
INDIANA DISTRICT 2 HEALTHCARE COALITION

RESPONSE PLAN



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

JANUARY 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
4/2/20		Whole Plan review/update	Elizabeth Buchanan
6/2021		Whole plan review, at-risk populations added.	Elizabeth Buchanan
6/2022		Whole plan review/update	Elizabeth Buchanan
6/20/23		Record of changes added. Review all appendices and annexes. Update HVA and Membership.	Elizabeth Buchanan
6/17/2024		Whole Plan review /update	Jennifer Tobey
4/19/2025		Review/update	Jennifer Tobey
5/22/2025		Add Avian Influenza	Jennifer Tobey
12/11/2-25		Whole plan review/update	Jennifer Tobey

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I. INTRODUCTION

A. Purpose

The purpose of this response plan is to document an All-Hazards approach (Example: flooding, Hazardous material incident, H5N1) to the organization and processes of the District 2 Healthcare Coalition (HCC) 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 to any threat to the District 2 population. (See also *Indiana District 2 Preparedness Plan*)

B. Scope

This plan does not supersede agency jurisdiction or response plans and activities but rather supports the existing plans of the HCC members (See Appendix A). It will be activated to support any coalition member during a localized or District-wide event where resources and support are required.

C. Situations and Assumptions

The information contained in this section will be based upon summaries of information contained in the Hazard and Vulnerability Assessment, the District Public Health and Risk Assessment (Appendix B), the *District Preparedness Plan*, etc.

The following were high-level risks for 2025 based upon supporting documents and inclusive consideration of medical risk assessment and public needs: external flooding, high winds, supply chain shortage/failure, Hazmat incident, cyber threat, tornado, temperature extremes, inclement weather- snow, communications/telephony failure, and ice event. The following assumptions and limitations will be made:

Assumptions and Limitations

1. An internal or external emergency that has impacted operations, including the need for an Agency to evacuate, can affect a member organization or the community.
2. Facilities utilize NIMS/HICS for event organizational structure.
3. Facilities have developed an Emergency Operations Plan.
4. Facilities have developed an Evacuation Plan.
5. Facilities/Agencies have developed Memorandums of Understanding (MOU), Letters of Agreement (LOA) or other forms of agreement with appropriate agencies to include, but not limited to:
 - a. Fuel
 - b. Food
 - c. Linen
 - d. Pharmaceuticals
 - e. Security
 - f. Transportation
 - g. Water

- h. Generators
- i. Other items as necessary by Agency

6. Impacted facilities have activated their emergency operations plan and staffing of their Agency operations center.
7. Local resources will be used first in the following order: within systems, county, district, and then State resources, followed by a Federal request as needed. However, State and Federal resources may not be available for 72-96 hours or more. State and Federal resources may be staged closer to an impact area to avoid delays.
8. The increased number of area residents and staff needing medical help may burden and overcome the health and medical infrastructure. This increase in demand may require a regional response and subsequent city, county, state, and federal level of assistance.
9. Facilities will communicate their medical needs to the HCC and non-medical needs to the ESF-8 Coordinator at the jurisdictional Emergency Operations Center (EOC) or EMA Liaison.
10. Healthcare organizations will report situational awareness information to the HCC but are assumed to be able to handle the incident on their own as much as possible before asking for assistance.
11. Healthcare organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance.
12. Processes and procedures outlined in the response plan are designed to support and not supplant individual healthcare organization emergency response efforts.
13. The HCC's consistent processes and procedures will promote integration with public sector response efforts by using the National Incident Management System (NIMS).
14. Except in unusual circumstances, individual private healthcare organizations retain the decision-making sovereignty during emergencies.
15. This plan is based on certain assumptions about the existence of specific resources and capabilities that are subject to change. Therefore, flexibility is built into this plan. Some variations in implementing the concepts identified in this plan may be necessary to protect the health and safety of patients, healthcare facilities, and staff.

D. Administrative Support

The Response Plan will be reviewed and updated annually by the Planning Coordinator, with updates to be approved by the Executive Board, which consists of the core four members (Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representative), and membership of the coalition. Additionally, when exercises or actual events warrant changes to the plan, the Planning Coordinator will be assigned an additional review at any time during the year.

II. CONCEPT OF OPERATIONS

A. Introduction

The following process defines the basic flow for response to disasters/emergencies. Not every step will apply to all hazards. (Example: flooding, hazardous material incident, H5N1).

