APPENDIX D

HEALTHCARE COALITION RESOURCE AND GAP ANALYSIS

Updated 12/31/18

HCC members should perform an assessment to identify the health care resources and services that are vital for continuity of health care delivery during and after an emergency. The HCC should then use this information to identify resources that could be coordinated and shared. This information is critical to uncovering resource vulnerabilities relative to the HVA that could impede the delivery of medical care and health care services during an emergency.

The resource assessment will be different for various HCC member types but should address resources required to care for all populations during an emergency. The resource assessment should include but is not limited to the following:

- Clinical services – inpatient hospitals, outpatient clinics, emergency departments, private practices, skilled nursing facilities, long-term care facilities, behavioral health services, and support services (see Capability 4 – Medical Surge)
- Critical infrastructure supporting health care (e.g., utilities, water, power, fuel, information technology [IT] services, communications, transportation networks)
- Caches (e.g., pharmaceuticals and durable medical equipment)
- Hospital building integrity
- Health care facility, EMS, corporate health system, and HCC information and communications systems and platforms (e.g., electronic health records [EHRs], bed and patient tracking systems) and communication modalities (e.g., telephone, 800 MHz radio, satellite telephone)
- Alternate care sites
- Home health agencies (including home and community-based services)
- Health care workforce
- Health care supply chain
- Food supply
- Medical and non-medical transportation system
- Private sector assets that can support emergency operations

A comparison between available resources and current HVA(s) will identify gaps and help prioritize HCC and HCC member activities. Gaps may include a lack of, or inadequate, plans or procedures, staff, equipment and supplies, skills and expertise, services, or any other resources required to respond to an emergency. Just as the resource assessment will be different for different member types, so will efforts to prioritize identified gaps. HCC members should prioritize gaps based on consensus and determine mitigation strategies based on the time, materials, and resources necessary to address and close gaps. Gaps may be addressed through coordination, planning, training, or resource acquisition. Ultimately, the HCC should focus its time and resource investments on closing those gaps that affect the care of acutely ill and injured patients.

Certain response activities may require external support or intervention, as emergencies may exceed the preparedness thresholds the HCC, its members, and the community have deemed reasonable. Thus, during the prioritization process, planning to access and integrate external partners and resources (i.e., federal, state, and/or local) is a key part of gap closure.

Coalition Resources

Coalition Resources

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
HCC Chempack/SNS Plan	In jurisdictions hosting Chempack assets the plan should document hospital and EMS actions related to storage, maintenance, notification mechanism of need for release of assets and authority by whom to release them, accompanying security to distribution point, resupply method. All jurisdictions should have an SNS receipt and distribution plan. Include SNS receipt, distribution, and replacement.	1 = Rare	3 = Moderate	3 = Possibly Adequate Plans/Assets	7	Requires testing via exercise, other	
HCC COOP, Recovery/Business Continuity Plan	Coalition role and coordination of HCC recovery activities and continuity of operations (COOP) of HCC response functions (not a healthcare facility or agency) including backup for personnel, communication systems, and logistical support (assets).	2 = Unlikely	2 = Insignificant	5 = No Plan/Asset	9	Lack of plans	
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.	2 = Unlikely	3 = Moderate	5 = No Plan/Asset	10	Lack of plans	
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).	3 = Possible	4 = Significant	5 = No Plan/Asset	12	Lack of plans	
HCC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	5 = Almost Certain	1 = Negligible	3 = Possibly Adequate Plans/Assets	9	Lack of plans	
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.	3 = Possible	3 = Moderate	5 = No Plan/Asset	11	Lack of plans	
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.	4 = Likely	4 = Significant	4 = Inadequate Plans/Assets	12	Lack of plans	

Assets – depending on coalition size may track specific numbers or relative adequacy			Add New Row
Item	Gap (Number or Y/N)	Comments	Notes
Communication Assets	Yes	May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system.* Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Funding	Yes	Including sources, structure of funding, budget, and spending authorities.	
Hardware/Connectivity	Yes	Coalition owned/managed/utilized with permission computers and other material resources to facilitate virtual or physical coordination center activities, including internet / data access.	
MAC/EOC	Yes	Physical and back-up location for HCC coordination efforts.	
Notification Platform	No	Electronic systems that provide notification to coalition leadership and partners. These systems are designed for event notification only, distinct from communication platforms listed below which are designed for ongoing, interactive information sharing.	
Response Equipment and Supplies (e.g., PPE, Evacuation, Medications, ventilators, mass casualty and specialty equipment)	No	May track through inventory management systems – this should be coalition owned / managed resources.	
Staff	Yes	Designated coalition response staff / team.	
Virtual Coordination	Yes	Platform for virtual coordination.	

