INDIANA DISTRICT 2 HEALTHCARE COALITION

PREPAREDNESS PLAN

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

May 2026

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RECORD OF CHANGES

The Healthcare Coalition Planning Section Chief will ensure any changes made to this plan outside the official cycle of plan review and update are documented and distributed using the Document Change Record (Table 1) as outlined in the Maintenance section of this plan.

Date	Page(s)	Revision Description (s)	By Whom
6/20/23	All	Added Record of Changes, all annexes reviewed. Membership, HVA, and Bylaws/Governance updated docs.	Jennifer Tobey
4/12/24	Appendix C	Update HVA Preparedness Appendix	Elizabeth Buchanan
4/26/24	5, 7, 8	Updated HVA and Gap Assessment Results	Elizabeth Buchanan
3/8/2024	All	Grammatical errors	Jennifer Tobey
6/2/2025	All	General review/ added Avian Influenza	Jennifer Tobey
5/2026	All	Review, New Bylaws, New CPA	Jennifer Tobey

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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. (Example: flooding, hazardous material incident, avian influenza)
B. This plan is not designed to supplant the plans, authorities, and responsibilities of the District 2 Healthcare Coalition members, but rather to support existing plans.

C. Administrative Support

The 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. The Preparedness Plan will be updated annually by the policies subcommittee with updates to be approved by the Executive Committee and membership.

II. COALITION OVERVIEW

A. Introduction

The primary mission of the District 2 HCC is to 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 efficiently and effectively.

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.

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

DISTRICT 2	
County Name	**County Population**
Elkhart	207,436
Fulton	20,358
Kosciusko	80,669
Marshall	46,464

Pulaski	12,385
St Joseph	272,848
Starke	23,206
***2024 (EST) US Census Bureau**	663,366

C. Coalition Members

The District 2 Healthcare Coalition consists of a variety of healthcare organizations and the 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 professional healthcare 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., childcare services, dental clinics, social work services, faith-based organizations)
- Medical examiners/ coroners and funeral homes
- Agency/facility public information specialists
- Board of Animal Health (avian influenza)

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 **D2 HCC Bylaws COI**. This document is 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, guidance and direction, funding management, and processes to ensure 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 implemented during prepared (steady state) activities. HCC members should utilize these elements and be part of regular reviews.

The HCC Governance and D2 Hospital Preparedness and Planning Committee, Inc. (D2HPPC) 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 D2HPPC Bylaws and maintaining status with the Corporation per the “Members in Good Standing” policy.

b. A Member in the Corporation may be removed if they 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 not 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 before a vote by the “Active Members”.

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

b. The hired Corporation Contractors shall be non-voting members of the Corporation.

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

HCC Organizational Structure

E. Risk

Healthcare system HVA is a systematic approach to identifying hazards or risks that are most likely to have an impact on the demand for healthcare services or the healthcare 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 2024 District 2 HVA:

2025

TOP 10 HVA	RANK	OCCURRENCE
Inclement Weather	1	5
Power Outage	2	9
Active Assailant	3	2
Chemical Spill	4	0
Temperature Extremes	5	2
Utility Failure	6	2
Chemical Exposure, Internal	7	0
Flood, External	8	1
HVAC Failure	9	1
Seasonal Influenza	10	0

2024

TOP 10 HVA	RANK	OCCURRENCE
Workplace Violence/Threat	1	4
Epidemic	2	1
Supply Chain Shortage/Failure	3	0
Cyber Incident	4	0
IT System Outage	5	13
Mass Casualty Incident-Medical	6	1
Pandemic	7	1
Evacuation	8	2
Patient Surge	9	1
Active Assailant	10	0

The full District HVA/Public Health and Medical Risk assessment can be found in **Appendix B – Healthcare Coalition District HVA**. This District HVA includes the top 10 Hazards, top 10 Actual Alerts, each County Health Ranking, the 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:

15 Highest Scoring Plan and Action Items

Item	Notes	Priority List	Priority Score
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	1.57
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.	5	1.57
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.).	5	1.67
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.	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 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	2.00
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.	4	2.20
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.	4	1.83
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.	4	2.20
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	2.20
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	4	2.75
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.	4	2.75
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	2.00
LTC Infectious Disease Plan	Details response plans / process for an epidemic / pandemic affecting the facility, including any closed points of dispensing plans.	4	2.50
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	2.50

See **Appendix C –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
Crisis Standards of Care	Alerting/notification plan	Infectious disease plan	Evacuation	Security	Surge Capacity Plan
Patient tracking and movement	Evacuation	Pediatric MCI plan		Exercise plan	
Evacuation	Hazmat/Decon plan	Security plan		Infectious disease plan	
	Patient tracking and movement plan	COOP, Recovery/ business continuity plan			
	Active Shooter/Armed assailant/active threat response plan	Crisis Care/ Crisis standards of care plan			
	Behavioral health plan	IT/IS system failure/ compromise			
	COOP/Recovery/Business continuity plan	Patient tracking and movement			
	Exercise plan	Staff and resource sharing plan			
	Infectious disease plan	Surge Capacity			
	IT system failure/compromise plan				
	Mutual aid plan				
	Patient distribution plan				
	Specialty mass casualty (burn, peds, MCI)				

			Avian Influenza		

See **Appendix C –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 apply 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 of 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. (Example: flooding, hazardous material incident, avian influenza)
- Update the 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, and 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 the 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 D – 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-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 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 federal, state, and local governments efficiently and effectively. HCC has a duty to plan for a full range of emergencies and both planned and unplanned events that could affect its community. (Example: flooding, hazardous material incident, avian influenza) HCC must have 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 in 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 donations 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 begin 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 continually. All members are required to share HCC information with their community/entity leaders. 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 have 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 training.

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 rollout 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 training. All Response Plan policies and Procedures must be approved by the Executive Committee Before 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 rollout 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 about evaluation and ensure evaluation of exercises and responses are done promptly, and all necessary paperwork is compiled and submitted on time.

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 the HSEEP template and turned into the D2 Executive Committee for submission to IDOH.

APPENDIX A

Healthcare Organizations and Coalition Members

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

May 2026

The following list of all organizations represents organizations that are located and or licensed within the Healthcare Coalition's geographical boundary.

Membership Status should be indicated by the status of membership level they have within the coalition, after meeting the required executive endorsement of their respective organization through the required letter of support, MOU, or other agreement.

ASPR CORE HCC MEMBERS

Hospitals

Hospitals consist of the following types of hospitals: Acute Care, Critical Access, Long Term, Rehabilitation, Psychiatric, Children's, Children's Psychiatric, Freestanding, Transplant, Veterans Affairs, Religious Non-Healthcare Institution, and License only.

Hospital Name	Hospital Type	County	Membership
Beacon Granger Hospital	Acute Care	St Joseph	
Beacon Memorial Hospital	Acute Care	St Joseph	CPA
St Joseph Health Mishawaka	Acute Care	St Joseph	CPA
Beacon Elkhart General Hospital	Acute Care	Elkhart	
Goshen Hospital	Acute Care	Elkhart	
St Joseph Health Plymouth	Acute Care	Marshall	CPA
Bremen Community	Critical Access	Marshall	CPA
Unity Med and Surg	License Only	St Joseph	
Northwest Health Starke Hospital	Critical Access	Starke	CPA
Pulaski Memorial	Critical Access	Pulaski	CPA
Woodlawn Hospital	Critical Access	Fulton	CPA
Kosciusko Community	Acute Care	Kosciusko	CPA
Parkview Warsaw	ER Only	Kosciusko	CPA

Emergency Medical Services (EMS)

EMS consists of the following transport types: Ground Transport, Air Transport, and Non-Transport. In addition, EMS consists of the following provider levels: Basic Life Support and Advanced Life Support. EMS should include fire departments, police departments, county based, hospital based, government, private, all types of volunteers, industry, or any other organization

with EMS provider status located within the jurisdiction. EMS organizations that serve the jurisdiction but are housed outside the jurisdiction should not be included here.

EMS Name	Transport Type	Provider Level	County	Membership
Elkhart Fire	Ground	ALS	Elkhart	
South Bend Fire	Ground	ALS	St Joseph	
Goshen Fire	Ground	ALS	Elkhart	CPA
Lutheran EMS	Ground	ALS	Kosciusko/Marshall	CPA
Warsaw-Wayne	Ground	ALS	Kosciusko	CPA
Starke Co EMS	Ground	ALS	Starke	CPA
Tippecanoe TWP	Ground	ALS	Kosciusko	CPA
Tri-County	Ground	ALS	Elkhart	CPA

Emergency Management Organizations

Emergency Management Organizations consist of the 92 Emergency Management Agencies in Indiana, as listed by IDHS. While other emergency management organizations should exist, those others should not be included here.

Emergency Management Name	County	Membership
Elkhart County EMA	Elkhart	CPA
Fulton County EMA	Fulton	
Kosciusko County EMA	Kosciusko	CPA
Marshall County EMA	Marshall	CPA
Pulaski County EMA	Pulaski	
St Joseph County EMA	St Joseph	CPA
Starke County EMA	Starke	CPA

Public Health Agencies

Public Health Agencies consist of the 93 Local Health Departments in Indiana, as listed by ISDH. While other public health organizations should exist, those others should not be included here.

Public Health Name	County	Membership
Elkhart County Health Department	Elkhart	CPA
Fulton County Health Department	Fulton	CPA
St Joseph County Health Department	St Joseph	CPA
Marshall County Health Department	Marshall	CPA

Starke County Health Department	Starke	
Pulaski County Health Department	Pulaski	CPA
Kosciusko County Health Department	Kosciusko	CPA

ASPR ADDITIONAL HCC MEMBERS

Behavioral Health Services and Organizations

Behavioral health includes organization types such as: Community Mental Health Center, Psychiatric Residential Treatment Facilities, Outpatient Services, or Other

Behavioral Health Name	Type	County	Membership
Oaklawn	PRTF, Outpatient	Elkhart & St Joseph	CPA
Bowen Center	PRTF, Outpatient	Kosciusko, Marshall	CPA

Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)

CERT and MRC include local teams within jurisdiction in the types: CERT or MRC

Unit Name	Type	County
St Joseph County MRC	MRC	St Joseph
Elkhart County CERT	CERT	Elkhart
Kosciusko County CERT	CERT	Kosciusko

Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks

Dialysis Name	County	Membership
Duneland Dialysis	Starke	

Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indian Health Service facilities, military treatment facilities)

Federal facilities include VA, military base clinics, and military medical centers within the jurisdiction, as well as any Indian Health service facilities.

Federal Facility Name	County
National Weather Service	Kosciusko

Home health agencies (including home and community-based services)

Home Health Name	County	Membership
Center for Hospice Care	Elkhart	CPA
Miami Homecare	St Joseph	CPA
St Joseph VNA Homecare	St Joseph	CPA

Infrastructure companies (e.g., utility and communication companies)

Company	Type	County
AEP	Utility	Elkhart/St Joseph
Nipsco	Utility	Elkhart
REMC	Utility	

Jurisdictional partners, including cities, counties, and tribes

Jurisdictional partners include governmental representatives into Levels of County, City, Town, Township, or Tribal. Representation may vary across councils, boards, or single people.

Government	Level	County	Membership

Local chapters of healthcare organizations (e.g., medical society, professional society, hospital association)

Local chapters include any type of healthcare related to professional organization, association, or societies. These should include only those that have a chapter specifically within the jurisdiction and not include statewide or multi-regional organizations.

Local Chapter	County	Membership

Local public safety agencies (e.g., law enforcement and fire services)

Local public safety agencies include any other type of agency that is not already included under EMS. Fire departments that house separate EMS and Fire Divisions may be included appropriately in each. Agency types include Fire, Law Enforcement, Hazmat, Animal Control, Corrections, Courts, other Emergency Management Organizations not listed previously, Dispatch and PSAPs if a separate entity, transportation, parks department, or any other local or district agency/organization that fulfills a response role.

Public Safety	Type	County	Membership
Elkhart City 911	Dispatch	Elkhart	
Fulton County 911	Dispatch	Fulton	
St Joseph County 911	Dispatch	St Joseph	CPA
Marshall County 911	Dispatch	Marshall	
Warsaw-Wayne Fire Territory	Fire Department	Kosciusko	CPA
Kosciusko County 911	Dispatch	Kosciusko	

Medical and device manufacturers and distributors

Manufacturer	County	Membership

Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)

NGOs include any type of local nonprofit organization with a response role. Statewide or multi-regional organizations should not be included here. Faith-based organizations should not be listed here.

