor health care facilities, then from the State. Local authorities retain responsibility for all response and recovery operations.

The HCC will support ESF-8 coordination through DPHHS PHEP/HPP and emergency management partners as able. The HCC is integrated with DPHHS and ensures information is provided to local, state and federal officials.

The HCC and its members are collaborating partners, participating in information sharing, incident planning, strategy development, and resource management and coordination. 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:

Emergency Management (DES)	Assisted Living Facility	Behavioral and Mental Health
Emergency Medical Services (EMS)	Primary Care Specialist	Home Health
Critical Access Hospitals (CAH)	Pharmacies	Hospice
Hospitals	Laboratories	Academic Facilities
Nursing Home	End Stage Renal Disease	Therapy Centers
Skilled Nursing Facility	Rural Health Center	Foster Homes
Outpatient Surgical	Community Health Center	Tribal Health
VA Medical Facilities		

1.1 Implementation

Coalition response coordination activities begin when DPHHS, HPP, or any other HCC 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 HCC 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. During a response, the coalition coordinators will collaborate with DPHHS / PHEP, HPP, and other ESF-8 partners to act as a conduit of information to the membership.

1.4 Functions

The HCC 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 state, local, and tribal governments’ emergency and disaster related health care planning needs. Planning takes an all-hazards approach to preparedness.

1.4.1 PREPAREDNESS CAPABILITIES

This preparedness plan follows the 2017-2022 Health Care Preparedness and Response Capabilities established by ASPR. The HCC 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 HCC 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 HCC and DPHHS, provide uninterrupted and optimal medical care to all populations in the face of damaged or disabled health care infrastructures. The HCC 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 HCC, 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 HCC consults its response partners and stakeholders to plan its operational functions for ESF-8 services.

Coalition Response

The emergency response structure for the HCC emphasizes coordination and collaboration. 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). These will be managed virtually using either a Bridge Line or virtual platform established by either the DES Duty Officer, DPHHS Duty Officer, or the Coalition Specialist.

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 Specialists 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. The HCC will provide as much assistance as possible to help members to return to pre-incident status.

Incident managers work with their local ESF-8 Partners and HCC Specialist to fulfill resource needs. If resources are not available locally, requests are made through their local DES to the State Emergency Coordination Center (SECC), where it will be fulfilled as able.

The HCC Specialists will remain in an advisory role, connected remotely as needed. The Executive Committee does not have a response function during an emergency.

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

During an emergency response involving the HCC, DPHHS PHEP/HPP will activate their response plans as appropriate and coordinate with the HCC Specialist 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
- Encourage NIMS compliance including incident management structure and development of IAPs as requested.

Information Sharing and Situational Awareness

The HCC and PHEP/HPP will exchange incident information as appropriate utilizing reliable, resilient, interoperable, and redundant information and communications systems. Member entities of the HCC will update statuses in EMResource for their respective facilities during an emergency. The JUVARE application suite contains essential elements of information (EEI) to provide PHEP/HPP with situational awareness and allow emergency managers to develop a common operating picture of response efforts.

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

- Internet Services
 - HPP Listserv
 - HCC 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

Patient Tracking

Patient tracking is a facility level responsibility.

Resource Coordination

PHEP, HPP, and Coalition Specialists will assist with resource coordination and management between partner organizations, particularly within the health care sector. Facilities may utilize the [Disaster Available Supplies in Hospitals](#) (DASH) tool to help estimate supplies that may need to be immediately available.

The HCC will collaborate with HPP recipients and DPHHS PHEP/HPP to facilitate resource requests for staffing, including volunteers, within health care settings. This will include:

- leveraging existing government and non-governmental volunteer registration programs, 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 coalition readiness and response coordination, the CRHCC, in conjunction with DPHHS, will integrate strategies and tactics with the Regional Disaster Health Response System (RDHRS). The CRHCC and RDHRS will promote communications, information sharing, resource coordination, and operational response planning.

SECTION III: MEMBER ROLES & RESPONSIBILITIES

The HCC’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 regards to preparedness and response considerations.

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

Core HCC 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

Emergency Medical Services

- 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
- Serves as a response point for mental illness and/or substance abuse services to disaster survivors and responders.
- Serves as a conduit to DPHHS Public Health Laboratory for specimen testing.

DEVELOPMENT OF AN ALTERNATE CARE SYSTEM

In the event that the utilization of nontraditional 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 lead ESF-8 lead agency and the Health Care Coalitions. 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 HCC 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.