*Coalitions may need to create a detailed analysis of the systems, strengths, and weaknesses depending on their size and complexity of their systems including consideration of HIPAA-compliant platforms if protected health information is being shared

EMS Resources

EMS Resources

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.	2 = Unlikely	4 = Significant	4 = Inadequate Plans/Assets	10	Requires testing via exercise, other	
EMS Alerting/ Notification Plan	Describes alert and notification of the following during an incident for public safety and private sector based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should including any indicators/triggers for activation of MCI plan.	5 = Almost Certain	4 = Significant	4 = Inadequate Plans/Assets	13	Lack of equipment / supplies	
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.	4 = Likely	3 = Moderate	4 = Inadequate Plans/Assets	11	Lack of plans	
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.	3 = Possible	4 = Significant	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).	4 = Likely	3 = Moderate	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).	3 = Possible	3 = Moderate	5 = No Plan/Asset	11	Lack of plans	
EMS Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	4 = Likely	2 = Insignificant	4 = Inadequate Plans/Assets	10	Lack of plans	
EMS HAZMAT/ Decontamination Plan	Describes roles of EMS and Fire including agent identification, setting up hot, warm and cold zones, capability for mass decontamination, and use of medical countermeasures for chemical, biological and radiological incidents. Include use of available antidotes (including CHEMPACK reference). Addresses delivery of contaminated patients to specialty care hospitals when needed and available.	5 = Almost Certain	4 = Significant	2 = Adequate Plans/Assets	11	Requires testing via exercise, other	
EMS Infectious Disease Plan	Includes guidelines for situational awareness and notification of outbreaks associated with seasonal and emerging infectious disease agents, dispatch communication to crews, hospitals and PH, personal protective equipment, infection prevention and control measures, specialized transport and response protocols to tiered levels of treatment facilities.	1 = Rare	4 = Significant	3 = Possibly Adequate Plans/Assets	8	Lack of trained providers / instructors	
EMS IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks (e.g. denial of service attack on 911), redundancy measures, training, PHI substitutions, and recovery measures.	4 = Likely	2 = Insignificant	3 = Possibly Adequate Plans/Assets	9	Lack of subject matter experts	
EMS Mutual Aid Plan	Specifies request process, commitment, notification, etc. between EMS agencies and details other services/assets. Include any written MOA/MOU and other agreements.	5 = Almost Certain	3 = Moderate	2 = Adequate Plans/Assets	10	Requires testing via exercise, other	
EMS Patient Distribution Plan	Specifies EMS role in conducting (if applicable) inter-facility transports and patient distribution to hospitals and other healthcare facilities (e.g., freestanding EDs, etc.) – coordinated to minimize overload on single facility when possible. Integrated with hospital MCI plans.	5 = Almost Certain	3 = Moderate	2 = Adequate Plans/Assets	10	Requires testing via exercise, other	
EMS Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including multi-model options- marine, air, ground transports, rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. (NOTE: this may be the same plan as developed under "Coalition Resources"). Should specify policies/procedures for MCI tracking versus healthcare facility evacuation patient tracking of transports.	4 = Likely	3 = Moderate	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
EMS Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Specifies on-scene command and unified command, roles, triage, staging, integration of response with law enforcement, and notification and casualty distributions to hospitals.	3 = Possible	4 = Significant	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	

Assets Note: Agency and HCC plans should document these assets as well as any triggers for use and request/activation processes
EMS agencies may need more specific breakdowns for local evacuation planning including NICU-capable transport units, bariatric transport units, etc.

Assets

Add New Row

Item	Gap (Number or Y/N)	Comments	Notes
Communication Assets	Yes	May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Community Paramedics	1	May include other community-based EMS personnel that may assume alternate roles in a disaster (e.g., paramedics are also firefighters, volunteer or paid, reserve personnel who can be called to assist with an MCI; those who are BLS or ACLS trained). In large metro areas may summarize / list agencies rather than specific resources.	South Bend Fire Department Suzie Krill
ALS Ambulances	194	May include scheduled and 911 assets, critical care transport, scheduled assets, reserve rigs, specialized units (pediatric, bariatric, isolation, etc.).	Includes ALS Non-transport vehicles, such as ALS Fire Trucks, ALS Chase vehicles, etc.
BLS Ambulances	15	May include scheduled and 911 assets	
EMS Agencies	34	Transport agencies – include all emergency transport agencies, may consider including scheduled BLS provider services if applicable. Assure names and contact info for all potential ground, air, marine transport agencies, both emergency and scheduled are available.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)	Yes	Should document what regional assets are available to support hospital evacuation. May be listed in Evacuation Plan annex from above. Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies.	
Fixed-wing Units	0	Within 60 minutes response time to area, specific for flight time to scene/facility. Assure contact information is available for all agencies.	
Rotor-wing Units	10	Within 60 minutes response time to area, specific for flight time to scene/facility. List contact information/agencies and priority ring down based.	Lutheran 3, Samaritan 2, Medflight 1, West. Mich. 2, Lifeline 2
HAZMAT Radiation Assets	Yes	Include detection/survey equipment	Isotope identifiers
HAZMAT Response Vehicle/Trailer	3	Include capabilities for agent identification, mass decontamination and throughput for ambulatory/non-ambulatory casualties, storage location, and contact info to request. Consider antidote availability.	GAP- ID Equipment- Hazmat 360
Mass Transit	N/A	Buses (school, public) and other contingencies should be documented – does not require a specific number. Assure points of contact and timeframe available. Include mass transit and paratransit assets and their capacities, contact info, and potential timeframe to mobilize them.	
MCI Trailers	3	Include contents, estimated number of casualties that can be treated, location, contact agency.	1 Elkhart County, 1 Kosciusko County (Contact D2), 1 Marshall County
MCI Bus/Vehicle	500	Include contents, estimated number of casualties that can be treated/transported, location, contact agency.	No MOU in place. Have used school busses in real world incidents. Gap noted and needs worked on.
Military Assets	N/A	Include assets that can be state or federally activated to support a medical response (National Guard, ground/air assets including ambulances, CERF-P units, CST, etc.). List key resources if activated by state.	Indiana Guard, Warsaw Indiana
Other Response Vehicles	No	May include, supervisor, physician, 'jump' vehicles, etc. In large metro areas may summarize / list agencies rather than specific resources.	
Technical/ Swiftwater/ Collapse Rescue	N/A	Resources and agencies that may be engaged locally or regionally to assist with technical / US&R situations. List point of contact and timeframe.	
Wheelchair Vans	30	Should include private services. In large metro areas may list points of contact and not specific numbers.	

