INDIANA DISTRICT 2 HEALTHCARE COALITION

PREPAREDNESS PLAN

Updated 12/28/18

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I. INTRODUCTION

A. Purpose of Plan

A Healthcare Coalition (HCC) preparedness plan should document the organization and process of the Coalition and how it prioritizes and works collectively to develop and test operational capabilities that promote communication, information sharing, resource coordination, and operational response and recovery.

B. Scope

A. This plan adopts an All-Hazards approach to coordinating disaster mitigation, preparedness, response, and recovery activities within District 2.
B. This plan is not designed to supplant the plans, authorities, and responsibilities of the District 2 Healthcare Coalition members, rather to support existing plans.

C. Administrative Support

Preparedness Plan will be approved by the Executive Committee which consists of the core 4 members, and then will be taken to the policies subcommittee for further approval or updates. Preparedness Plan will be updated annually by policies subcommittee with updates to be approved by Executive Committee and membership.

II. COALITION OVERVIEW

A. Introduction

The primary mission of the District 2 HCC is to efficiently and effectively manage and coordinate a core set of preparedness activities that focus on strategic and operational planning; resource allocation and resource management; training and exercises; as well as promoting coordination and communication with all levels of healthcare, as well as federal, state, and local governments.

B. Coalition Boundaries

The District 2 HCC encompasses 7 north-central Indiana Counties; Elkhart, Fulton, Kosciusko, Marshall, Pulaski, St Joseph, and Starke. This specific boundary area also includes a Trauma Regional Advisory Council headed by Memorial Hospital of South Bend and the District 2 District Planning Council.

District 2 Healthcare Coalition is made up of the following counties:

DISTRICT 2	
County Name	**County Population**
Elkhart	199,258
Fulton	20,672
Kosciusko	77,678
Marshall	47,035

Pulaski	13,072
St Joseph	266,461
Starke	23,203
***2012 US Census**	647,379

C. Coalition Members

The District 2 Healthcare Coalition consists of a variety of healthcare organizations and membership. A full list of participating organizations and members can be found in **Appendix A – Healthcare Organizations and Coalition Members.** In general, membership is consistent with the following ASPR requirements:

HCCs **must** ensure the following core membership:

- Hospitals (a minimum of two acute care hospitals)
- EMS (including interfacility and other non-EMS patient transport systems)
- Emergency management organizations
- Public health agencies

Additional HCC members may include, but are not limited to, the following:

- Behavioral health services and organizations
- Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
- Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end stage renal disease (ESRD) networks
- Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities)
- Home health agencies (including home and community-based services)
- Infrastructure companies (e.g., utility and communication companies)
- Jurisdictional partners, including cities, counties, and tribes
- Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
- Local public safety agencies (e.g., law enforcement and fire services)
- Medical and device manufacturers and distributors
- Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
- Outpatient health care delivery (e.g., ambulatory care, clinics, community and tribal health centers, Federally Qualified Health Centers (FQHCs), urgent care centers, freestanding emergency rooms, stand-alone surgery centers)
- Primary care providers, including pediatric and women's health care providers
- Schools and universities, including academic medical centers

- Skilled nursing, nursing, and long-term care facilities
- Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
- Other (e.g., child care services, dental clinics, social work services, faith-based organizations)
- Medical examiners/ coroners and funeral homes
- Agency/facility public information specialists

Specialty patient referral centers (e.g., pediatric, burn, trauma, and psychiatric centers) should ideally be HCC members within their geographic boundaries. They may also serve as referral centers to other HCCs where that specialty care does not exist. In such cases, referral centers' support of HCC planning, exercises, and response activities can be mutually beneficial and their liaison role should be documented. Some HCCs may choose to tier the additional members by membership level/type since some may be part of another coalition

D. Organizational Structure and Governance

The HCC organizational structure and governance can be found in **Appendix B – Healthcare Coalition Bylaws**. This Appendix documents the HCC structure and processes to execute activities related to health care readiness and coordination. The elements of governance include organizational structures, roles and responsibilities, mechanisms to develop priorities, provide guidance and direction, funding management, and processes to ensure integration of planning and exercises with the ESF-8 lead agency (local and state). The HCC should specify how structure, processes, and policies may be developed and be implemented during preparedness (steady-state) activities. HCC members should utilize these elements and be part of regular reviews.