APPENDICES

Appendix 1 – Acronyms	20
Appendix 2 – The Health Care Coalition.....	23
Appendix 3 – The WHCC HVA	26
Appendix 4 – Information Sharing, Management, and Situational Awareness	28
Appendix 5 – Communications Plan	29
Appendix 6 – Training & Exercise Plan	30
Appendix 7 – Access and Functional Needs Planning Considerations.....	32
Appendix 8 – Evacuation Planning Considerations	34
Appendix 9 – Volunteer Coordination	35
Appendix 10 – Protecting Responders.....	36
Appendix 11 – 1135 Waiver Requests	37
Appendix 12 – Facility Closed Point of Dispensing (POD).....	38
Appendix 13 – CHEMPACK Host Facilities.....	40
Appendix 14 – Supply Chain.....	43
Appendix 15 - Coalition Coordination Plan for Surge Incidents.....	44
Appendix 16 – Resources and References.....	47

Appendix 1 – Acronyms

ASPR – Administration for Strategic Preparedness and Response

CDC – Centers for Disease Control and Prevention

CHIP – Children’s Health Insurance Program

CMS – Centers for Medicare and Medicaid Services

CRHCC – Western Health Care Coalition

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

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 – 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

SHCC – Southern 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 detail within the By-Laws.

Composition

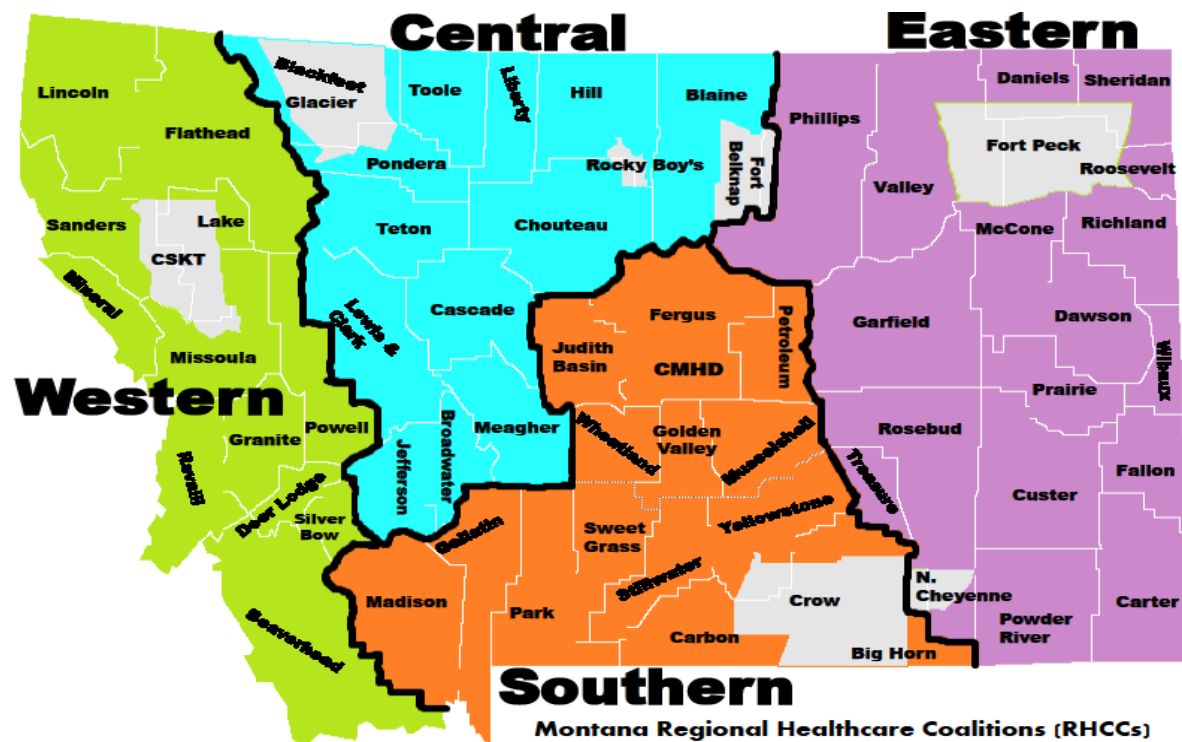
At a minimum; 2 hospitals, Emergency Medical Services (EMS), emergency management organizations, and public health agencies must be represented within each HCC.

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	

Coalition Boundaries

The HCCs in Montana were initially established utilizing the preexisting boundaries established by the trauma referral patterns for patient care.



Planning Considerations and Gap Analysis, Identification of Objectives

A Coalition Hazard Vulnerability Assessment (HVA) will be accomplished. See Appendix 3– The WHCC HVA.