Hospital Resources

Hospital/Healthcare Resources

Hospitals may wish to use the more comprehensive TRACIE Resource Vulnerability Analysis (RVA) tool in combination with the Coalition aggregator and integrate these priorities into a more comprehensive annual update/assessment.
An important, and often neglected, part of the planning process involves agreeing on reasonable thresholds for hospital preparedness. All hospitals in the coalition should agree on baseline requirements for communications, HAZMAT/decontamination, mass casualty, pharmacy, incident management, N95 masks, and other resources. These may be adjusted for different event types based on the community HVA/THIRA as well as the size of the hospital and the role of the hospital in the community (e.g. a Level 1 trauma center has different supply needs from a small community hospital). Medication, surgical supply, and other stocks are contingent on planning for a spectrum of what could occur in the community. Developing assumptions for weather related natural disasters (e.g. tornado), active threat (shooting/blast), epidemic/bioterrorism (e.g. moderate pandemic), burn, pediatric, and HAZMAT events (chemical and radiologic) may be very helpful in setting preparedness targets for the community and avoiding situations in which some hospitals are inadequately prepared.

Plan Elements: All plans may not be applicable to all jurisdictions. Some jurisdictions may have additional plans based on area hazards (nuclear detonation response plans, nuclear power plant plans, hurricane response plans, etc.) and some may integrate multiple elements (pediatric, burn, etc.) into a single mass casualty plan. Many of the 'plans' listed may be annexes to an Emergency Operations Plan. As long as the specifics of the existing plans are adequate to address the function, this is completely appropriate. Each facility must have an Emergency Operations Plan including the elements below and conduct appropriate training. Each facility is assumed to use a NIMS-compliant ICS systems (e.g. HICS).

It is difficult to categorize multiple facility plans into an HCC-level analysis due to significant variability between plans - but common areas of deficiency should be identified for regional attention (examples might include HAZMAT/decontamination training, infectious disease response training, burn training, COOP planning) by the hospitals participating in the analysis.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Hospital Behavioral Health Plan	Support within the healthcare system for providers and patients – information, psychological first aid, access to services, assessments, treatment and referral. Include planning collaboration with EMS.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
Hospital Blood Bank Plan	Details support for hospitals during a mass casualty incident including delivery during access controlled situations.	2 = Unlikely	4 = Significant	3 = Possibly Adequate Plans/Assets	9	Lower priority area	
Hospital Closed POD Plans	Plans for internal vaccination/prophylaxis of healthcare personnel. May be helpful to quantify the number of employees who would be in need of vaccination or prophylaxis depending on role / job class.	2 = Unlikely	4 = Significant	3 = Possibly Adequate Plans/Assets	9	Lack of commitment (see notes)	Poor buy-in from all facilies
Hospital COOP, Recovery/Business Continuity Plan	Hospital continuity of operation (COOP) plans may help address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, food, communications, transportation, and other issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning, staffing plans, and structural / damage assessments.	2 = Unlikely	3 = Moderate	4 = Inadequate Plans/Assets	9	Lack of plans	
Hospital Crisis Care/ Crisis Standards of Care Plan	Details facility and regional approach to coordination of service and resource management, interface with State plans, and plans for on-site and community-based alternate care systems/sites including relevant facility and regional triggers where defined. Should also address 1135 waivers, and modification of other pertinent local/state rules and regulations to address surge issues, ACS, volunteers, etc.	2 = Unlikely	3 = Moderate	4 = Inadequate Plans/Assets	9	Lack of plans	
Hospital Decontamination Plan	Details facility and coalition capabilities and policies surrounding decontamination of patients. Includes protocols and training policies, includes CHEMPAK acquisition and utilization.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Hospital Evacuation Plan	Describes process and support for urgent/emergent evacuation of healthcare facility. Include partial and full emergency evacuation decision making and process, shelter-in-place options, and protocols.	3 = Possible	4 = Significant	2 = Adequate Plans/Assets	9	Lack of subject matter experts	
Hospital Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	4 = Likely	1 = Negligible	3 = Possibly Adequate Plans/Assets	8	Requires testing via exercise, other	
Hospital Infectious Disease Plan	Plans for receiving, assessing, and transferring highly infectious patients including seasonal influenza, Ebola/VHF, avian influenza, and SARS/MERS. Includes protocols and training policies. Include planning collaboration with EMS	2 = Unlikely	5 = Extensive	3 = Possibly Adequate Plans/Assets	10	Lower priority area	
Hospital IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks, redundancy measures, training, PHI substitutions, and recovery measures.	5 = Almost Certain	4 = Significant	1 = Sustainability Only	10	Lower priority area	
Hospital Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. Also include inbound and outbound patient movement and airhead plans including coalition NDMS facilities. (NOTE: this may be the same plan as developed under "Coalition Resources")	3 = Possible	3 = Moderate	2 = Adequate Plans/Assets	8	Lower priority area	
Hospital Pediatric MCI Plan	Include local and regional supplies and patient distribution, pediatric referral centers and resources. Detail hospital's level of preparedness to manage pediatric casualties.	2 = Unlikely	4 = Significant	4 = Inadequate Plans/Assets	10	Lack of plans	
Hospital Security Plan	Facility plans may be supported by jurisdictional EM and law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence, active shooter, suspected explosive devices, and civil unrest.	4 = Likely	5 = Extensive	4 = Inadequate Plans/Assets	13	Lack of plans	
Hospital Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols. Include written plan for how needed assistance will be reported to others (phone, information sharing platform etc.) and hospital's role in HCC MOU/MAA to support emergency staffing and resource support.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Lack of plans	
Hospital Surge Capacity Plan	Describe how the hospital will prepare for a surge of patients requiring medical treatment beyond normal operating capacity. Include immediate bed availability as a means to provide adequate levels of care to all patients during a disaster as applicable.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Hospital Surgical/ Burn MCI Plan	Including local and regional supplies and patient distribution. Includes protocols and training policies. Surgical burn mass casualty incident (MCI) plans can address events such as active shooter or bombings.	2 = Unlikely	4 = Significant	4 = Inadequate Plans/Assets	10	Requires testing via exercise, other	
Hospital Volunteer Management Plan	Including capabilities, deployment parameters/priorities, and process inclusive of Medical Reserve Corps as applicable.	3 = Possible	4 = Significant	3 = Possibly Adequate Plans/Assets	10	Lack of personnel to complete	