NGO	***Type***	***County***
American Red Cross	Relief Org.	All D2 Counties

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)

Outpatient should include the following types: Ambulatory Surgical Center, Community Health Center, Federally Qualified Community Health Center, Rural Health Clinic, Urgent Care Center, or Other.

Primary care providers, including pediatric and women's health care providers

Primary care providers include all types of office within the jurisdiction.

Primary Care Provider	County	Membership

Schools and universities, including academic medical centers

Schools and universities include any campus within the jurisdiction, higher education or traditional.

School/University	County	Membership
University of Notre Dame	St Joseph	

Skilled nursing, nursing, and long-term care facilities

Skilled nursing, nursing, and long-term care facilities include all licensed long-term care facilities within the jurisdiction. This includes the following types: Nursing Home (comprehensive, nursing only, residential care, S/NF district part, skilled nursing only, skilled/nursing only dual certified) and Intermediate Care Facilities for Intellectually Disabled.

Long Term Care Facility	Type	County	Membership
Pilgrim Manor	LTC	Marshall	CPA

Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, and poison control centers)

Support service providers include any local providers within the jurisdiction, supportive to healthcare response. Statewide organizations should not be included here.

Support Provider	Type	County	Membership

Other (e.g., childcare services, dental clinics, social work services, faith-based organizations)

Other includes any other organization not already listed – including Hospice, Organ procurement, any local coalitions, and the above examples.

Organization	Type	County	Membership
Center for Hospice Care	Hospice	St Joseph (All of D2)	CPA
ADEC	Adult/Child Services	St Joseph (Serves all D2)	

Other HCC Partnerships

Additional note: State Agencies – such as ISDH, IDHS, BOAH, etc. should not be listed in any of the preceding organizations. Neither should any form of military, federal, or uniform services except for specific military healthcare facilities be included as a local organization. While they may serve as partnerships with the Healthcare Coalition, they are not local entities and thus not on any of these lists. If those are desired to be listed, list below

Partnership Organization	**Type**
Indiana Department of Health	State Office
Indiana Department of Homeland Security	State Office
Integrated Public Safety Commission	State Office
Indiana Rural Health Association	State Association
Indiana Department of Transportation	State Association
Indiana Department of Environmental Management	State Association/Response Agency
Indiana Toll road	State Transportation

APPENDIX B

HEALTHCARE COALITION HVA

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

May 2026

A hazard vulnerability analysis (HVA) is a systematic approach to identifying hazards or risks that are most likely to impact the demand for health care services or the health care delivery system's ability to provide these services. Based on the identified risks, this assessment may also include estimates of potential injured or ill survivors, fatalities, and post-emergency community needs.

General principles for the HVA process include, but are not limited to the following:

- HCC members should participate in the HVA process, using various HVA tools.
- The HVA process should be coordinated with state and local emergency management organization assessments (e.g., Threat and Hazard Identification and Risk Assessment [THIRA] 20) and any public health hazard assessments (e.g., jurisdictional risk assessment). The intent is to ensure completion, share risk assessment results, and minimize duplication of effort
- Health care facilities, EMS, and other health care organizations should provide input into the development of the regional HVA based on their facilities' or organizations' HVAs
- The assessment components should include regional characteristics, such as risks for natural or man-made disasters, geography, and critical infrastructure
- The assessment components should address population characteristics (including demographics), and consider those individuals who might require additional help in an emergency, such as children, pregnant women, seniors, individuals with access and functional needs, including people with disabilities, and others with unique needs
- The HCC should regularly review and share the HVA with all members

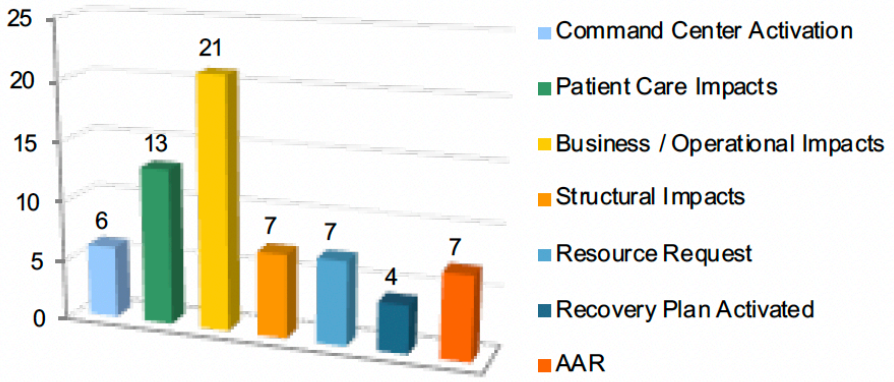
The following is the completed 2025 District 2 HVA with associated county health rankings and SVI maps.

Indiana District 2 Healthcare Coalition HVA Summary

Kaiser Permamente HVA Tool

2025 Impacts

ALERT TYPE	OCCURRENCE
Command Center Activation	6
Patient Care Impacts	13
Business / Operational Impacts	21
Structural Impacts	7
Resource Request	7
Recovery Plan Activated	4
AAR	7
Total Alert	**31**



2025 Results

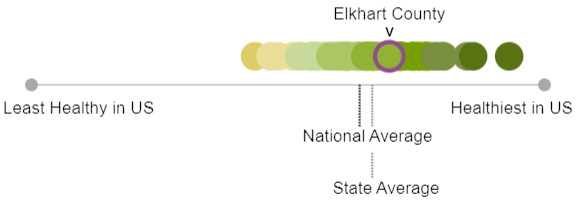
TOP 10 HVA	RANK	OCCURRENCE
Inclement Weather	1	5
Power Outage	2	9
Active Shooter	3	2
Chemical Spill	4	0
Temperature Extremes	5	2
Utility Failure	6	2
Chemical Exposure, Internal	7	0
Flood, External	8	1
HVAC Failure	9	1
Seasonal Influenza	10	0

2024 Results

TOP 10 HVA	RANK	OCCURRENCE
Workplace Violence/Threat	1	4
Epidemic	2	1
Supply Chain Shortage / Failure	3	0
Cyber Incident	4	0
IT System Outage	5	13
Mass Casualty Incident - Medical	6	1
Pandemic	7	1
Evacuation	8	2
Patient Surge	9	1
Active Shooter	10	0

County Health Rankings & Roadmaps

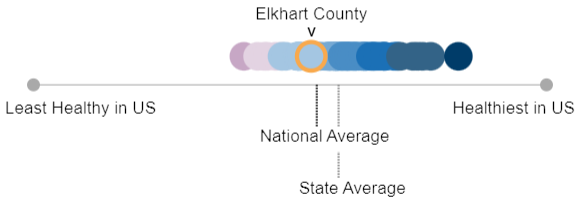
Elkhart County Population Health and Well-being - 2025



Elkhart County is faring about the same as the average county in Indiana for Population Health and Well-being, and slightly better than the average county in the nation.

County Health Rankings & Roadmaps

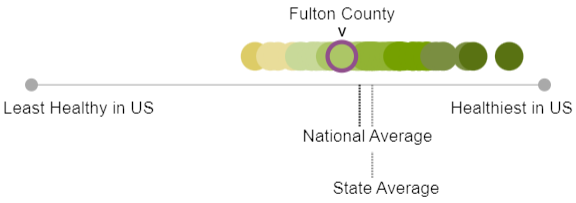
Elkhart County Community Conditions - 2025



Elkhart County is faring slightly worse than the average county in Indiana for Community Conditions, and slightly worse than the average county in the nation.

County Health Rankings & Roadmaps

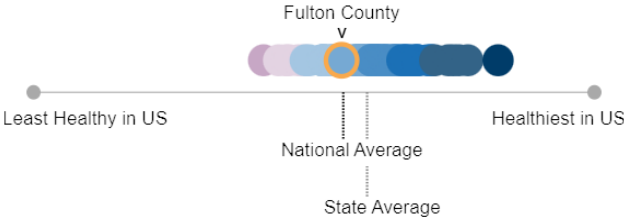
Fulton County Population Health and Well-being - 2025



Fulton County is faring slightly worse than the average county in Indiana for Population Health and Well-being, and about the same as the average county in the nation.

County Health Rankings & Roadmaps

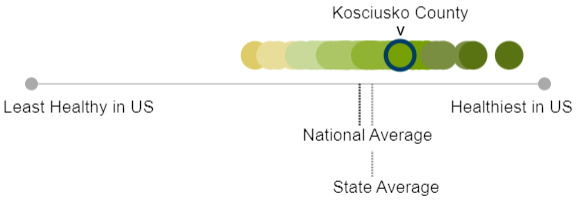
Fulton County Community Conditions - 2025



Fulton County is faring about the same as the average county in Indiana for Community Conditions, and about the same as the average county in the nation.

County Health Rankings & Roadmaps

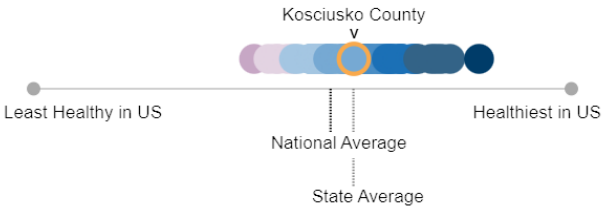
Kosciusko County Population Health and Well-being - 2025



Kosciusko County is faring slightly better than the average county in Indiana for Population Health and Well-being, and better than the average county in the nation.

County Health Rankings & Roadmaps

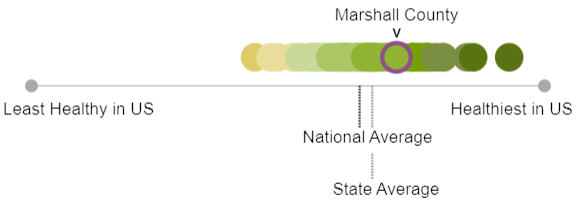
Kosciusko County Community Conditions - 2025



Kosciusko County is faring about the same as the average county in Indiana for Community Conditions, and about the same as the average county in the nation.

County Health Rankings & Roadmaps

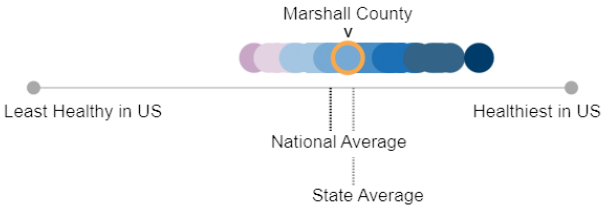
Marshall County Population Health and Well-being - 2025



Marshall County is faring about the same as the average county in Indiana for Population Health and Well-being, and slightly better than the average county in the nation.

County Health Rankings & Roadmaps

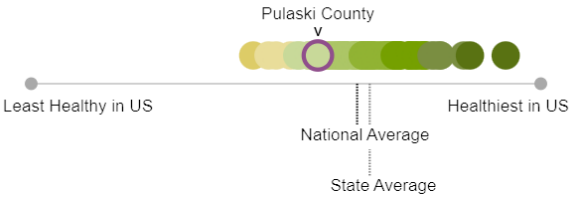
Marshall County Community Conditions - 2025



Marshall County is faring about the same as the average county in Indiana for Community Conditions, and about the same as the average county in the nation.

County Health Rankings & Roadmaps

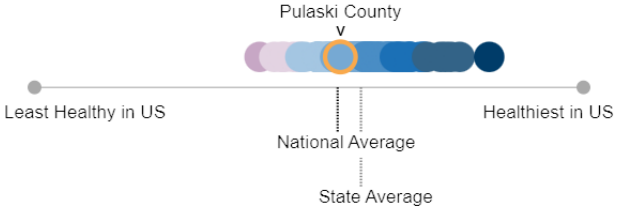
Pulaski County Population Health and Well-being - 2025



Pulaski County is faring worse than the average county in Indiana for Population Health and Well-being, and slightly worse than the average county in the nation.

County Health Rankings & Roadmaps

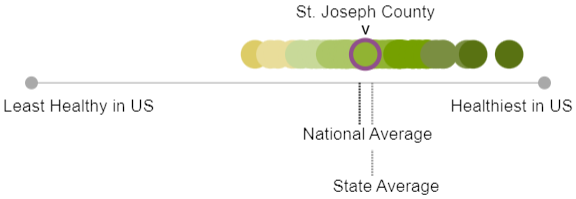
Pulaski County Community Conditions - 2025



Pulaski County is faring about the same as the average county in Indiana for Community Conditions, and about the same as the average county in the nation.