Gaps will be identified through utilization of the ASPR Readiness Assessment Tool. 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, resources and assistance, alternate care site, 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, Evaluations, and Improvement Plans, Notification of Emergency or Impending Emergency, Emergency Codes, Communications, Staff Call-Back, Notifying External Authorities, Resource Requests, The Media, HIPPA, Strategic National Stockpile, Transporting Patient, Foodservice Emergency Planning, Security, Legal Evidence and Chain of Custody, Labor Pool, Staff Health and Safety, Staff Rest Periods, Family Care and Support During an Emergency, HO/Shelter In-Place, Facility Role during 1135 Waiver, Use of Volunteers, Credentialing/Privileging of Licensed Independent Providers During Disasters, Contaminated Patients, Communication of Threats/Incidents, Mail Room Security, Infection Prevention, Use of POD (Point of Dispensing), SNS, 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 begins 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, the request is routed to the Montana Disaster and Emergency Services (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 Health Care Coalition facility or send 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.

Requests for assistance from outside the State of Montana may be tasked. MT DES is the office of primary responsibility for staffing and delegating these requests. MT DPHHS/ PHEP/ (HPP) office will submit a proposal to fulfill an EMAC request as able. Results will be provided to DES.

Appendix 3 – The WHCC HVA

The HCC 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	Other	0	86%	Low
2	Patient Surge	0	78%	Medium
3	Power Outage	0	78%	Medium
4	Inclement Weather	0	74%	Medium
5	Infectious Disease Outbreak	0	74%	Medium
6	Mass Casualty Incident	0	74%	Medium
7	Water Disruption	0	74%	Medium
8	Transportation Failure	0	72%	Medium
9	Hazmat Incident	0	71%	Medium
10	IT System Outage	0	71%	Medium
11	Wildland Fire	0	71%	Medium
12	Workplace Violence / Threat	0	71%	Medium
13	Evacuation	0	68%	Medium
14	Communication / Telephony Failure	0	67%	Medium
15	Earthquake	0	67%	High
16	External Flood	0	67%	Medium
17	Hazmat Incident with Mass Casualties	0	65%	Medium
18	Active Shooter	0	64%	Medium
19	Sewer Failure	0	64%	Medium
20	Suicide	0	63%	Medium
21	Acts of Intent	0	61%	Low
22	Bomb Threat	0	60%	High
23	Generator Failure	0	60%	High
24	HVAC Failure	0	60%	High
25	Tornado	0	60%	Medium
26	Explosion	0	57%	High
27	Hostage Situation	0	57%	Low
28	Suspicious Package / Substance	0	57%	Low
29	Drought	0	56%	Medium
30	Fire	0	56%	High

JUVARE

Hazard Vulnerability Analysis

31	Temperature Extremes	0	55%	High
32	Abduction	0	53%	Medium
33	Dam Failure	0	53%	High
34	Internal Fire	0	53%	High
35	Internal Flood	0	52%	High
36	Water Contamination	0	52%	High
37	Trauma	0	51%	High
38	Gas / Emissions Leak	0	49%	Medium
39	Radiation Exposure	0	49%	Medium
40	Civil Unrest	0	46%	Medium
41	Shelter in Place	0	46%	High
42	Forensic Admission	0	43%	High
43	VIP Situation	0	43%	High
44	Landslide	0	42%	Medium
45	Natural Gas Disruption	0	42%	Medium
46	Supply Chain Shortage / Failure	0	42%	High
47	Planned Power Outages	0	34%	High

Appendix 4 – Information Sharing, Management and Situational Awareness

During the response to an event, HPP, in cooperation with the HCCs, will coordinate with the DPHHS communication director in order to avoid disinformation, misinformation, and mal-information.

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 HCC 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://pheap.formstack.com/forms/system_status_report_hics_251

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 5 – 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).

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 6– Training and Exercise Plan

The HCC will develop, and update annually, a Readiness Plan that includes a Training and Exercise Plan detailing the expected training opportunities and needs, as well as designating exercise events. These events are subject to change at the discretion of the HCCs.

Refer to the WHCC Readiness Plan.