Assets

Add New Row

Item	Gap (Number or Y/N)	Comments	Notes
Number of Hospitals	10	Total hospitals in coalition providing emergency care / acute care services	
Critical Access Hospitals	5	Should include in total number above	
Specialty Hospitals	3	Long-term care hospitals, psychiatric or other specialty hospitals that do not provide emergency services	Unity, Michiana Behavioral Health, Epworth Psych
Level 1 / Level 2 Trauma Centers	1		Memorial Hospital South Bend
Level 3 / Level 4 Trauma Centers	1	May include other/non-designated in this category if receive trauma	Elkhart General Hospital
ED Capacity	208	Based on usual spaces used for patient care for hospital-based ED	
ED Isolation (AIIR) Rooms	16	Alternate may be ED Positive /Negative pressure rooms.	
ED Surge Beds	41	These are beds in addition to usual ED beds -- overflow / surge capacity only -- may include adjacent procedure or other areas used for ED care.	
Operating Rooms	64		
Pre / Post Anesthesia Beds (PACU)	106	To be used for trauma, ICU overflow / boarding.	
Intensive Care Bed Adult	96		
Intensive Care Bed Pediatric	24		
NICU Beds	59	Consider Level in the case of evacuating NICU to other NICU's.	
Intensive Care Surge Beds	26	May include doubling, use of step-down areas (therefore may count stepdown and some monitored beds twice), and procedure areas. Must have dedicated cardiac monitors, appropriate medical gases, etc. Include capacity for NICU, PICU and Adult beds. Do not include PACU space here (list under PACU-specific line) -- include both PICU and adult ICU potential surge beds.	
Stepdown (Intermediate Care) Beds	231	Intermediate care including cardiovascular drip medications, potentially BiPAP but not mechanical ventilation or pressor support.	
Stepdown Surge Beds	40	Must include cardiorespiratory monitoring capability including remote telemetry.	
Medical/Surgical Beds	461	Include operating (not licensed) adult and pediatric.	
Medical/Surgical Surge Beds	57	May include activating closed areas or doubling patients in private rooms.	
Inpatient Isolation (AIIR) Rooms	35	Include capacity for AIIR's and for cohorting.	
Inpatient Psychiatry Beds	53	Include capacity including for adults and pediatric patients.	
Burn Center Beds	0	Dedicated burn beds	
Surge Discharge Potential	110	Number of beds that could be made available via early discharge based on exercises or real-world events.	
Crisis Care	160	Number of cots that could be appropriately placed in flat space areas on hospital premises to create alternate care areas and including utilizing space where patients can be held awaiting treatment, actual treatment space (using cots, chairs, recliners, mobile vans, tents, air mattresses etc.).	
Communication Assets	Yes	May include traditional phone lines, radios, cellular, satellite, internet-based -- at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Decontamination Capacity - Ambulatory	105	Patients / hour based on exercises - assume 10 minutes/person through process (e.g. 6 patients/hour per decon station)	
Decontamination Capacity -- Non-ambulatory	39	Patients / hour based on exercises - assume 10 minutes/person at each decon station	
Patient Redress / Dry Decon Kits	468	Redress kits that allow a patient to disrobe under a large bag/cover and therefore remove contaminated clothing that can then be sealed in another bag. Limits continued exposure and potential for secondary contamination of EMS/hospital assets.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)	Yes	May be listed in Evacuation Plan annex from above. Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies. Include availability of adult, child and infant evacuation equipment.	151 throughout all hospitals, Gap noted
Long-term care (LTC) Beds*	36	May approximate in large metro areas -- skilled nursing facility only. Quantify in the event of emergency evacuations.	
Outpatient Clinics*	No	Not at hospitals, may approximate in large metro areas. Do plans incorporate use of clinics in response and communication with clinics?	
Home Health Agencies / Home Hospice*	No	May approximate in large metro areas	No in hospital Home health/hospice but multiple agencies
Personal Protective Equipment (PPE)-- Infectious Disease	No	Please note a report of inventory is not expected, but that facilities should agree on baseline stocks that should be maintained and identify resources/caches that could be used and/or purchase caches if reasonable. Consider an acceptable par level of 20% above daily use. Includes surgical masks and N-95 masks. Consider adding the number of PAPR kits (Butyl and Bio specific), spare Tyvek suits of various sizes, and Bio hoods.	PPE Cache maintained by SJMC Mishawaka, all hospitals have internal cache
PPE HAZMAT	No	PPE ensembles for the decontamination team including respiratory protection.	All hospitals have Decon equipment. SBFD houses MHSB Decon trailer.
Ventilators (Hospital Owned)	120	Do not include anesthesia machines in OR. Include transport ventilators with high/low pressure and other alarms suitable for longer-duration simple ventilation situations. Quantify adult & pediatric vents. Also ECMO.	Extreme Gap if Pan Flu event.