County Health Rankings & Roadmaps

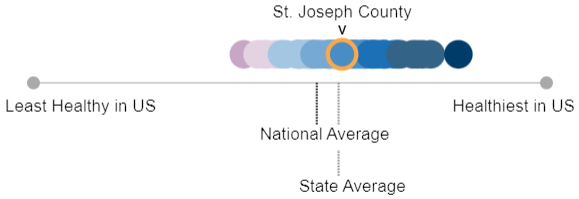
St. Joseph County Population Health and Well-being - 2025



St. Joseph County is faring about the same as the average county in Indiana for Population Health and Well-being, and slightly better than the average county in the nation.

County Health Rankings & Roadmaps

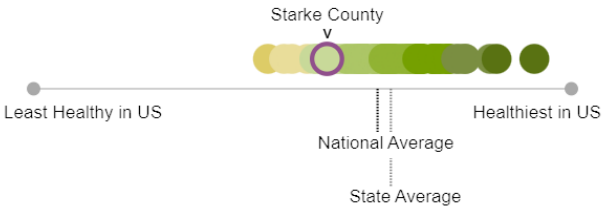
St. Joseph County Community Conditions - 2025



St. Joseph County is faring slightly better than the average county in Indiana for Community Conditions, and slightly better than the average county in the nation.

County Health Rankings & Roadmaps

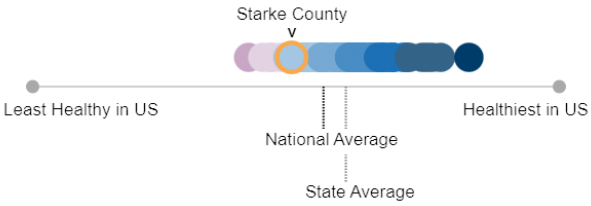
Starke County Population Health and Well-being - 2025



Starke County is faring worse than the average county in Indiana for Population Health and Well-being, and slightly worse than the average county in the nation.

County Health Rankings & Roadmaps

Starke County Community Conditions - 2025

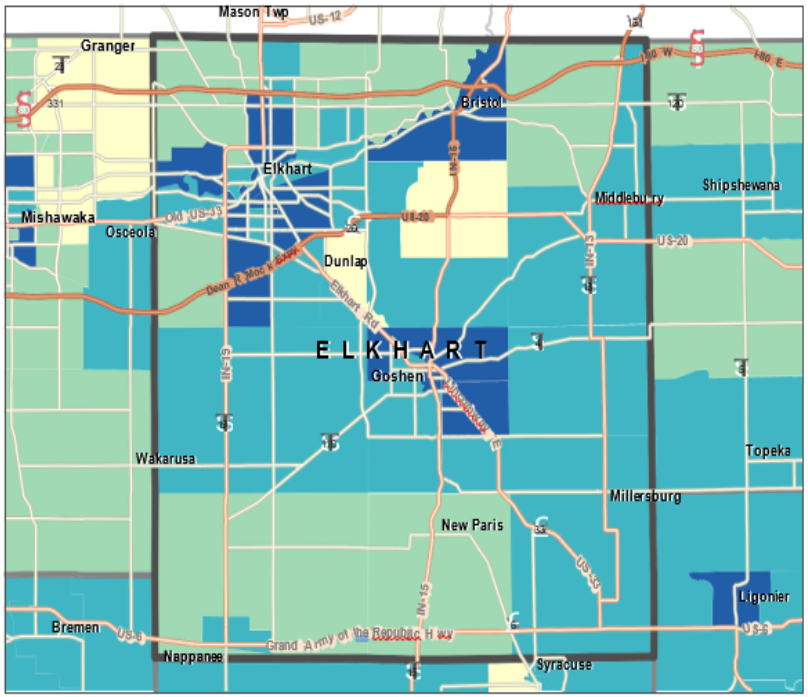


Starke County is faring slightly worse than the average county in Indiana for Community Conditions, and slightly worse than the average county in the nation.

CDC/ATSDR Social Vulnerability Index 2022

ELKHART COUNTY, INDIANA

Overall Social Vulnerability[1]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Unavailable[3]

0 1 2 4 6 Miles

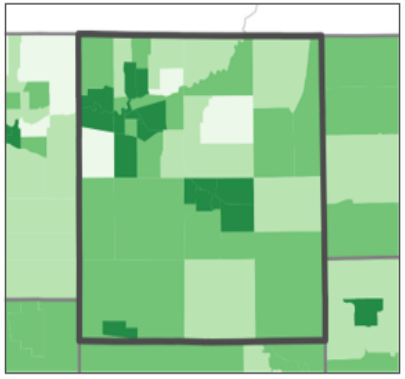
Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The **CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI 2022)[4] County Map** depicts the social vulnerability of communities, at census tract level, within a specified county. CDC/ATSDR SVI 2022 groups **sixteen census-derived factors** into **four themes** that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

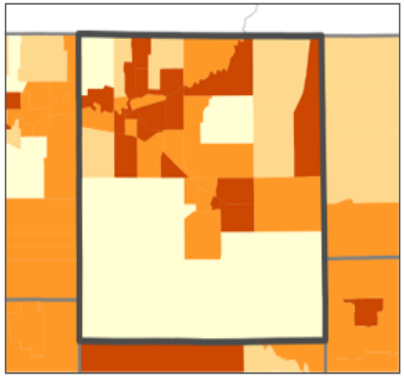
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



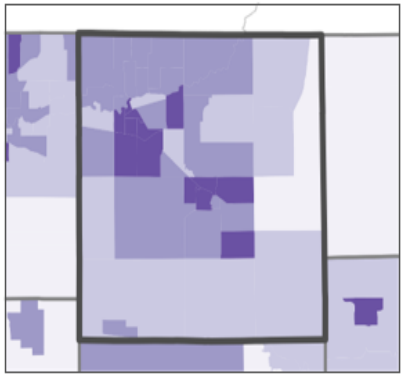
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



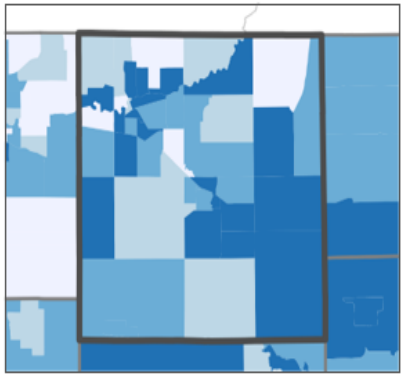
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

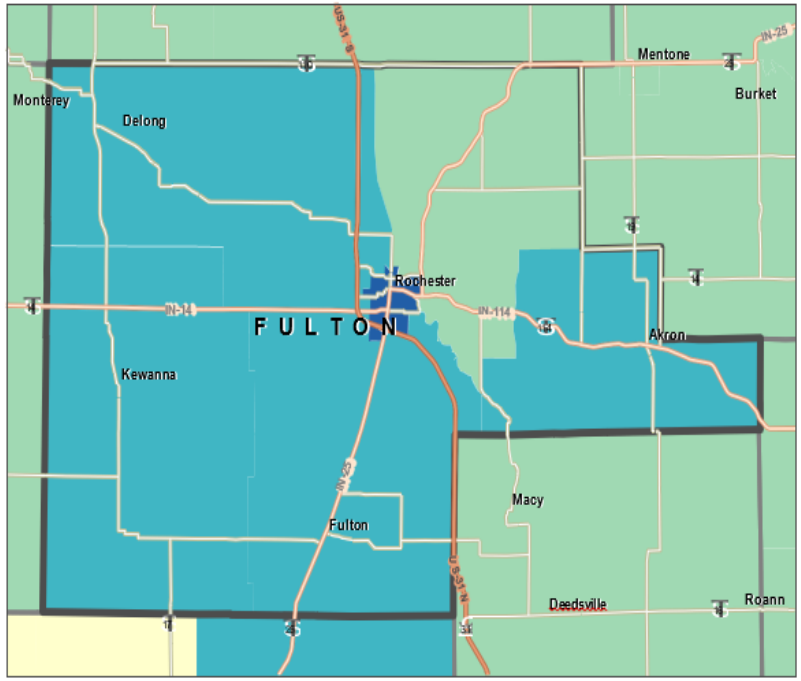
Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).
CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

FULTON COUNTY, INDIANA

Overall Social Vulnerability[1]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Unavailable[3]

0 1 2 4 6 Miles

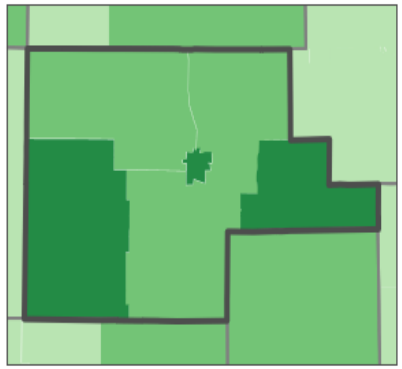
Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The **CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI 2022)[4] County Map** depicts the social vulnerability of communities, at census tract level, within a specified county. CDC/ATSDR SVI 2022 groups **sixteen census-derived factors** into **four themes** that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

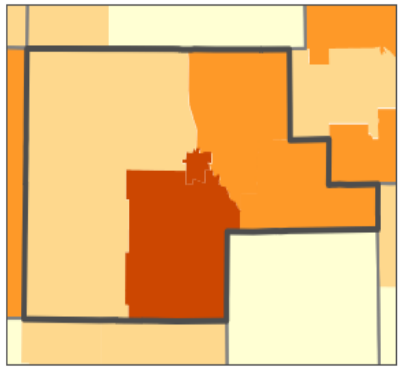
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



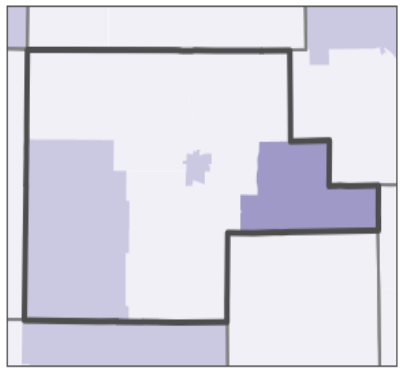
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



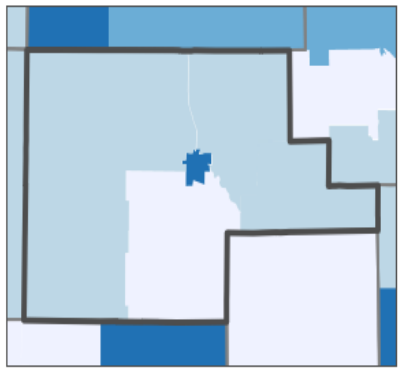
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

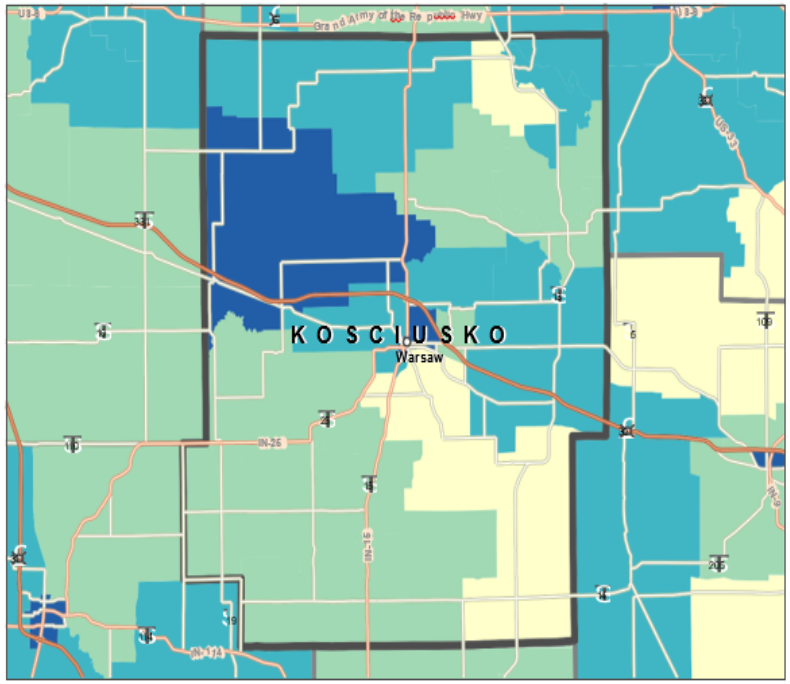
Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).
CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