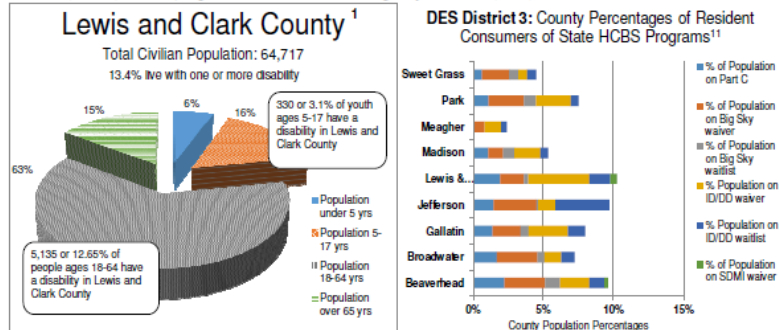
Appendix 7 – Access and Functional Needs Planning Considerations

County profile information can be access at the following website:

<https://rtc.ruralinstitute.umt.edu/geography/>

Example:

Data and Resources for a Whole Community Approach to Emergency Planning
 The pie chart shows county population, size of age groups, and percentages of residents living with disability. The bar chart shows the smaller percentages of people participating in state Medicaid Home and Community Based Service (HCBS) waiver programs for Division of Emergency Services (DES) District 3 counties.



HALF OF ALL AMERICANS HAVE A FORM OF FUNCTIONAL NEEDS.² BELOW, COUNTY DATA ARE PROVIDED BY SIX FUNCTIONAL NEEDS CATEGORIES. (County population % = in bold; others = counts).

Functional Need: Communication

Serious hearing difficulty/deaf (all ages) ¹	3,185
Serious vision difficulty/blind (all ages) ¹	1,162
Cognitive difficulty (over 5 yrs) ¹	2,973
Speak English "Less than very well" ¹	0.5%

Functional Need: Transportation

Zero car households ¹	623
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Functional Need: Social Economic

Chronically Homeless (District 8) ⁶	101
Population Receiving SSI ¹	1,125
Average Monthly Medicaid Enrollment ⁴	5,953
SNAP recipients ¹	2,614
Estimated WIC Eligible ⁹	29.1%
Households below poverty ¹	8.3%
Percent Uninsured ⁷	10.6%
Percent Population on Medicaid ⁴	8.8%

Functional Need: Mobility

Serious difficulty walking or climbing stairs (over 5 yrs) ¹	4,616
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Functional Need: Daily Living Activity & Participation

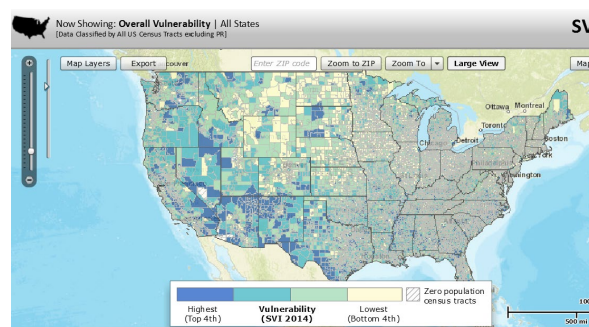
Independent living difficulty (over 14 yrs) ¹	3,281
Self-care difficulty (over 5 yrs) ¹	2022
PAS Recipients ¹¹	141
Medicaid Mental Health recipients ¹⁰	1,553
Non-Medicaid Mental Health recipients ¹¹	4

Functional Need: Women, Children, and Seniors

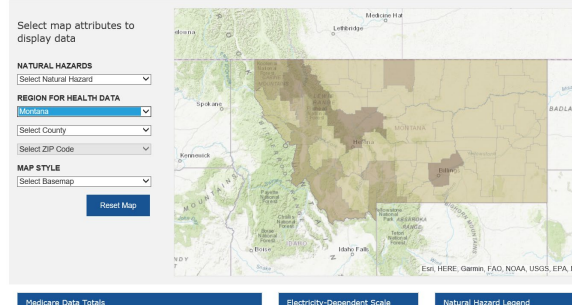
Live Births ³	788
Children Enrolled in Special Education ⁸	1,165
Youth Served by Children's Mental Health	
Medicaid Services ⁵	1,156
Householders (65+) living alone ¹	2,595

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://www.atsdr.cdc.gov/place-health/php/svi/svi-interactive-map.html>



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://empowerprogram.hhs.gov/empowermap>.



Appendix 8 – Evacuation Planning Considerations

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

Appendix 9 – Volunteer Coordination

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, and verify licensed volunteer health care professionals before a major disaster or public health emergency occurs.

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

Appendix 10 –Responders Safety and Health

The HCC supports responder safety and health, through training, education, and exercises. 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 responding agency or facility has determined the likely threats to affect their staff, proper personal protective equipment should be identified, acquired, stocked, and trained on.