*Other Coalition, regional, or facility-based caches of disaster materials should be added in rows in this section as applicable by clicking 'Add New Row' at top. Bed numbers are based on actual operating beds, not licensed beds.

Total Conventional Beds:	812
Total Contingency Beds:	123

Public Health Resources

Public Health Resources

Some of the functions described below have significant overlap with the roles and responsibilities of other coalition partners. However, public health must provide oversight and coordination to ensure the functions are addressed. Coalitions must verify their assumptions are consistent with the expectations of other partners, and that planning is complete enough and/or exercised enough to assure success. These functions may vary between jurisdictions within a single healthcare coalition and these variations should be identified and discussed when generating 'work' scores. The variability between plans may itself require additional discussion and contingency planning to ensure conflict or misunderstandings do not result during a response.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Public Health Access and Functional Needs Plan*	Defines populations in the community at risk of potential access/care based on emPOWER and other databases, demographic information, coordination with renal and other patient networks, liaison with cultural and advocacy groups and defining challenges and solutions for the needs of specific populations in relation to access to care, appropriate shelter accommodations, transport, and treatment needs.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Public Health Alternate Care Systems/ Sites Plan	Including telephonic/telemedicine, screening/early treatment, and non-ambulatory care – EM and hospitals will have contributing responsibilities.	2 = Unlikely	2 = Insignificant	3 = Possibly Adequate Plans/Assets	7	Requires testing via exercise, other	
Public Health Behavioral Health Plan	Including identification of population at risk, community support, screening, access to services, treatment.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
Public Health COOP, Recovery/Business Continuity Plan	Describes the continuity of operations (COOP) of public health response functions including backup for personnel, communication systems, and logistical support (assets).	2 = Unlikely	3 = Moderate	4 = Inadequate Plans/Assets	9	Lack of plans	
Public Health ESF-8 / Emergency Operations Plan	The jurisdictional emergency management plan should specify the lead agency for health and medical issues. Either this plan or the Public Health Emergency Operations Plan should specify the integration of the hospitals and EMS into the jurisdictional plan. This should include how information is shared with and between agencies, the process for resource requests, and the role of PH and EM relative to the coalition partners.	4 = Likely	2 = Insignificant	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Public Health Evacuation Plan	Describes the PH role and coordination efforts during an evacuation. (NOTE: this can be the same plan or coordinated with coalition evacuation plans for hospitals, long term care, etc.)	3 = Possible	4 = Significant	4 = Inadequate Plans/Assets	11	Lack of plans	
Public Health Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	5 = Almost Certain	1 = Negligible	2 = Adequate Plans/Assets	8	Lower priority area	
Public Health Family Assistance Center Plan	Integrated with hospitals, EOCs, and support organizations (e.g. ARC) – may include physical and virtual operations for re-unification and notifications	2 = Unlikely	1 = Negligible	2 = Adequate Plans/Assets	5	Lower priority area	
Public Health IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks, redundancy measures, training, PHI substitutions, and recovery measures.	2 = Unlikely	2 = Insignificant	3 = Possibly Adequate Plans/Assets	7	Lower priority area	
Public Health Legal/ Regulatory Plan	Defines powers of State vs. local jurisdictions and local ordinances that may affect disaster response (e.g. disaster declarations, emergency orders, seizure powers, isolation and quarantine, changes to usual rules/requirements in disasters)	3 = Possible	4 = Significant	2 = Adequate Plans/Assets	9	Lower priority area	
Public Health Mass Mortuary/Fatality Plan	Includes role of the facilities, medical examiner/coroner and roles and responsibilities of the local agencies.	2 = Unlikely	5 = Extensive	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
Public Health Medical Countermeasures Plan	Include mass vaccination/prophylaxis (closed and open PODs), Chempack, and plans for receipt and distribution of other countermeasures from the SNS and other assets.	2 = Unlikely	4 = Significant	2 = Adequate Plans/Assets	8	Requires testing via exercise, other	
Public Health Risk Communication Plan	Integrated with community / state JIS and coalition partners	4 = Likely	1 = Negligible	2 = Adequate Plans/Assets	7	Requires testing via exercise, other	
Public Health Shelter Support Pla	Provision of medical care / support in shelter environments.	2 = Unlikely	1 = Negligible	4 = Inadequate Plans/Assets	7	Lack of plans	
Public Health Volunteer Management Plan	Including capabilities, deployment parameters/priorities, and process inclusive of Medical Reserve Corps as applicable.	3 = Possible	1 = Negligible	3 = Possibly Adequate Plans/Assets	7	Requires testing via exercise, other	