KOSCIUSKO COUNTY, INDIANA

Overall Social Vulnerability[1]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Unavailable[3]

0 1.25 2.5 5 7.5
Miles

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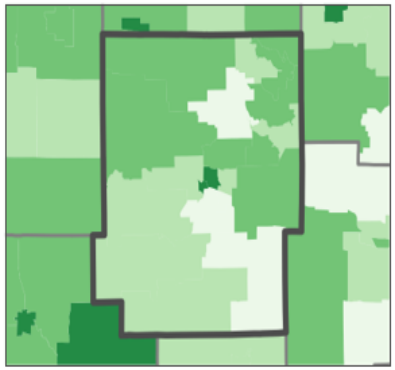
ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

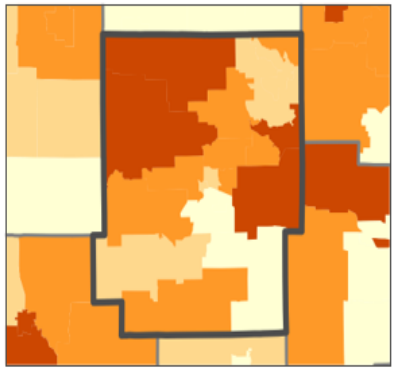
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



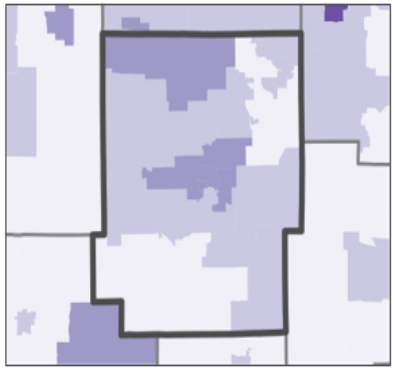
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



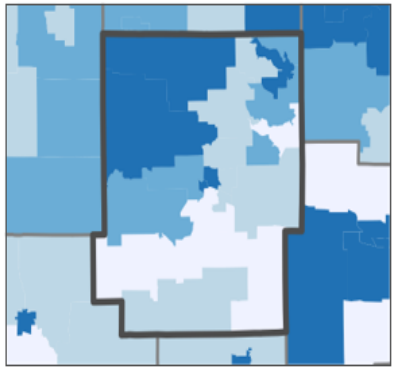
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

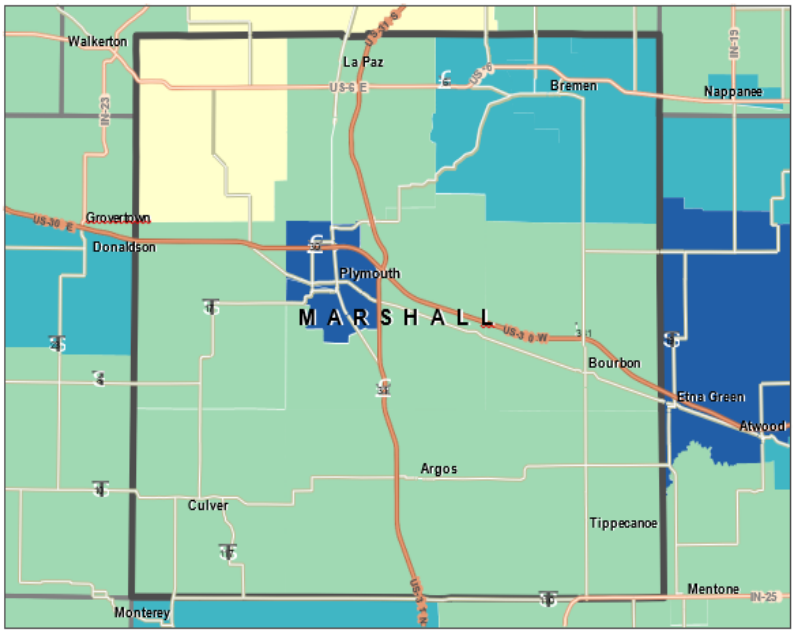
References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).

CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

MARSHALL COUNTY, INDIANA

Overall Social Vulnerability[1]



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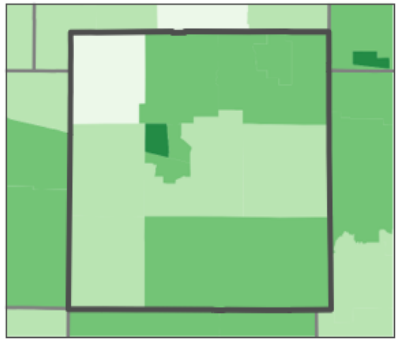
ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

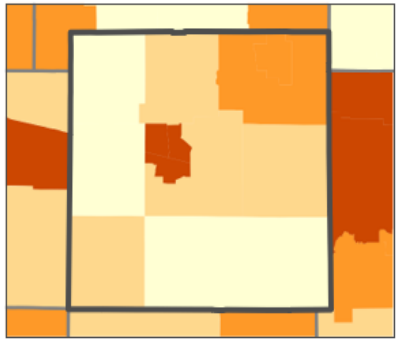
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



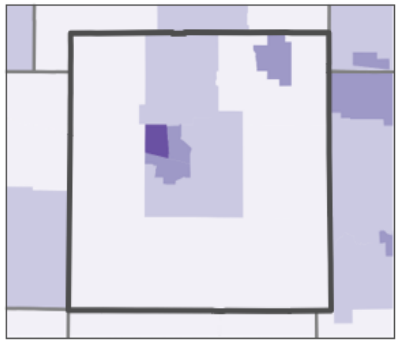
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



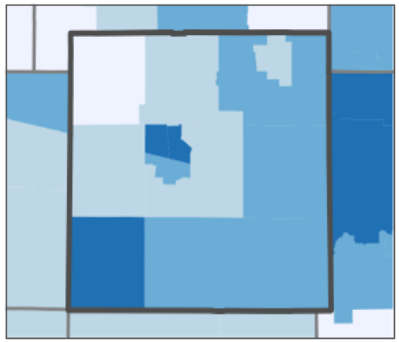
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

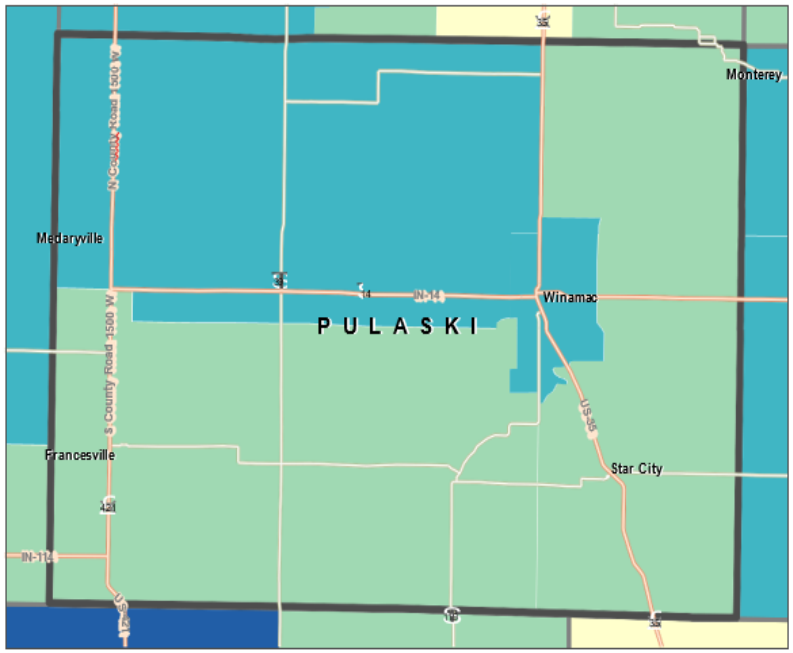
References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).

CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

PULASKI COUNTY, INDIANA

Overall Social Vulnerability[1]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Unavailable[3]

0 1 2 4 6 Miles

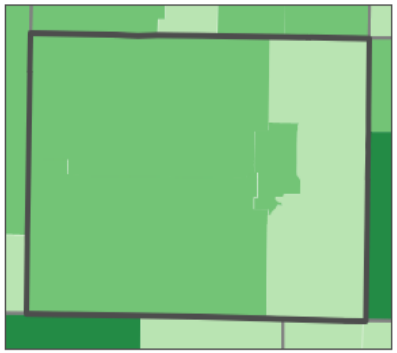
Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The **CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI 2022)[4] County Map** depicts the social vulnerability of communities, at census tract level, within a specified county. CDC/ATSDR SVI 2022 groups **sixteen census-derived factors** into **four themes** that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

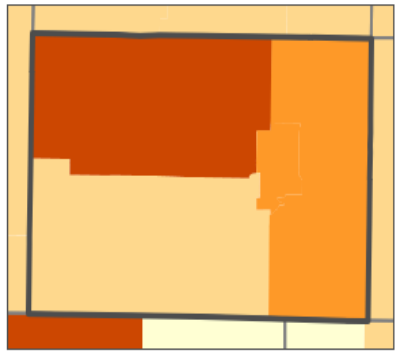
CDC/ATSDR SVI Themes

Socioeconomic Status[5]



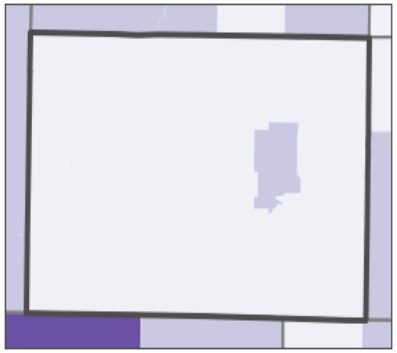
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Household Characteristics[6]



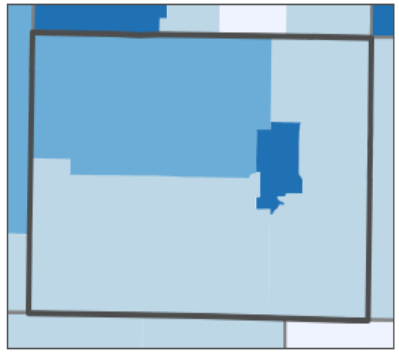
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

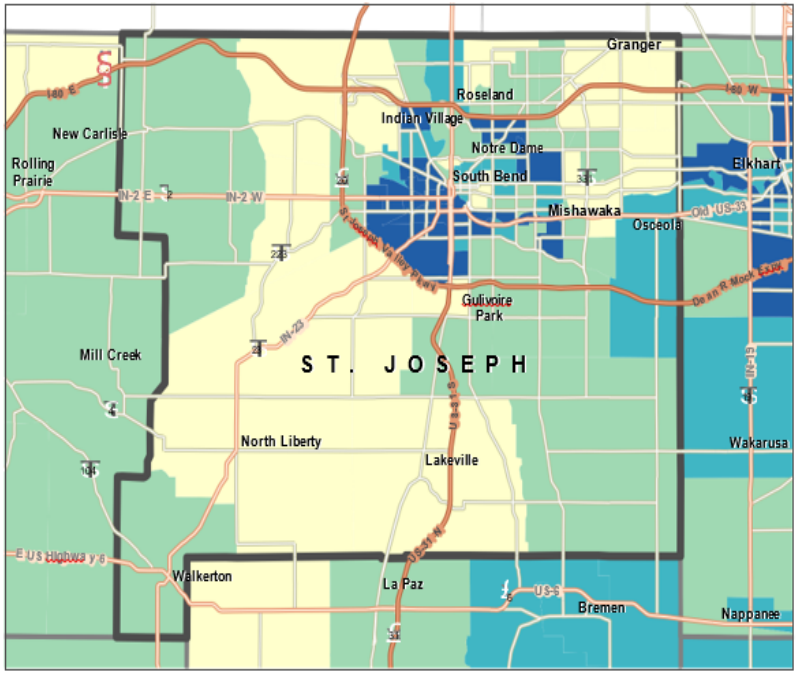
References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).

CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

ST. JOSEPH COUNTY, INDIANA

Overall Social Vulnerability[1]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Unavailable[3]

0 1 2 4 6 Miles

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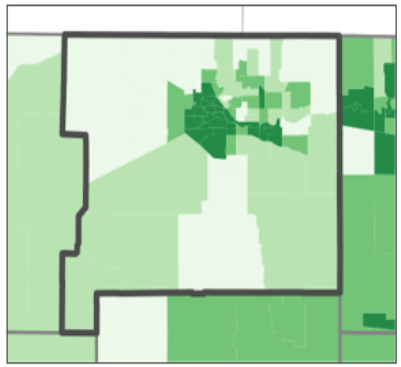
ATSDR Agency for Toxic Substances and Disease Registry

GRASP Geospatial Research, Analysis, and Services Program

CDC/ATSDR SVI Themes

Socioeconomic Status[5]



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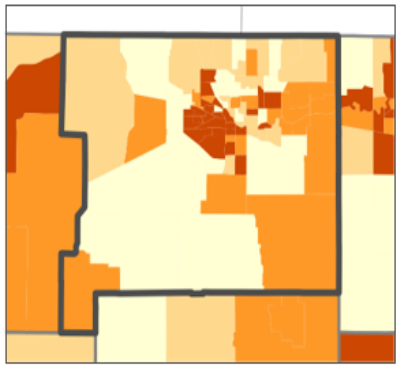
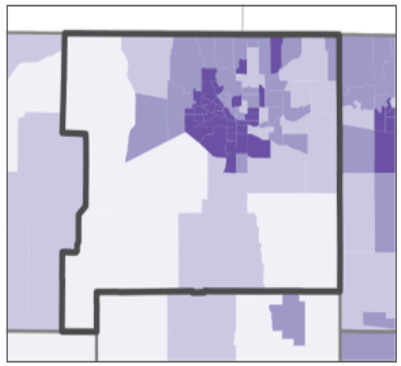
Household Characteristics[6]



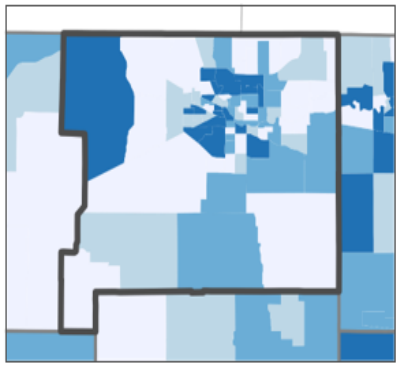
Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Racial and Ethnic Minority Status[7]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Housing Type/Transportation[8]



Highest (Top 4th) | Vulnerability (SVI 2022)[2] | Lowest (Bottom 4th)

Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

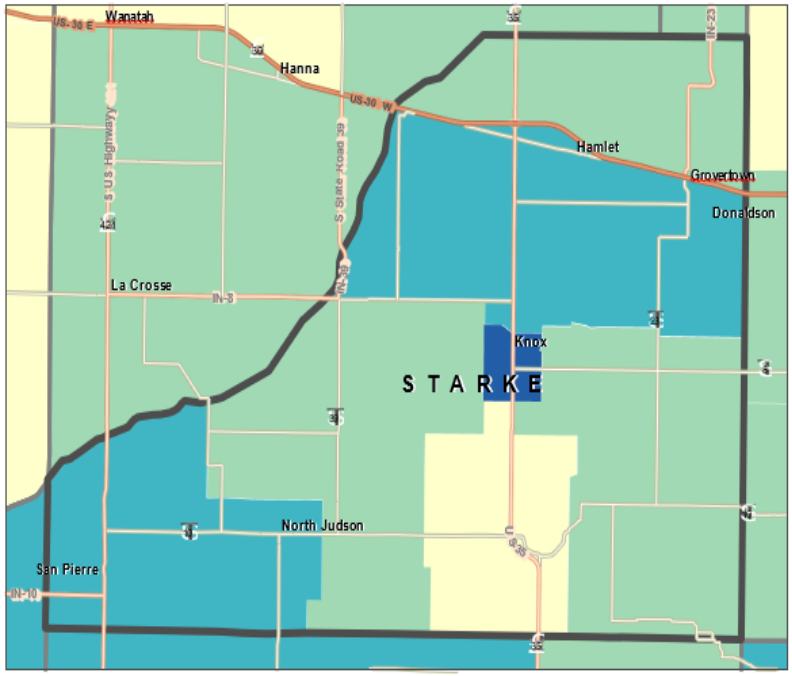
References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).

CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

CDC/ATSDR Social Vulnerability Index 2022

STARKE COUNTY, INDIANA

Overall Social Vulnerability[1]



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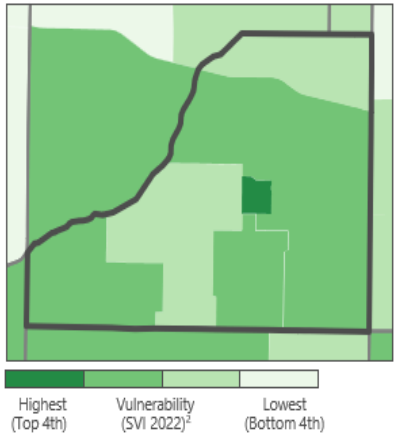
ATSDR Agency for Toxic Substances and Disease Registry

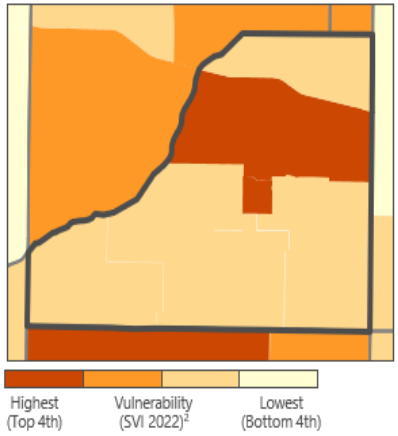
GRASP Geospatial Research, Analysis, and Services Program

CDC/ATSDR SVI Themes

Socioeconomic Status[5]



Household Characteristics[6]



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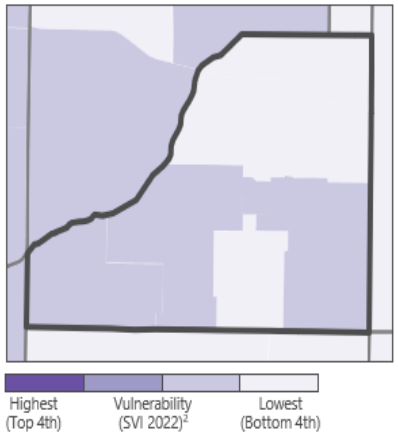
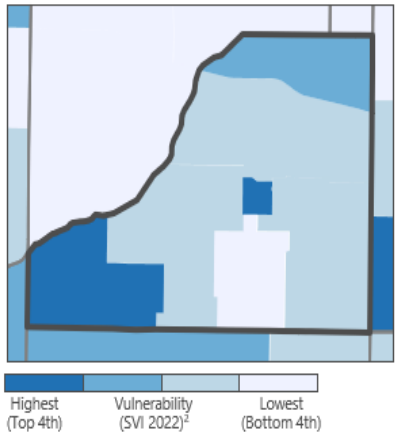


Housing Type/Transportation[8]



Data Sources: [2]CDC/ATSDR/GRASP, U.S. Census Bureau, ArcGIS StreetMap Premium.

Notes: [1]Overall Social Vulnerability: All 16 variables. [3]One or more variables unavailable at census tract level. [4]The CDC/ATSDR SVI combines percentile rankings of U.S. Census American Community Survey (ACS) 2018-2022 variables, for the state, at the census tract level. [5]Socioeconomic Status: Below 150% Poverty, Unemployed, Housing Costs Burden, No High School Diploma, No Health Insurance. [6]Household Characteristics: Aged 65 and Older, Aged 17 and Younger, Civilian with a Disability, Single-Parent Household, English Language Proficiency. [7]Race/Ethnicity: Hispanic or Latino (of any race); Black and African American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino. [8]Housing Type/Transportation: Multi-Unit Structures, Mobile Homes, Crowding, No Vehicle, Group Quarters.

Projection: NAD 1983 StatePlane Indiana East FIPS 1301.

References: Flanagan, B.E., et al., A Social Vulnerability Index for Disaster Management. *Journal of Homeland Security and Emergency Management*, 2011. 8(1).
CDC/ATSDR SVI web page: https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.

APPENDIX C

HEALTHCARE COALITION RESOURCE AND GAP ANALYSIS

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

June 2026

HCC members should assess the healthcare resources and services that are vital for the continuity of healthcare 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 healthcare services during an emergency.

The resource assessment will be different for various HCC member types but should address the 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)
- Healthcare Workforce
- Healthcare 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 other resources required to respond to an emergency. The resource assessment will vary for different members and will make 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, 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, or local) is a key part of gap closure.
See the link to the HCC Gap Assessment below.

https://district2hospitalpreparedne-my.sharepoint.com/:x:/g/personal/d2admin_indianadistrict2_com/IQDvzp44cisFTq_IoXH_CXArAZ7ycXz_XNB5HfbcsNsaG0Q?e=gGV57C&xsdata=MDV8MDJ8anRvYmV5QGVsa2hhcnRjb3VudHkuY29tfGY1NDhlMWQxMjE2MjRmZTNmOGNiMDhkZWJiMzdhYzhhfGQ3MTY4YTE0ZDE5MTQ1NTJhOTFkYWVjMzZhYTJmZjlhfDB8MHw2MzkxNTQwNDQ5NTI3NzMwMjN8VW5rbm93bnxUV0ZwYkdac2IzZDhleUpGYlhCMGVVMWhjR2tpT25SeWRXVXNJbFlpT2lJd0xqQXVNREF3TUNJc0lsQWlPaUpYYVc0ek1pSXNJa0ZPSWpvaVRXRnBiQ0lzSWxkVUlqb3lmUT09fDB8fHw%3d&sdata=U1JQdXRlcEc0aG1mNFF4RGg1Z2M4dEp3allPd2U0cEVCcDZFODltNGZaaz0%3d

APPENDIX E

SELECTED FEDERAL LEGAL AUTHORITIES

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

June 2026

Selected Federal Legal Authorities Pertinent to Public Health Emergencies

Prepared by the Public Health Law Program
Centers for Disease Control and Prevention

Updated August 2017[1]

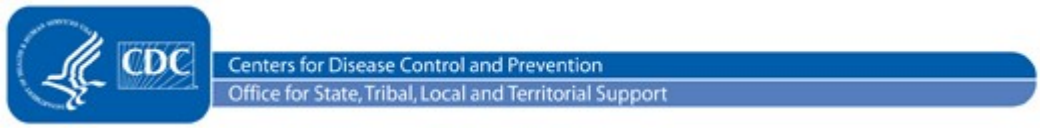
Introduction

In the wake of the 2001 terrorist attacks, the 2003 severe acute respiratory syndrome (SARS) epidemic, Hurricane Katrina in 2005, the influenza A (H1N1) pandemic in 2009, Hurricane Sandy in 2012, and the ongoing concern about future similar events, public health officials have acted to strengthen their jurisdictions' legal preparedness for all types of public health emergencies.

Federal laws and legal authorities address a variety of concerns central to public health emergencies, such as emergency declarations, quarantine and isolation, liability and licensure of workers, and mutual aid, among others. Because these laws involve multiple federal agencies and appear in many official documents, the Centers for Disease Control and Prevention's (CDC's) Public Health Law Program (PHLP) prepared the following annotated list of selected, commonly cited federal legal authorities for reference by public health officials, legal counsel, and others.

This compilation is subject to three caveats: 1) it is not intended to be exhaustive of all relevant legal authority; 2) it was compiled in September 2009 and updated in 2014 and 2017 and reflects the laws current at the time of the latest update; and 3) only selected portions of the laws relevant to public health emergencies are presented.

Topics



[1] Originally drafted in 2009 by Stacie Kershner, JD, an Oak Ridge Institute for Science and Education legal fellow at CDC's PHLP. Updated by Gregory Sunshine, JD, Cherokee Nation Assurance serving CDC's PHLP. Special thanks to the CDC partners who helped develop this resource.

Please note that some laws listed have broad application and thus may be included under more than one topic area; only the relevant portion of the law is discussed under each topic area. These laws might have other provisions not discussed here.

General Emergency Legal Authorities

- **Homeland Security Act of 2002**
  Pub. L. No. 107-296, as amended; 6 U.S.C. §§ 311–321m
  The Homeland Security Act merges 22 disparate agencies and organizations into the new Department of Homeland Security (DHS), including the Federal Emergency Management Agency (FEMA). The Act charges DHS with securing the nation against terrorist attacks and carrying out the functions of all transferred entities, including acting as a focal point regarding natural and manmade crises and emergency planning. The law establishes the National Homeland Security Council, the Directorate of Border and Transportation Security, and the Office for State and Local Government Coordination, and it transfers powers from Immigration and Naturalization Service (abolished under 6 U.S.C. § 291[a]).