The HCC bylaws additionally include the following information related to its governance:

- HCC membership
- An organizational structure to support HCC activities, including executive and general committees, election or appointment processes, and any necessary administrative rules and operational functions (e.g., bylaws, decision-making)
- Member guidelines for participation and engagement that consider each member and region's geography, resources, and other factors
- Policies and procedures, including processes for making changes, orders of succession, and delegations of authority
- HCC integration within existing state, local, and member-specific incident management structures and specified roles—such as a primary point of contact who serves as the liaison to the ESF-8 lead agency and EOCs during an emergency
- Development and use of mutual aid agreements and memorandums of agreement

Role of Leadership within Member Organizations

Active Members: Active Membership in the Corporation shall consist of the appointed authorized representatives (referred to hereinafter as the "Coordinator" or "Alternate Coordinator") of licensed hospitals or healthcare facilities within the geographical area who sign a reaffirmation letter with the Corporation.

a. Membership in the Corporation is achieved by compliance with the District 2 Healthcare Coalition Bylaws and maintaining status with the Corporation per the "Members in Good Standing" policy.

b. A Member in the Corporation may be removed if their conduct warrants such action. A member may be removed from the Corporation with a two thirds majority vote of the Corporation Active Membership.

c. Membership in the Healthcare Coalition is open to all healthcare organizations and jurisdictions within Indiana Preparedness District 2 that agree to work collaboratively on emergency preparedness and response activities. Representatives from state, federal, and other out of district organizations are welcomed as Associate Members.

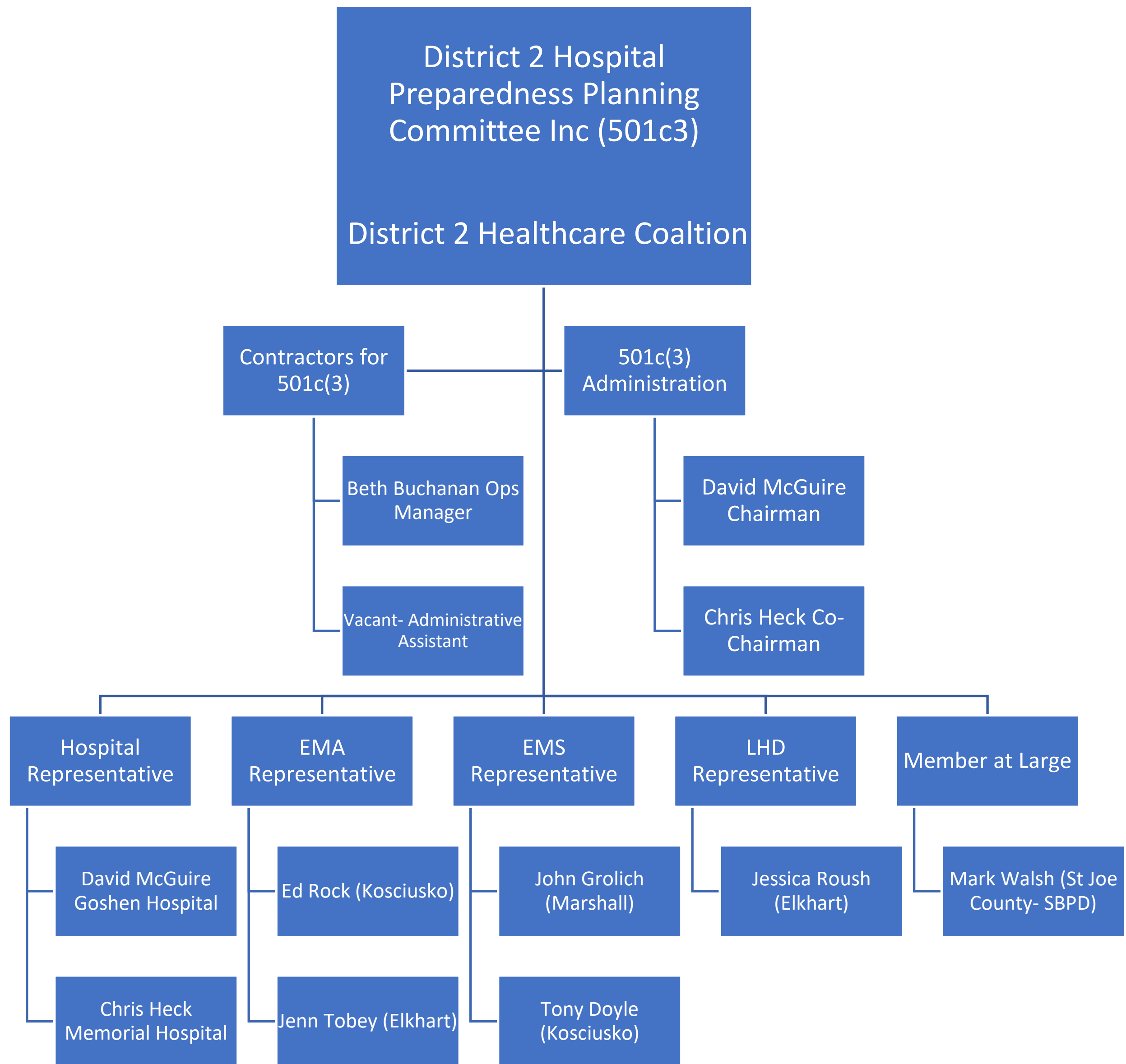
Associate Members: Associate Membership may consist of appointed representatives from District 2 licensed healthcare facilities or other partner agencies (Public Health, EMS, EMA, etc.) that do not receive ASPR funds or have signed a reaffirmation letter with the Corporation (herein referred to as "District 2 Coalition Partners"). Appointed Coalition Partners or "Associate Members" can provide input and feedback on projects and programs that benefit the whole healthcare community prior to a vote by the "Active Members".