*Including for example children, pregnant women, seniors, those with disabilities or physical/cognitive limitations, behavioral health conditions, and renal patients

Assets

Add New Row

Item	Gap (Number or Y/N)	Comments	Notes
Alternate Care System / Site	Yes	Includes materials for alternate care sites – may be managed by hospitals or EM	
Communication Assets	No	May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Mass Mortuary / Body Bags	No	Including processing / identification / storage	
Medical Countermeasures Administration/Distribution	No	Physical assets that support Chempack, antidote, vaccination/prophylaxis operations and distribution of other countermeasures from SNS and state and local assets that may include databases and electronic systems as well as physical resources (signage, badging systems, coolers, etc.)	
PH Agencies	7	Number of agencies participating in the coalition	

Long Term Care Resources

Long Term Care/ Skilled Nursing Facility Resources

Though LTC facilities are not a 'core' coalition member, their partnership is critical to community response success particularly when infrastructure is damaged. Therefore, completion of this section is highly encouraged. Enagement with the long-term care (LTC)/ skilled nursing sector is critical to encourage resilience and realistic planning and avoid failure that would further strain emergency and inpatient resources. Facility-level plans are difficult to incorporate into an HCC-level analysis as there is significant variability between plans but common areas of deficiency should be identified for regional attention (examples might include evacuation planning and training).

Individual health care entities are not permitted to use HPP funds to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation, including CMS-3178-F Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; however, HCCs are permitted to use HPP funding to provide technical assistance to their individual members to assist them with the development of plans, policies and procedures, and exercises that may enable individual health care entities to meet the CMS conditions of participation. The primary goal of the funding is to improve the ability of the community to provide acute medical care to disaster survivors. As a part of that effort, prepared and resilient LTC services are important to ensure facility resilience and reduce the likelihood of LTC facilities evacuating, which would further stress acute care services.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
LTC COOP, Recovery/ Business Continuity Plan	LTC continuity of operations (COOP) plans should address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, food, communications, transportation, and other relevant issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning as well as IT/IS contingency plans, staffing plans, and structural / damage assessments.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
LTC Emergency Operations Plan	All-hazards response plan for the facility. Include appropriate incident management system (NIMS, modified HICS) and relevant training. This should include documentation of information sharing and coordination process with the healthcare coalition and its partners.	4 = Likely	3 = Moderate	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
LTC Evacuation Plan	Describes process and support for urgent/emergent evacuation of healthcare facility. Includes triggers for patient movement and evacuation, protocols and policies as well as records and belongings transfer (to and from LTC). The facility plan should integrate with coalition-level plans for evacuation coordination.	3 = Possible	4 = Significant	3 = Possibly Adequate Plans/Assets	10	Requires testing via exercise, other	
LTC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	4 = Likely	3 = Moderate	4 = Inadequate Plans/Assets	11	Lack of plans	
LTC Infectious Disease Plan	Details response plans / process for an epidemic / pandemic affecting the facility, including any closed points of dispensing plans.	2 = Unlikely	4 = Significant	4 = Inadequate Plans/Assets	10	Lack of plans	
LTC Information Sharing Plan/ Communications Plan	Including between LTC facilities and with the coalition during preparedness and response activities.	3 = Possible	3 = Moderate	4 = Inadequate Plans/Assets	10	Lack of plans	
LTC Security Plan	Facility plans should be coordinated with and supported by jurisdictional law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence and active shooter events.	3 = Possible	5 = Extensive	4 = Inadequate Plans/Assets	12	Lack of plans	
LTC Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.	3 = Possible	4 = Significant	4 = Inadequate Plans/Assets	11	Lack of plans	

Assets

Add New Row

Item	Gap (Number or Y/N)	Comments	Notes
Assisted Living Facilities		Optional	
Communication Assets	100	May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)	65	Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies	
Group Homes		Optional	
Long-term Acute Care Facilities	40	For prolonged, high-intensity management of chronic conditions	
Long-term Acute Care Beds	500		
LTC Beds	500	May approximate in large metro areas – skilled nursing facility only	
PPE	1000	Including N95 masks, training/fit-testing. Do not need to track masks at individual facilities but should reflect overall situation as well as any caches / specific assets	
Skilled Nursing Facilities (SNF)	30	Number of free-standing facilities	
SNF as Part of Hospital	2	Number of SNF (included in the total above) that are physically connected to an acute care hospital	

Outpatient Care Resources

Outpatient Care Resources

Though outpatient care facilities are not a 'core' coalition member, their partnership is critical to community response success particularly when infrastructure is damaged. Therefore, completion of this section is highly encouraged. Engagement with the outpatient care sector is critical to encourage resilience and realistic planning and avoid failure that would further strain emergency and inpatient resources. Facility-level plans are difficult to incorporate into an HCC-level analysis as there is significant variability between plans but common areas of deficiency should be identified for regional attention (examples might include evacuation planning and training, role in pandemic / epidemic). Note that some items/issues are specific to facilities and others are generic.