- **Post-Katrina Emergency Management Reform Act of 2006 (Post-Katrina Act) Pub. L. No. 109-295; 6 U.S.C. §§ 701 et. seq.**
  Enacted as part of the DHS Appropriations Act, 2007, the Post-Katrina Act is intended to address various shortcomings identified in the preparation for and response to Hurricane Katrina. The Act establishes new DHS leadership positions, brings additional functions into FEMA, creates and reallocates functions to other components within DHS, and amends the Homeland Security Act in ways that both directly and indirectly affect the organization and functions of various entities within DHS. The Act enhances FEMA's responsibilities and its autonomy within DHS.

- **Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Stafford Act)**
  Pub. L. No. 93-288, as amended; 42 U.S.C. §§ 5121–5207
  The Stafford Act authorizes the President to declare a "major disaster" or "emergency" in response to an event (or threat) that overwhelms state or local governments. Declaration under the Act triggers access to federal technical, financial, logistical, and other assistance to state and local governments. The Act directs FEMA to coordinate administration of disaster relief to the states. The governor of an affected state must first respond to the disaster and execute the state's emergency plan before requesting that the President declare a major disaster or emergency, and the governor must certify that the magnitude of the emergency exceeds the state's capability. As of 2013, tribal leaders can also request a Stafford Act declaration from the President (see Sandy Recovery Improvement Act of 2013, below). The President may declare an emergency without the request of a governor or tribal leader if the emergency involves "federal primary responsibility" (such as an event occurring on federal property; for example, the bombing of the Murrah Federal Building in 1995). Title VI of the Act provides for a national system for all-hazards emergency preparedness, with authority located at both the federal and state levels.

- **Sandy Recovery Improvement Act of 2013**
  Pub. L. No. 113-2 §§ 1101–1111; 42 U.S.C. §§ 5170, 5191

The Sandy Recovery Improvement Act authorizes the chief executive of a tribal government to directly request disaster or emergency declaration from the President, much as a governor can for a state. Previously, tribal groups were treated like local governments in that they could receive a federal disaster declaration only if the governor of the state in which the tribe was located requested one.

- **Sections 201 and 301 of the National Emergencies Act**
  50 U.S.C. §§ 1621, 1631
  The National Emergencies Act authorizes the President to declare a "national emergency." The proclamation of a national emergency must be transmitted immediately to Congress and published in the Federal Register. The declaration of emergency (or contemporaneous or subsequent executive orders) must specify the powers or authorities made available by virtue of the declaration. A national emergency can be terminated if the President issues a proclamation or if Congress enacts a joint resolution terminating the emergency. A national emergency will terminate automatically upon the anniversary of the proclamation unless the President renews the proclamation by transmitting notice to Congress and publishing it in the Federal Register.

- **Pets Evacuation and Transportation Standards (PETS) Act of 2006**
  Pub. L. No. 109-308; **42 U.S.C. §§ 5170(b), 5196, 5196(b)**
  The PETS Act amends the Stafford Act to require the FEMA Director to ensure that state and local emergency preparedness plans "take into account the needs of individuals with household pets and service animals prior to, during, and following a major disaster or emergency."

- **Homeland Security Presidential Directive 5 (HSPD-5) (February 28, 2003)**
  HSPD-5 is intended to "enhance the ability of the United States to manage domestic incidents." The Directive describes federal policies and objectives; identifies steps for improved coordination among federal, state, and local authorities; and tasks the Secretary of Homeland Security with developing a National Incident Management System and National Response Plan.

- **Homeland Security Presidential Directive 8 (HSPD-8) (December 17, 2003)**
  HSPD-8, as a companion to HSPD-5, "establishes policies to strengthen the preparedness of the United States to prevent and respond to" manmade and natural disasters and other emergencies. The Directive requires the Secretary of Homeland Security to develop a national domestic all-hazards preparedness goal, which establishes "measurable readiness priorities and targets" and "readiness metrics and elements." The Directive also requires relevant federal agencies to make financial assistance and support available to states, support the development of first responder equipment standards, and establish a training program to meet the national preparedness goals.

- **Emergency Management Assistance Compact (EMAC) of 1996**
  Pub. L. No. 104-321
  EMAC facilitates resource sharing among member states during an emergency. The National Emergency Management Association (NEMA) administers EMAC, which has been enacted by every state. A governor's declaration of emergency and request for assistance triggers EMAC for the requesting state. An assisting state then responds to the request by providing the needed

resources. Further, EMAC establishes that the requesting state is responsible for compensating the assisting state for any expenses incurred.

Legal Authorities Specific to Public Health Emergencies

- **Section 319 of the Public Health Service Act: Public Health Emergencies**
  42 U.S.C. § 247d
  This section of the Public Health Service Act authorizes the Secretary of the Department of Health and Human Services (HHS) to determine that a public health emergency exists if "1) a disease or disorder presents a public health emergency; or 2) a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists." From the determination of a public health emergency flows the ability of the Secretary to "take such action as may be appropriate" and to use funds from the Public Health Emergency Fund (when appropriated). The public health emergency determination remains effective until the Secretary either declares that the emergency no longer exists, or at the expiration of 90 days, whichever occurs first. If the Secretary determines that the same or additional facts continue to warrant a public health emergency, he or she may renew the declaration for 90-day periods. As amended by the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013, Pub. L. No. 113-5, section 319 also allows the Secretary, upon request by a governor or tribal organization, to authorize the temporary reassignment of state and local public health department or agency personnel funded in whole or in part through programs authorized under the Public Health Service Act for the purpose of immediately addressing a federally declared public health emergency. As amended by the 21st Century Cures Act of 2016, Pub. L. No. 114255, the Secretary may waive the requirements of the Paperwork Reduction Act with respect to voluntary collections of information after 1) issuing a 319 public health emergency determination or determining that a disease or disorder is significantly likely to become a public health emergency, and 2) determining that the public health emergency or significant likelihood of a public health emergency necessitates waiver of the Paperwork Reduction Act. The Secretary may waive these requirements during the immediate investigation of, and response to, such public health emergency, or for the period necessary to determine whether a disease or disorder will become a public health emergency. The waiver also extends to the immediate post-response review of a public health emergency if such review does not exceed a reasonable length of time.

- **Section 311 of the Public Health Service Act: General Grant of Authority for Cooperation 42 U.S.C. § 243**
  This provision of the Public Health Service Act states that the Secretary of HHS shall assist states and local authorities in the prevention and suppression of communicable diseases and to help state and local authorities enforce quarantine regulations. This section also authorizes the Secretary to accept state and local authorities' assistance with enforcement of federal quarantine regulations. Further, this section authorizes the Secretary to develop a public health emergency management plan and, at the request of a state or local authority, extend temporary assistance regarding public health emergencies.

- **Section 319F-2 of the Public Health Service Act: Strategic National Stockpile and Security (the Stockpile)**

42 U.S.C. § 247d-6b; 42 U.S.C. § 300hh-10(c)(3)(b)

The Stockpile (including drugs, vaccines, biological products, medical devices, and other supplies) is maintained by the Secretary of HHS, in collaboration with CDC's Director, and in coordination with the Secretary of Homeland Security, to provide for the emergency health security of the United States. The Secretary may deploy the Stockpile to respond to an actual or potential public health emergency, protect the public health or safety, or as required by the Secretary of Homeland Security, respond to an actual or potential emergency. The responsibility and authority to coordinate the Strategic National Stockpile has been assigned to the Assistant Secretary for Preparedness and Response under 42 U.S.C. § 300hh-10(c)(3)(b).

- **Public Health Security and Bioterrorism Preparedness and Response Act of 2002 Pub. L. No. 107-188**

  The Act amends the Public Health Service Act to "improve the ability of the United States to prevent, prepare for, and respond to bioterrorism and other public health emergencies." The Act requires the Secretary of HHS to "develop and implement" a coordinated strategy in the form of a national preparedness plan. The Act also establishes the position of Assistant Secretary for Public Health Emergency Preparedness (renamed the "Assistant Secretary for Preparedness and Response," see Pandemic and All-Hazards Preparedness Act, below), who is responsible for coordinating the operations of the National Disaster Medical System and other emergency response activities within HHS. The Act also provides the Secretary of HHS with the authority to regulate select agents and toxins and to temporarily exempt individuals or entities from the requirements of these regulations if necessary to provide for a timely response to a public health emergency. Additionally, several provisions for protection of the food and drug supply are included. Further, the Act directs the Secretary to establish and maintain the Emergency System for Advance Registration of Health Professions Volunteers (ESAR-VHP).

- **Pandemic and All-Hazards Preparedness Act of 2006**
  Pub. L. No. 109-417

  The Act identifies the Secretary of HHS as the lead federal official for public health emergency preparedness and response and establishes the Assistant Secretary for Preparedness and Response (formerly named the "Assistant Secretary for Public Health Emergency Preparedness," see Public Health Security and Bioterrorism Preparedness and Response Act of 2002, above). The Act also provides new authorities for developing countermeasures, establishes mechanisms and grants to continue strengthening state and local public health security infrastructure, and addresses surge capacity by placing the National Disaster Medical System and the ESAR-VHP under the purview of HHS.

- **Pandemic and All–Hazards Preparedness Reauthorization Act (PAHPRA) of 2013**
  Pub. L. No. 113-5; 42 U.S.C. §§ 247d, 300hh-1(b)(3)(E), 247d-3a(b)(2)(a)(iii), 247d-6d(i)(7)(iii), 21 U.S.C. § 360bbb-3, et seq.

  PAHPRA reauthorized funding for provisions of the Pandemic and All-Hazards Preparedness Act of 2006, as well as amended several provisions of the Public Health Service Act and the Food Drug and Cosmetic Act. PAHPRA requires Pandemic and All-Hazards Preparedness Act fund recipients to account for children and "at-risk individuals" in their All-Hazards Public Health Emergency Preparedness and Response Plan, as well as coordinate with local Metropolitan

Medical Response Systems, local Medical Reserve Corps, and the local Cities Readiness Initiative. Additional PAHPRA changes made to authorities described elsewhere in this document are contained in the entries addressing

- Section 319 of the Public Health Service Act: Public Health Emergencies
- The Public Readiness and Emergency Preparedness (PREP) Act of 2005
- Emergency Use Authorization

- **Section 1135 of the Social Security Act: Authority to Waive Requirements During National Emergencies**
  42 U.S.C. § 1320b-5
  Section 1135 of the Social Security Act authorizes the Secretary of HHS to waive or modify certain requirements of Medicare, Medicaid, and the State Children's Health Insurance Program during certain emergencies. Section 1135 waivers require both 1) a declaration of national emergency or disaster by the President under the National Emergencies Act or the Stafford Act, and 2) a public health emergency determination by the Secretary under the Public Health Service Act. Waivers may be requested by affected healthcare providers in the emergency area during the emergency period. The Secretary may make a waiver retroactive to the beginning of the emergency period or any subsequent date thereafter. The waiver generally expires at the termination of the applicable declaration of emergency or disaster under the National Emergencies Act or Stafford Act or determination of public health emergency under the Public Health Service Act. In addition, the Secretary may specify that the waivers terminate 60 days from publication, which may be extended, provided that neither the original 60-day period nor any extension extends beyond termination of the applicable declaration or determination. Waivers related to the Emergency Medical Treatment and Active Labor Act and the Health Information Portability and Accountability (HIPAA) Privacy Rule (see below) are subject to different requirements and may terminate after 72 hours.

- **Public Readiness and Emergency Preparedness (PREP) Act of 2005**
  Pub. L. No. 109-148; 42 U.S.C. §§ 247d-6d, 247d-6e
  The PREP Act authorizes the Secretary of HHS to issue a declaration that provides immunity from tort liability for claims of loss (except willful misconduct) caused by, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats, and conditions determined by the Secretary to constitute a present or credible risk of a future public health emergency. The immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. As amended by PAHPRA (see above), the PREP Act immunity explicitly applies to products or technology intended to enhance medical countermeasures, in addition to the countermeasures themselves. PAHPRA also extends immunity to countermeasures authorized under sections 564A and 564B of the Federal Food, Drug, and Cosmetic Act (see below). The Secretary's declaration includes, among other things,
  - The countermeasures covered by the declaration
  - The category of diseases, health conditions, or health threats for which administration and use of the countermeasures recommended
  - The effective time period of the declaration

- The population of individuals receiving the countermeasure
- Limitations, if any, on the geographic area for which immunity is in effect
- Limitations, if any, on the means of distribution of the countermeasure
- Any additional persons identified by the Secretary as qualified to prescribe, dispense, or administer the countermeasures

The Act also authorizes a fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of the countermeasure covered by the Secretary's declaration.