a. The assigned Indiana State Department of Health Area Hospital/Healthcare Coalition Coordinator shall be ex-officio, non-voting member of the Corporation.

b. The hired Corporation Business Manager shall be a non-voting member of the Corporation.

c. Hospitals and Coalition Partners might also appoint additional (non-voting) members at their own discretion to serve on any committees or to work on special projects.

HCC Organizational Structure



E. Risk

A healthcare system HVA is a systematic approach to identifying hazards or risks that are most likely to have an impact on the demand for health care services or the health care delivery system's ability to provide these services. This annual assessment may also include estimates of potential injured or ill survivors, fatalities, and post-emergency community needs based on the identified risks.

The following Table represents the top 10 Hazards and Actual Alerts from the 2019 District 2 HVA:

Top 10 HVA	Rank	Occurrence
External Flood	1	1
Cyber Threat	2	1
Hazmat Incident	3	0
IT System Outage	4	2
Patient Surge	5	2
Seasonal Influenza	6	1
Bomb Threat	7	2
Communication/Telephone Failure	8	0
Severe Winter Storm	9	0
Internal Flood	10	0

Top 10 Actual Alerts	Occurrence	HVA Rank
IT System Outage	2	4
Patient Surge	2	5
Internal Flood	2	7
Seasonal Influenza	1	6
External Flood	1	1
Gas/Emissions Leak	1	17
Tornado	1	11
Power Outage	1	19
CyberThreat	1	2

The full District HVA can be found in **Appendix C – Healthcare Coalition District HVA**. This District HVA includes the top 10 Hazards, top 10 Actual Alerts, each County Health Ranking, social and vulnerability index of each county, and District EmPower information.

F. Gaps

This section requires completion of the ASPR TRACIE HEALTHCARE COALITION RESOURCE AND GAP ANALYSIS https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-healthcare-coalition-resource-and-gap-analysis-final.xlsm

District 2 HCC's Executive Committee will review the Gap Analysis with appropriate partners present yearly.