Individual health care entities are not permitted to use HPP funds to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation, including CMS-3178-F Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; however, HCCs are permitted to use HPP funding to provide technical assistance to their individual members to assist them with the development of plans, policies and procedures, and exercises that may enable individual health care entities to meet the CMS conditions of participation. The primary goal of the funding is to improve the ability of the community to provide acute medical care to disaster survivors, but prepared and resilient outpatient services are important to prevent additional patient surge on acute care services, and to assist with rapid decompression of acute care facilities in the wake of a disaster.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Outpatient Care COOP, Recovery/ Business Continuity Plan	Outpatient continuity of operations (COOP) plans may help address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, communications, transportation, and other issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning as well as IT/IS contingency plans, staffing plans, and structural / damage assessments.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Lack of trained providers / instructors	
Outpatient Care Crisis Care/ Service Prioritization Plan	Details facility and regional approach to coordination of service and resource management and plans for on-site alternate care areas. This includes plans to determine what critical services/patient care activities can be sustained given the impact of the incident as well as triggers for changes to conventional practice.	2 = Unlikely	4 = Significant	3 = Possibly Adequate Plans/Assets	9	Lack of subject matter experts	
Outpatient Care Emergency Operations Plan	All-hazards response plan for the facility. Include appropriate incident management system and relevant training.	4 = Likely	3 = Moderate	2 = Adequate Plans/Assets	9	Requires testing via exercise, other	
Outpatient Care Evacuation Plan	Describes triggers, process, and support for urgent/emergent evacuation of healthcare facility. Includes protocols and policies as well as records and belongings transfer expectations/process.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Outpatient Care Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	3 = Possible	2 = Insignificant	4 = Inadequate Plans/Assets	9	Lack of plans	
Outpatient Care Infectious Disease Plan	Details response plans / process for an epidemic / pandemic affecting the facility.	2 = Unlikely	3 = Moderate	3 = Possibly Adequate Plans/Assets	8	Requires testing via exercise, other	
Outpatient Care Information Sharing Plan/ Communications Plan	Including with any parent organizations and with the coalition during preparedness and response activities.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Outpatient Care Security Plan	Facility plans may be supported by jurisdictional EM or law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for violent patients, active shooter, suspected explosive devices, and civil unrest.	3 = Possible	3 = Moderate	3 = Possibly Adequate Plans/Assets	9	Requires testing via exercise, other	
Outpatient Care Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.	3 = Possible	2 = Insignificant	3 = Possibly Adequate Plans/Assets	8	Requires testing via exercise, other	
Outpatient Care Surge Capacity Plan	Describe the facility role in common disasters including potential role supporting emergency care as well as communication and notification procedures.	3 = Possible	4 = Significant	4 = Inadequate Plans/Assets	11	Lack of plans	

Assets			Add New Row
Item	Gap (Number or Y/N)	Comments	Notes
Ambulatory Surgery Centers	15	May be used for overflow acute care, overflow outpatient care	
Communication Assets	100	May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Dialysis Centers	7	Number of facilities optional – document major chains and interface with coalition activities	
Evacuation Resources	20	Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies (NOTE: this may only apply to ambulatory surgery centers and freestanding emergency rooms for non-ambulatory patients)	
Home Health Agencies	20	May approximate in large metro areas. Point of contact list should be available to coalition.	
Home Hospice Agencies	20	May approximate in large metro areas. Point of contact list should be available to coalition.	
Mental Health Providers	N/A	Document interface of major associations / provider groups / MRC or other assets with coalition activities	
Outpatient Clinics	100	Not on hospital campus, may approximate in large metro areas	
Retail Pharmacy		Number optional – document major chains and interface with coalition activities	
Surge Supplies	100	Does not need to include specifics of facility supplies but each facility should be accountable to be prepared according to their role in a disaster	
Telephone / Web-based Care	N/A	Document local system providers and interface with coalition activities	
Urgent Care Centers / Freestanding Emergency Rooms	25	Not at hospitals, may approximate in large metro areas – note may have significant differences in level of service/capabilities particularly for imaging. May also inlclude number of ORs.	

Gap Analysis

Gap Analysis

The thirty highest scoring plans and assets items are pre-populated into the following table. Based on the scores, these are gaps that the Coalition should consider closing. To assist in priority setting, this section allows inclusion of the time and cost required to address the gap. Though this is not a required step it may help the Coalition recognize areas with the greatest return on investment.

These gaps should be discussed by subject matter experts / coalition planners / coalition leadership to determine which of these items will be the focus of coalition and member work. The scores are not the only variables that may be considered when assigning priority. The motivation to close certain gaps may be stronger based on partner priorities, available funds, recent or upcoming events, and other factors. Therefore, an inclusive prioritization process should be developed by the coalition. The discussion may take place at a workgroup meeting or with the Coalition general or steering committee members to assure broad input and agreement. For each priority agreed upon by the Coalition a lead individual / agency should be documented and initial estimates of commitments should be discussed. The final list of priorities should be brought to the broader Coalition membership for discussion and acceptance and can then be integrated into a Preparedness Plan / workplan and specific strategies and tactics developed.