- **Emergency Use Authorization of Section 564 of the Federal Food, Drug, and Cosmetic Act**

  21 U.S.C. § 360bbb-3

  Under section 564 of the Federal Food, Drug, and Cosmetic Act, if

  1) The Secretary of HHS has determined that there is a public health emergency or a significant potential for a public health emergency that affects or may affect national security or the health of US citizens abroad that involves a chemical, biological, radiological, or nuclear (CBRN) agent or agents
  2) The Secretary of Homeland Security has determined that there is an actual or significant potential for a domestic emergency involving a heightened risk of attack with a CBRN agent or agents
  3) The Secretary of Defense has determined that there is an actual or significant potential for heightened risk to the military involving a heightened risk of attack with a CBRN agent or agents, *or*
  4) The Secretary of Homeland Security has identified a material threat pursuant to section 319F-2 of the Public Health Service Act sufficient to affect national security or the health and security of US citizens abroad that involves a CBRN agent or agents

  The Secretary of HHS may, based upon one of the preceding determinations, declare that circumstances exist to justify an Emergency Use Authorization (EUA) for an unapproved drug, device, or biological product, or for an unapproved use of an approved drug, device, or biological product. Once an emergency is declared, the Food and Drug Administration (FDA) Commissioner may issue an EUA for a particular product or products, assuming other statutory criteria and conditions are met. The EUA expires when the declaration of emergency terminates or when authorization is revoked. The FDA Commissioner may impose conditions on the use of the drug or device. EUA authority for sections 564, 564A, and 564B of the Federal Food, Drug, and Cosmetic Act was expanded by the 21st Century Cures Act of 2016, Pub. L. No. 114-255, to include drugs approved for use in animals.

  - **Section 564A of the Federal Food, Drug, and Cosmetic Act**

    21 U.S.C. § 360bbb-3a

    Enacted by PAHPRA (see above), section 564A established streamlined mechanisms to facilitate certain medical countermeasure preparedness and response activities without

having to issue an EUA (which can be a time- and resource-intensive process). These new authorities, applicable to eligible FDA-approved medical products intended for use during a CBRN emergency, include

1) Allowing CDC, under delegated authority, to create and issue, and government stakeholders to disseminate, special emergency use instructions about the FDA approved conditions of use for such medical countermeasures before a CBRN event occurs
2) Permitting the FDA to waive otherwise applicable manufacturing requirements, such as storage or handling, to accommodate emergency response needs; allowing mass dispensing of medical countermeasures during an actual CBRN emergency event without requiring an individual prescription for each recipient of the medical countermeasure, if permitted by state law or if in accordance with an order issued by the FDA Commissioner, and
3) Expanding the current waiver authority for risk evaluation and mitigation strategies to encompass any element for medical countermeasures to mitigate the health effects of a CBRN emergency

- **Section 564B of the Federal Food, Drug, and Cosmetic Act**

  21 U.S.C. § 360bbb-3b

  Enacted by PAHPRA (see above), section 564B permits federal, state, and local governments to pre-position medical countermeasures in anticipation of approval or clearance, or issuance of an EUA, enabling them to better prepare for potential rapid deployment during an actual CBRN emergency.

Public Safety and Security

- **Posse Comitatus Act of 1878**
  18 U.S.C. § 1385
  The Posse Comitatus Act generally prohibits the use of federal military personnel in a law enforcement capacity within the United States unless authorized by the US Constitution or an act of Congress. Certain exceptions exist, such as when the Department of Defense aids the Department of Justice in responding to an emergency involving a weapon of mass destruction [10 U.S.C.A. § 382].

- **Insurrection Act of 1807**
  10 U.S.C. §§ 331-335
  The Insurrection Act grants authority to the President to call the National Guard into federal service in the event of an insurrection in any state or if a state fails to uphold the constitutional rights of its citizens.

- **Emergency Federal Law Enforcement Assistance Act of 2006 42 U.S.C. § 10501, et seq.**
  Under the Emergency Federal Law Enforcement Assistance Act, the Attorney General may provide law enforcement assistance, including federal personnel, in response to a governor's written request, when he or she determines that such assistance is necessary to provide an

adequate response to a law enforcement emergency. To the extent federal personnel would be used to enforce state or local law, they should be deputized or otherwise authorized under state or local law to exercise the key law enforcement powers (arrest, search, seizure) involved in enforcing those laws.

Control of Communicable Diseases

- **Section 311 of the Public Health Service Act: General Grant of Authority for Cooperation 42 U.S.C. § 243**
  This provision of the Public Health Service Act states that the Secretary of HHS shall assist states and local authorities in the prevention and suppression of communicable diseases and to help state and local authorities enforce quarantine regulations. This section also authorizes the Secretary to accept state and local authorities' voluntary assistance with enforcement of federal quarantine regulations. Further, this section authorizes the Secretary to develop a public health emergency management plan and, at the request of a state or local authority, extend temporary assistance regarding public health emergencies.

- **Section 361 of the Public Health Service Act: Regulations to Control Communicable Diseases 42 U.S.C. § 264**
  This section of the Public Health Service Act authorizes the Secretary of HHS to make and enforce regulations "to prevent the introduction, transmission, or spread of communicable diseases" into the states and possessions of the United States from foreign countries or possessions or from one state into another. This section also authorizes the apprehension, detention, examination, and conditional release of individuals with certain communicable diseases that are specified in an executive order of the President (see Executive Order 13296 (April 4, 2003), as amended by Executive Order 13375 (April 1, 2005) and Executive Order 13674 [July 31, 2014]). The process prescribed for isolating or quarantining such individuals is provided for in 42 C.F.R. Parts 70 and 71 (see below).

- **Section 362 of the Public Health Service Act: Suspension of Entries and Imports from Designated Places to Prevent Spread of Communicable Diseases 42 U.S.C. § 265**
  This section of the Public Health Service Act authorizes the Secretary of HHS, if he or she determines that a communicable disease exists in a foreign country and that introduction of persons from this foreign country poses a serious danger of introducing the disease into the United States, to suspend in the interests of public health the "introduction of persons" from those foreign countries or places for the time necessary to avert the danger, in accordance with approved regulations. This provision may also be applied to the introduction of property (see below).

- **Interstate Quarantine 42 C.F.R. Part 70**
  These federal regulations allow the CDC Director to take measures to prevent the spread of communicable diseases from one state or possession into another, including in the event that the Director determines that the measures taken by the health authorities of a state (including

political subdivisions) or possession are insufficient to prevent such communicable disease spread. These regulations also authorize the detention, isolation, quarantine, or conditional release of persons for purposes of preventing the interstate spread of communicable diseases listed in an executive order of the President. See Executive Order 13296, as amended by Executive Order 13375 and Executive Order 13674.

- **Foreign Quarantine 42 C.F.R. Part 71**
  These federal regulations allow the CDC Director to take measures to prevent the introduction, transmission, and spread of communicable diseases into the United States from foreign countries. Among other things, the regulations require the commander of an aircraft or master of a ship destined for a US port to report the occurrence of any deaths or ill persons onboard to CDC. These regulations also authorize the Director to inspect and detain ships and planes arriving into the United States as may be necessary to prevent the spread of communicable diseases, as well as regulate the importation of infectious biological agents, infectious substances, and vectors. The Director may also isolate, quarantine, or place arriving persons under public health surveillance whenever the Director reasonably believes that the person is infected with or has been exposed to any of the communicable diseases listed in an executive order of the President. See Executive Order 13296, as amended by Executive Order 13375 and Executive Order 13674.

- **Executive Order 13295: Revised List of Quarantinable Communicable Diseases (April 4, 2003)**
  This Executive Order identifies the eight communicable diseases (cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, and SARS), for which an individual can be apprehended, detained, examined, or conditionally released by federal public health authorities under 42 C.F.R. §§ 70 and 71.

- **Executive Order 13375: Amendment to Executive Order 13295 Relating to Certain Influenza Viruses and Quarantinable Communicable Diseases (April 1, 2005)**
  This Executive Order Amends Executive Order 13295 by adding "influenza caused by novel or reemergent influenza viruses that are causing, or have the potential to cause, a pandemic" to the list of communicable diseases for which an individual can be apprehended, detained, examined, or conditionally released by federal public health authorities under 42 C.F.R. §§ 70 and 71.

- **Executive Order 13674: Amendment to Executive Order 13295 Revised List of Quarantinable Communicable Diseases (July 31, 2014)**
  This Executive Order amends Executive Orders 13295 and 13375 by updating the reference to SARS on the list of communicable diseases for which an individual can be apprehended, detained, examined, or conditionally released by federal public health authorities under 42 C.F.R. §§ 70 and 71 to read as follows: "Severe acute respiratory syndromes, which are diseases that are associated with fever and signs and symptoms of pneumonia or other respiratory illness, are capable of being transmitted from person to person, and that either are causing, or have the potential to cause, a pandemic, or, upon infection, are highly likely to cause mortality or serious morbidity if not properly controlled."

- **Penalties for Violation of Quarantine Law**
  42 U.S.C. § 271
  This statutory provision states that violation of federal quarantine regulations is a crime punishable by a fine of not more $1,000 or by imprisonment for not more than one year, or both. Implementing regulations are found at 42 C.F.R. Part 71.2. These penalties are strengthened under the sentencing classification provisions of 18 U.S.C. §§ 3559 and 3571, which provide for more strict penalties for criminal violations that would otherwise be classified as Class A misdemeanors. Under these strengthened penalties, individuals may be punished by a fine of up to $100,000 per violation not resulting in the death of an individual, or up to $250,000 per violation resulting in the death of an individual [18 U.S.C. 3559, 3571(b)]. Organizations may be fined up to $200,000 per violation not resulting in the death of an individual and $500,000 per violation resulting in the death of an individual [18 U.S.C. 3559, 3571(c)].

- **Emergency Medical Treatment and Active Labor Act (EMTALA)**
  42 U.S.C. § 1395dd
  EMTALA requires that hospitals accepting Medicare payments provide patients coming to the emergency department appropriate medical screening for emergency medical conditions without regard to citizenship, legal status, or ability to pay. If the patient is found to have an emergency medical condition, the hospital must either provide further examination and treatment until the patient is stabilized, or, if the hospital is unable to stabilize the patient, the hospital must arrange for transfer of the individual to a capable facility. Patients cannot be denied stabilizing treatment or discharged prematurely based on prior unpaid debts to the hospital. While patients cannot be held criminally liable, hospitals may seek judgments against non-paying patients in civil court for the amounts owed.

- **State Health Laws Observed by United States Officers**
  42 U.S.C. § 97
  This provision states that US Coast Guard and customs officers, as well as "military officers commanding in any fort or station upon the seacoast," shall observe quarantines and health laws imposed by states regarding the arrival of vessels, and according to their respective powers, aid in the execution of such state health laws and quarantines as directed from time to time by the Secretary of HHS.

- **Quarantine Duties of Consular and Other Officers**
  42 U.S.C. § 268(b)
  These statutes state the duty of Customs and Border Protection and the US Coast Guard to aid in the execution of federal quarantine and the enforcement of federal quarantine rules and regulations.

- **Immigration Authority**
  8 U.S.C. §§ 1182 and 1222, 42 U.S.C. § 252
  Under these provisions, DHS and HHS are charged with conducting physical and mental examinations of arriving aliens. Under 8 U.S.C. § 1182, aliens are inadmissible in to the United States on health-related grounds if determined to have a communicable disease of public health significance, certain mental or physical defects, to be a drug abuser or addict, or to have failed

to present documentation of vaccination against vaccine-preventable diseases as set forth in the statute. The process that HHS prescribes for conducting the medical examinations is provided for in 42 C.F.R. Part 34 (see below).

- **Medical Examination of Aliens**
  42 C.F.R. Part 34
  CDC administers this regulation, which describes and specifies the medical examination criteria that aliens must undergo before they may be admitted to the United States. The medical examination applies to aliens outside the US applying for an immigrant visa; aliens arriving in the US; aliens required by DHS to have a medical examination; and applicants in the US applying for adjustment of their immigration status to that of permanent legal resident. Aliens determined to have a communicable disease of public health significance are generally inadmissible unless granted a waiver by DHS.