The following table represents the top 15 highest scoring Plan and Action Items completed from the ASPR Healthcare Coalition Resource and Gap Analysis:

High Priority Plan and Action Items	Priority List	Priority Score
HCC Patient Tracking and Movement Plan	5	1.57
HCC Crisis Standards of Care Plan	5	1.43
HCC Resource Plan/Annex	5	1.67
HCC Response Plan	5	1.67
EMS COOP, Recovery/Business Continuity Plan	5	1.67
EMS Crisis Care/ Crisis Standards of Care Plan	5	2.00
Hospital Security Plan	4	2.60
HCC Evacuation Plan	4	2.00
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	4	2.40
LTC Security Plan	4	2.20
EMS Behavioral Health Plan	4	2.75
EMS Evacuation Plan	4	2.75
LTC Staff and Resource Sharing Plan	4	2.00
Outpatient Care Surge Capacity Plan	4	2.50
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	4	2.50

See **Appendix D –Healthcare Coalition Resource and Gap Analysis** for full gap analysis data

Utilizing the ASPR Healthcare Coalition Resource and Gap Analysis Tool, the HCC has identified the following resource gaps:

Coalition	EMS	Hospital	Public Health	Long Term Care	Outpatient Care
Communication Assets	Communication Assets	Communication Assets	N/A		
Funding	Evacuation Resources				
Hardware/ Connectivity	HAZMAT Radiation Assets				
MACC/EOC					
Staff					
Virtual Coord.					

See **Appendix D –Healthcare Coalition Resource and Gap Analysis** for full resource assessments

G. Compliance Requirements & Legal Authorities

The District 2 HCC, in collaboration with the ESF-8 lead agency and state authorities, should assess and identify regulatory compliance requirements that are applicable to day-to-day operations and may affect planning for, responding to, and recovering from emergencies.

CMS Emergency Preparedness Rule

Published September 16, 2016 with implementation date November 15, 2017, the CMS Emergency Preparedness Rule applies to the following 17 Providers/Suppliers:

1. Hospitals
2. Religious Nonmedical Health Care Institutions (RNHCIs)
3. Ambulatory Surgical Centers (ASCs)
4. Hospices
5. Psychiatric Residential Treatment Facilities (PRTFs)
6. All-Inclusive Care for the Elderly (PACE)
7. Transplant Centers
8. Long-Term Care (LTC) Facilities
9. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
10. Home Health Agencies (HHAs)
11. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
12. Critical Access Hospitals (CAHs)
13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
14. Community Mental Health Centers (CMHCs)
15. Organ Procurement Organizations (OPOs)
16. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
17. End-Stage Renal Disease (ESRD) Facilities

The CMS Preparedness Rule consists of Four Provisions

<u>Risk Assessment and Planning</u>

- Develop an emergency plan based on a risk assessment.
- Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities.
- Update emergency plan at least annually.

<u>Policies and Procedures</u>

- Develop and implement policies and procedures based on the emergency plan and risk assessment.
- Policies and procedures must address a range of issues including subsistence needs, evacuation plans, and procedures for sheltering in place, tracking patients and staff during an emergency.

- Review and update policies and procedures at least annually.

Communications Plan

- Develop a communication plan that complies with both Federal and State laws.
- Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems.
- Review and update plan annually.

Training and Testing Program

- Develop and maintain training and testing programs, including initial training in policies and procedures.
- Demonstrate knowledge of emergency procedures and provide training at least annually.
- Conduct drills and exercises to test the emergency plan.

Source: CMS General Presentation Overview (2017) https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/General-Presentation-Overview-EP-.pptx

See **Appendix E – Selected Federal Legal Authorities** for a list of commonly referenced Federal statutes for Public Health and Healthcare preparedness and response.

III. COALITION OBJECTIVES

Coalition objectives are based upon strategic and operational priorities for the HCC and established based on the results from the risk and gap analysis. The following sections will include preparedness activities that include:

- Defined priorities for the plan and how they address gaps
- Short-term and long-term objectives that support the priorities- these can be supporting objectives associated with each overarching coalition objective
- Support for the objectives
- Foster effective information sharing with HCC members and timely and effective messaging to the public

A. Maintenance and Sustainability of HCC

- Promote the value of health care and medical readiness (Capability 1, Objective 5, Activity 1)The primary mission of the District 2 Healthcare Coalition is to efficiently and effectively manage and coordinate a core set of preparedness activities that focus on strategic and operational planning; resource allocation and resource management; training and exercises; as well as promoting coordination and communication with all levels of healthcare and of federal, state, and local governments. The HCC has a duty to plan for a

full range of emergencies and both planned and unplanned events that could affect its community. It is essential that the HCC has leaders who can serve as primary points of contact to promote preparedness and response needs to community leaders. Additionally, members have a shared responsibility to ensure the HCC has visibility into their activities in the region.