30 Highest Scoring Plan and Action Items

Item	Notes	Composite Risk (L+I+W)	Cost to address ($)	Time to address (T)	Priority (L+R+W) / $+T	Priority List
EMS Alerting/ Notification Plan	Describes alert and notification of the following during an incident for public safety and private sector based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should including any indicators/triggers for activation of MCI plan.	13	2	2	3.25	3
Hospital Security Plan	Facility plans may be supported by jurisdictional EM and law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence, active shooter, suspected explosive devices, and civil unrest.	13	2	3	2.60	4
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).	12	3	3	2.00	4
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.	12	2	3	2.40	4
LTC Security Plan	Facility plans should be coordinated with and supported by jurisdictional law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence and active shooter events.	12	3	3	2.00	4
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.	11	3	4	1.57	5
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.	11	2	3	2.20	4
EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).	11	2	3	2.20	4
EMS HAZMAT/ Decontamination Plan	Describes roles of EMS and Fire including agent identification, setting up hot, warm and cold zones, capability for mass decontamination, and use of medical countermeasures for chemical, biological and radiological incidents. Include use of available antidotes (including CHEMPACK reference). Addresses delivery of contaminated patients to specialty care hospitals when needed and available.	11	1	2	3.67	3
Public Health Evacuation Plan	Describes the PH role and coordination efforts during an evacuation. (NOTE: this can be the same plan or coordinated with coalition evacuation plans for hospitals, long term care, etc.).	11	1	2	3.67	3
LTC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	11	1	1	5.50	1
LTC Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.	11	2	2	2.75	4
Outpatient Care Surge Capacity Plan	Describe the facility role in common disasters including potential role supporting emergency care as well as communication and notification procedures.	11	2	2	2.75	4
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.	10	3	4	1.43	5
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.	10	3	3	1.67	5
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.	10	3	3	1.67	5
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.	10	3	2	2.00	4
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.	10	3	3	1.67	5
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).	10	2	3	2.00	5
EMS Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	10	1	1	5.00	2
EMS Mutual Aid Plan	Specifies request process, commitment, notification, etc. between EMS agencies and details other services/assets. Include any written MOA/MOU and other agreements.	10	1	1	5.00	2
EMS Patient Distribution Plan	Specifies EMS role in conducting (if applicable) inter-facility transports and patient distribution to hospitals and other healthcare facilities (e.g., freestanding EDs, etc.) – coordinated to minimize overload on single facility when possible. Integrated with hospital MCI plans.	10	2	2	2.50	4
EMS Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including multi-model options- marine, air, ground transports, rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. (NOTE: this	10	1	2	3.33	3
EMS Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Specifies on-scene command and unified command, roles, triage, staging, integration of response with law enforcement, and notification and casualty distributions to hospitals.	10	1	2	3.33	3
Hospital Behavioral Health Plan	Support within the healthcare system for providers and patients – information, psychological first aid, access to services, assessments, treatment and referral. Include planning collaboration with EMS.	10	2	2	2.50	4
Hospital Infectious Disease Plan	Plans for receiving, assessing, and transferring highly infectious patients including seasonal influenza, Ebola/VHF, avian influenza, and SARS/MERS. Includes protocols and training policies. Include planning collaboration with EMS.	10	1	1	5.00	1
Hospital IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks, redundancy measures, training, PHI substitutions, and recovery measures.	10	1	1	5.00	1
Hospital Pediatric MCI Plan	Include local and regional supplies and patient distribution, pediatric referral centers and resources. Detail hospital's level of preparedness to manage pediatric casualties.	10	2	2	2.50	4
Hospital Surgical/ Burn MCI Plan	Including local and regional supplies and patient distribution. Includes protocols and training policies. Surgical burn mass casualty incident (MCI) plans can address events such as active shooter or bombings.	10	2	2	2.50	4
Hospital Volunteer Management Plan	Including capabilities, deployment parameters/priorities, and process inclusive of Medical Reserve Corps as applicable.	10	2	2	2.50	4

High Priority and Action Items

High Priority Plan and Action Items

The list below displays the highest scoring plans based on the user-selected values in the Priority List column on the "Gap Analysis - Plans" tab. Please add additional details or plans of action in the rightmost column.

15 Highest Scoring Plan and Action Items

Item	Notes	Priority List	Priority Score	Additional Details/Plan of Action
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.	5	1.57	
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.	5	1.43	
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.	5	1.67	
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.	5	1.67	
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.	5	1.67	
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).	5	2.00	
Hospital Security Plan	Facility plans may be supported by jurisdictional EM and law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence, active shooter, suspected explosive devices, and civil unrest.	4	2.60	
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).	4	2.00	
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.	4	2.40	
LTC Security Plan	Facility plans should be coordinated with and supported by jurisdictional law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence and active shooter events.	4	2.20	
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.	4	2.75	
EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).	4	2.75	
LTC Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.	4	2.00	
Outpatient Care Surge Capacity Plan	Describe the facility role in common disasters including potential role supporting emergency care as well as communication and notification procedures.	4	2.50	
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.	4	2.50	