Managing Transportation

- **Transportation Security Administration Authority to Cancel or Ground Flights**
  49 U.S.C. §§ 114 and 44905(b)
  The Transportation Security Administration has the authority to cancel a flight or prevent planes from landing if "a decision is made that a particular threat cannot be addressed in a way adequate to ensure, to the extent feasible, the safety of passengers and crew of a particular flight or series of flights."

- **Federal Aviation Administration Authority to Restrict Airport Access or Airspace**
  49 U.S.C. §§ 40101(d), 40103(b), 44701, and 46105(c)
  The Federal Aviation Administration (FAA) has authority to stop, redirect, or exclude flights in US airspace for public safety and has the authority to restrict airport access due to emergency conditions on the ground. If the FAA Administrator believes it necessary, he or she may "prescribe regulations and issue orders immediately to meet the emergency."

Managing Animals, Food, and Other Property

- **Control of Communicable Diseases**
  21 C.F.R. Part 1240
  Similar to the regulations governing interstate quarantine, these regulations allow the FDA Commissioner to take measures to prevent the spread of communicable diseases from one state or possession into another in the event that the Commissioner determines that the measures taken by the health authorities of a state (including political subdivisions) or possession are insufficient to prevent such communicable disease spread. These regulations also govern the interstate transport of mollusks, milk, turtles, certain birds, garbage, and drinking water.

- **Foreign Quarantine**
  42 C.F.R. Part 71

In addition to allowing the CDC Director to take measures to prevent the introduction, transmission, and spread of communicable diseases into the United States from foreign countries, including through the isolation and quarantine of arriving individuals, these regulations also govern the importation of certain animals, including dogs, cats, turtles, and nonhuman primates, as well as regulate the importation of infectious biological agents, infectious substances, and vectors.

- **Section 361 of the Public Health Service Act: Regulations to Control Communicable Diseases 42 U.S.C. § 264**
  For purposes of carrying out and enforcing regulations enacted under section 361 of the Public Health Service Act, this section states that the Secretary of HHS "may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings . . ."

- **Section 362 of the Public Health Service Act: Suspension of Entries and Imports from Designated Places to Prevent Spread of Communicable Diseases 42 U.S.C. § 265**
  This section of the Public Health Service Act authorizes the Secretary of HHS, if he or she determines that a communicable disease exists in a foreign country and that introduction of property from this foreign country poses a serious danger of introducing the disease into the United States, to suspend in the interests of public health the "introduction of property" from those foreign countries or places for the time necessary to avert the danger, in accordance with approved regulations.

- **Pets Evacuation and Transportation Standards (PETS) Act of 2006**
  Pub. L. No. 109-308; **42 U.S.C. §§ 5170(b), 5196, 5196(b)**
  The PETS Act amends the Stafford Act to require the FEMA Director to ensure that state and local emergency preparedness plans "take into account the needs of individuals with household pets and service animals prior to, during, and following a major disaster or emergency."

Liability, Workers' Compensation, and Licensure

- **Federal Tort Claims Act**
  28 U.S.C. §§ 1346(b), 2671–2680
  The Act waives the doctrine of sovereign immunity so that the United States can be held liable for the negligent acts or omissions of federal employees committed within the scope of their federal employment. Claims based on discretionary functions or intentional torts are explicitly precluded. Further, suits by military personnel for injuries sustained during service (also known as the *Feres* doctrine) have been deemed by the courts as outside of the Act. To proceed against the United States, the Attorney General must certify that the federal employee was acting within the scope of his office or employment, or, if the Attorney General refuses, the employee may petition the court to make this finding and certify. Once certified, the United States replaces the employee as the party defendant in the suit.

- **Federal Employee Compensation Act of 1993**
  Pub. L. No. 103-3; 5 U.S.C. § 81
  The Federal Employee Compensation Act provides workers' compensation to civilian federal employees injured or killed while performing their duties. An injured employee or the family of an employee killed while performing his duties is entitled to related medical services and benefits unless the employee intended to bring about the injury or death, caused the injury or death through the employee's own willful misconduct, or the injury or death was proximately caused by the employee's intoxication.

- **Public Readiness and Emergency Preparedness (PREP) Act of 2005 Pub. L. No. 109-148; 42 U.S.C. §§ 247d-6d, 247d-6e**
  The PREP Act authorizes the Secretary of HHS to issue a declaration that provides immunity from tort liability for claims of loss (except willful misconduct) caused by, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats, and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency. The immunity applies to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. As amended by PAHPRA (see above), PREP Act immunity also explicitly applies to products or technology intended to enhance medical countermeasures, in addition to the countermeasures themselves. PAHPRA also extends immunity to countermeasures authorized under sections 564A and 564B of the Federal Food, Drug, and Cosmetic Act (see above). The Secretary's declaration includes, among other things, the countermeasures covered by the declaration; the category of diseases, health conditions, or health threats for which administration and use of the countermeasures recommended; the effective time period of the declaration; the population of individuals receiving the countermeasure; limitations, if any, on the geographic area for which immunity is in effect; limitations, if any, on the means of distribution of the countermeasure; and any additional persons identified by the Secretary as qualified to prescribe, dispense, or administer the countermeasures. The Act also authorizes a fund in the United States Treasury to provide compensation for injuries directly caused by administration or use of the countermeasure covered by the Secretary's declaration.

- **Volunteer Protection Act of 1997**
  Pub. L. No 105-295; 42 U.S.C. §§ 14501–14505
  The Volunteer Protection Act supports and promotes the activities of organizations that rely on volunteers by providing the volunteers some protections from liability for economic damages for activities relating to the work of the organizations. Under the Act, to be found not liable for the injury caused by a negligent act or omission of the volunteer, the volunteer must have been acting within the scope of his or her responsibilities in the nonprofit or government agency. The volunteer must have appropriate licensure or certification if required for the volunteer's duties; he or she must not have acted with gross negligence, reckless disregard, willful or criminal misconduct, or flagrant indifference; and the injury cannot have occurred while the volunteer was intoxicated. Further, the injury cannot have occurred while the volunteer was operating an automobile or other vehicle for which the state requires an operator's license and insurance. This Act does not limit the liability of the nonprofit or government agency. The Act does not limit an injured party's ability to sue for non-economic damages, provide immunity to the nonprofit organization or government entity supervising the volunteer, nor limit a nonprofit or

government entity's ability to bring a civil action against the volunteer. States may opt out of the Volunteer Protection Act.

- **Emergency Management Assistance Compact (EMAC) of 1996**
  Pub. L. No. 104-321
  EMAC facilitates resource sharing among member states during an emergency. The National Emergency Management Association (NEMA) administers EMAC, which has been enacted by every state. A governor's declaration of emergency and request for assistance triggers EMAC for the requesting state. An assisting state then responds to the request by providing the needed resources, including personnel. EMAC stipulates that a provider who is licensed or certified in one state will be considered licensed or certified in the receiving state subject to limitations described in the requesting state's governor's order. EMAC provides for protection of officers or employees of the assisting state from tort liability for negligent acts or omissions unless the officer or employee acted with gross negligence, recklessness, or willful misconduct. EMAC also requires that each state provide for worker's compensation in instances of injury or death for their own employees.

Personal Health Information and Privacy

- **Privacy Act of 1974**
  5 U.S.C. § 552a
  The Privacy Act describes the fair collection, maintenance, use and dissemination by a government agency of records containing personal identifiers (e.g., name, social security number, date of birth). Generally, the Act requires that information compiled in a federal record for a specific individual may not be used for another purpose without consent of the individual. The Act prevents disclosure of information contained in the record without an individual's written consent, unless the disclosure is one of the 12 exceptions expressly stated within the Act. Under most circumstances, individuals are allowed to request access to their own records and to challenge inaccurate information. The Act also outlines the civil remedies available if a government agency makes an unauthorized disclosure of an individual's personal information.

- **Health Insurance Portability and Accountability Act (HIPAA) of 1996: Privacy Rule Pub. L. No. 104-191**
  The HIPAA Privacy Rule protects certain patient information (including health insurance and billing information, medical records, and conversations with providers) from being disclosed by covered entities (including most health insurance companies, healthcare providers, and health information clearinghouses) for reasons other than providing treatment and care, billing and payment, protecting the public's health (such as through surveillance of specific diseases), or reporting required information to police (such as gunshot wounds). Information cannot be disclosed outside the HIPAA provisions without the patient's express written permission. Covered entities must have safeguards in place to protect patient health information to ensure that it is not mishandled. If a Section 319 Emergency has been declared, the Secretary of HHS may waive certain sanctions for non-compliance with HIPAA. Note that CDC is not a covered entity under HIPAA, nor are state or local public health departments, unless they also treat patients. Regulations are found at 34 C.F.R. Part 160 and Subparts A and E of 164.

- **Family Educational Rights and Privacy Act (FERPA) of 1973**
  Pub. L. No. 93- 380, as amended; 20 U.S.C. § 1232g
  FERPA applies to all educational agencies and institutions receiving funds under any program from the United States Department of Education, which encompasses virtually all public schools and universities, as well as some private schools. The school or agency may not disclose student records without a parent's or eligible student's written consent (an eligible student is either 18 years or older or is attending a post-secondary institution at any age). FERPA also gives parents and eligible students the right to access and review records. Parents and eligible students may request explanation of items in the record, seek amendment to records for information that is "inaccurate, misleading, or in violation of the student's privacy" and may request a hearing to challenge the content of the record if the school or agency does not agree to the amendment. Disclosure to teachers and other relevant employees of the school or agency without consent of the parent or eligible child is allowed for legitimate educational purposes; disclosure without consent is also allowed in several express purposes, including "in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals." For this exception, the school or agency must decide that there is an "articulable and significant threat" to the health and safety of the student or other individuals, taking into consideration the totality of the circumstances. Regulations are found at 34 C.F.R. Part 99.

Related Federal Guidance

- **National Response Framework (January 2008; updated May 2013)**
  The National Response Framework is a guide to how the United States conducts all-hazards response and is intended to capture specific authorities and best practices for managing incidents that range from the serious but purely local, to large-scale terrorist attacks or catastrophic natural disasters. In addition to the core document, the framework contains Emergency Support Function (ESF) Annexes, which group federal resources and capabilities into functional areas to serve as the primary mechanisms for aiding at the operational level. Common roles of federal agencies during emergencies are grouped together into 15 ESFs with different responsibilities based on these roles. Within each ESF, there is at least one primary agency, support agencies, and an ESF coordinator that is selected to oversee the ESF.
    - ESF #8 is designated for Public Health and Medical Services. HHS is the Primary Agency and Coordinator for ESF #8. ESF #8 outlines the roles of the Primary Agency and each Supporting Agency when aiding with state, tribal, and local governments during public health emergencies or threats.
    - ESF#13 is designated for Public Safety and Security. The US Department of Justice is the Primary Agency and Coordinator for ESF #13. This ESF is activated in situations requiring extensive public safety and security and where state, tribal, and local government resources are overwhelmed or are inadequate or for federal-to-federal support.

  The Framework also contains Incident Annexes that describe the concept of operations to address specific contingency or hazard situations or an element of an incident requiring

specialized application of the Framework. The Biological Incident Annex outlines the actions, roles, and responsibilities associated with a human disease outbreak of known or unknown origin requiring federal assistance. HHS is the coordinating agency for this annex. The Food and Agriculture Incident Annex describes the roles and responsibilities associated with incidents involving agriculture and food systems that require a coordinated federal response. Both HHS and the Department of Agriculture are the coordinating agencies for this annex.

Disclaimer

CDC's Public Health Law Program provides technical assistance and public health law resources to advance the use of law as a public health tool. PHLP cannot provide legal advice on any issue and cannot represent any individual or entity in any matter. PHLP recommends seeking the advice of an attorney or other qualified professional with questions regarding the application of law to a specific circumstance. The findings and conclusions in this document are those of the author and do not necessarily represent the official views of CDC.

APPENDIX G

PROGRAM PLAN AND BUDGET

INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

May 2026

The District 2 Healthcare Coalition strives to locate alternate grant funding methods whenever possible. The District 2 Operations Manager along with the Executive Committee continually seeks alternate grant funding throughout the year.

District 2 Healthcare Coalition is continually cost sharing by combining exercises with the Local Health Departments, Local Emergency Management, and Local Healthcare Organizations whenever possible. District 2 always strives to seek cost saving methods by obtaining multiple quotes for services, cost researching, and other methods. Whenever possible, the lowest cost for items will be spent.

District 2 Hospital Preparedness Planning Committee Inc. is a 501c3 corporation and serves as the Fiscal Agent for the District 2 Healthcare Coalition.