- Promote sustainability of HCC (Capability 1, Objective 5, Activity 5) - There are a variety of ways to promote greater community effectiveness and organizational and financial sustainability. Full investment in readiness includes in-kind donation of time, resources, financial support (e.g., donations fees etc.), and continued engagement with HCC members and the community. Financial strategies, including cost- sharing techniques and other funding options, enhance stability and sustainment.

- Sharing leading practices and lessons learned (Capability 1, Objective 4, Activity 6) - The HCC coordinates with its members, government partners, and other HCCs to share leading practices and lessons learned. Sharing information between HCCs will improve cross-HCC coordination during an emergency and will help further improve coordination efforts.

B. Engagement of Partners and Stakeholders

Health Care Executives

The HCC continues to strive to engage Healthcare leadership. A membership appointment letter is signed by each Healthcare Entity CEO to become a member of the HCC that designates their appointed coordinator. In turn each coordinator is required to take all shared information and training opportunities from the district back to their institutions. Grant funding will only be made available to institutions that have a signed letter of intent on file.

Clinicians

The HCC encourages input from clinical members and leaders from all areas. Drill planning includes input from all facilities which begins at a facility level. Typically, mass casualty drills are headed by the hospitals and all hospitals are encouraged to include their key stakeholders in their planning, to include medical directors, ER leadership, nursing leadership, and so forth. After hospital planning begins the information/input obtained at these planning meetings is brought back to the district level planning meetings and drives district level planning efforts.

Community Leaders

The HCC engages community, and private leadership on a continual basis. All members are required to share HCC information with their community/entity leaders. The HCC has also merged with the D2 District Planning Council who are appointed members by the District County leaders and closely work with each County Mayor and County Council Members. Each County Emergency Manager is a member of the HCC and regularly attends meetings.

Children, Pregnant Women, seniors, Individuals with Access and Functional Needs
Continuous planning has occurred on the ESF8 side to address this special population. Assessments of functional needs and planning to address these needs in an emergency has occurred by each county. Each Local Health Department and Hospital has a plan to address the needs of these special populations in an emergency.

IV. WORKPLAN

A. Policy development and process:

Primary Member Roles: Lead and coordinate policy development subcommittee to include coordination of stakeholder input meetings, implementation rollout and trainings.

Supporting Member Roles: Assist with policy development, implementation and training.

Proposed Outputs: Develop identified policies/plans with stakeholders to address gaps.

Timelines: All identified policies completed including full roll out and training of district members and stakeholders within (6) months of policy start.

B. Role and responsibilities of committees/work groups in developing response plans policies and procedures:

Primary Member Roles: Lead and coordinate policy development subcommittee to include coordination of stakeholder input meetings, implementation rollout and trainings. All Response Plan policies and Procedures must be approved by Executive Committee Prior to rollout.

Supporting Member Roles: Assist with policy development, implementation and training.

Proposed Outputs: Develop identified policies/plans with stakeholders to address gaps.

Timelines: All identified policies completed including full roll out and training of district members and stakeholders within (6) months of policy start.

C. Evaluate exercises and responses to emergencies

Primary Member Roles: Compile workgroup/subcommittee and schedule meetings. Lead meetings pertaining to evaluation and ensure evaluation of exercises and responses are done in a timely manner, and all necessary paperwork is compiled and submitted in a timely manner.

Supporting Member Roles: All supporting members will provide necessary input and documentation. All members will attend scheduled meetings and other duties as requested.

Proposed Outputs: All evaluations will be filled out in HSEEP format to include evaluation and improvement planning. The committee with assistance from the Executive Committee will then monitor improvement planning to ensure follow up items are resolved.

Timelines: All evaluations will be completed within 45 days of exercises/responses on HSEEP template and turned into the D2 Executive Committee for submission to ISDH.