Appendix 11 – 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 12 – Facility Closed Point of Dispensing (POD)

FREQUENTLY ASKED QUESTIONS

What is a Point of Dispensing (POD)?

A POD is a mass dispensing site that provides medications (prophylaxis) or vaccinations to protect the general population from biological threats or epidemics. **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 13 – 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 14 – Supply Chain

Facilities are responsible for maintaining their own supply chain plans and policies. Coalitions 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 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 15 – Coalition Coordination Plan for Surge Incidents

1. Introduction

1.1. Purpose

The purpose of the Coalition Surge Coordination Plan is to:

- Provide preparedness recommendations and outline the support available from the Coalition to all facilities and agencies responding to these events.
- Identify the roles, responsibilities and actions required of local health care community organizations (HCOs) and other agencies in preparing for and responding to incidents that exceed the medical surge capabilities of individual health care facilities. Medical surge capability is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community.
- Provide a framework within which the Coalition can demonstrate, through exercise or real incident, its ability as a coalition to deliver appropriate levels of care to all patients and provide immediately available surge capacity coalition wide equal to no less than 20% of staffed members' beds within 4 hours of a disaster. This is known as immediate bed availability.

1.2. Scope

The scope of the Coalition Surge Coordination Plan includes the Coalition's role in the process to respond to a health care community incident where a facility's surge capacity and surge capabilities have been met or exceeded, and patient movement may be necessary through coordination within the Coalition..

This surge appendix involves all participating organizations, agencies, and jurisdictions contained within the geographical boundaries of the CRHCC. Many of these participants may have their own protocols for responding to a patient surge. This document is designed to work with those protocols and does not define or supplant any emergency operating procedures or responsibilities for any member agency or organization in the CRHCC. It is not a tactical plan or field manual, nor does it provide Standard Operating Procedures (SOP). Rather, it is a framework for maintaining the scope of the Coalition and outlining the support that may be available as requested. 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 left to incident management.

2. Assumptions

This Coalition Surge Coordination Plan will be used in conjunction with individual facility plans for medical care surge and other individual facility emergency plans that are activated to respond to the incident when requested.

3. Activation

During an incident that meets or exceeds a facility's medical surge capability, individual facilities in the coalition will expand services according to their facility surge plan. The coalition surge plan is activated when the level of the surge event warrants a coalition response.

4. Operations

Individual facilities activating their surge plans do not necessarily trigger the Surge Coordination Plan.

Individual healthcare facilities who are exceeding their surge capacity/capabilities and are in need of outside assistance should notify their local Office of Emergency Management and the WHCC.

When WHCC hospitals are implementing decompression procedures, the WHCC will assist as able.

In many events there may be large numbers of patients who can be treated and released, causing a much greater demand for outpatient services than for inpatient services. Some of this demand can be met by other health care organization members of the coalition.

If further assistance is needed, the HCC may call on other HCCs or request state assistance. If necessary, the state may request federal resources.

5. Public Information

Individual organizations should refer to their respective public information plans and policies when determining what information to share publicly. The Coalition shall not speak on behalf of any individual member organization and will defer to the individual organization's Public Information Officer.

6. Special Considerations

Provision of psychosocial support to patients, patient families and the staff is handled by individual facilities. Additional coordination of resources may be available through the Coalition.

Planning for emergencies includes medical needs associated with mental, 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. The Coalition recommends that all health care entities include these special populations within their facility specific plans.

Appendix 16 – Resources and References

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Centers for Disease Control and Prevention. (n.d.). Retrieved August 26, 2020, from <https://www.cdc.gov/>

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Montana Healthcare Mutual Aid System: <https://mhmas.org/DashTool>. (2022, August 19). DISASTER AVAILABLE SUPPLIES IN HOSPITALS – Dash Tool. <https://dashtool.org/>

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

EI in HICS 251://phep.formstack.com/forms/system_status_report_hics_251

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

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

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

Social Vulnerability mapping can be obtained at: <https://www.atsdr.cdc.gov/place-health/php/svi/svi-interactive-map.html>

Generic emPOWER data can be obtained at <https://empowermap.hhs.gov/>

ANNEXES

Annex 1 – Pediatric Surge Annex	Included as Separate Document
Annex 2 – Highly Infectious Disease Annex	Included as Separate Document
Annex 3 – Burn Surge Annex	Included as Separate Document
Annex 4 – Continuity of Operations Plan (COOP)	Included as a Separate Document
Annex 5 – Radiation Annex.....	Included as a Separate Document
Annex 6 - Chemical Annex	Included as a Separate Document