B. Role of Coalition in Events

The following is the overall role of the HCC during a disaster or emergent event. These steps are inclusive but not limited to the following:

- Promote a common operating picture through shared information with Coalition members
- Assist with resource management between partner entities
- Assist with patient tracking among healthcare entities
- Support evacuation activities
- Support shelter-in-place activities
- Coordinate with the local EOC and serve as the healthcare and information-sharing intermediaries.
- The following are time-sensitive performance metrics for HCC response. Some items will be monitored if stationed within the EOC (e.g., notification of incident to HCC members – dependent upon notification to the HCC, within 15 minutes); Bed availability reporting will occur via email within 30 minutes of request; Based on EMS best practices, EMS continuously triages in the field and to the hospital, once scene command is established other resources are requested from the HCC if needed; For distribution of casualties location specific plans should be referenced for differences in response and distribution of patients; Transportation resources will be staged based on best practices for EMS; Field patient tracking is completed by hand, within the hospitals it is expected that the hospital uses a HICS or other best practice form for tracking and updating patient locations upon arrival and upon dispensation to different departments or discharge; Family Assistance Center/Family Reunification Centers will be established based upon existing county plans with ESF-8 as lead; HCC to provide situational updates to coalition partners on an hourly basis (at minimum and as necessary based on incident).
- Should reports of distress to an Agency be received outside the parameters of the *Communication Plan* (See Annex F), the HCC shall contact the Agency directly to confirm reports.
- Coordinate between HCC facilities, agencies, counties that see a rise in dead birds to BOAH and or DNR.

C. Member Roles and Responsibilities

The following provides a general overview of the roles and responsibilities of the partner agencies and organizations during a response. More detailed roles and responsibilities are defined under the functional areas of the Plan.

- Hospitals—provide bed counts when requested (See Also *Information Sharing* (Annex A)), provide status reports to the HCC, identify resource needs/ability to share, and address any expectations that arise during the incident. Requests for resources should be made formally, in writing, to the HCC for tracking and fulfillment purposes.

- EMS working through the EOC and ESF-8 lead, will coordinate strategies and resources with the HCC during an incident response. This will include any activation of MOUs or different teams within the district.
- Emergency Management—Working collaboratively within the EOC and with the ESF-8 lead, will coordinate strategies and resources with the ESF-8 Lead/HCC during an incident response.
- Public Health – will serve as the ESF-8 lead within the EOC, will partner with the District 2 Readiness and Response Coordinator (or designee) as needed for coalition resources; the ESF-8 lead will work with the other entities represented in the EOC to coordinate situational awareness and response activities on behalf of the HCC.
- Other membership partners: Healthcare/medical agencies shall have the same essential functions as hospitals in providing their availability of resources/needs to the HCC. (See also *Information Sharing* (Annex A)).

D. Decision Making and Engagement

Individual or system resources should be utilized and requested from an in-network Agency before requesting resources from the county or district.

During an incident, local resources should be requested and utilized initially through contact with the local EMA (See *Communication Plan* Annex F).

For HCC resources (See also *Inventory of Assets Appendix E*), the Executive Board (A quorum is preferred, however; if unable to have a quorum, the ultimate decision will rest with the Chair/Co-Chair in emergency situations) will vote and prioritize deciding when and where to deploy resources upon request. Decisions will be made based on the scope and magnitude, location of a resource, ability to obtain and deliver the resource, and essential need for the resource.

E. Coalition Response and Organizational Structure

The HCC will not form a defined ICS/HICS structure. The role that will coordinate requests and share information with members will be the Liaison Officer. No other ICS positions will be filled.

The Liaison officer may work remotely or virtually for small-scale events or deploy to the EOC during a large-scale event if requested or if the event itself requires it.

ICS/HICS forms or EICS (Appendix D) shall be used to track activity, resource requests, tracking of resources, etc.

F. Population At Risk Operations

- Support HCC members with situational awareness and information technology (IT) tools already in use that can help identify children, seniors, pregnant women, people with disabilities, and others with unique needs.
- Support HCC member agencies in developing or augmenting existing response plans for these populations, including mechanisms for family reunification.

- Identify potential healthcare delivery system support for these populations (pre-event and post-event) that can prevent stress on hospitals during a medical surge event.
- Assess needs and contribute to medical planning that may enable individuals to remain in their residences during specific emergencies. If that is not possible, coordinate with the jurisdiction's ESF-8 lead agency to support the jurisdiction's ESF-6 (Mass Care, Emergency Assistance, Housing, and Human Services) lead agency with access to medical care, including at shelter sites.
- Coordinate with the jurisdiction's ESF-8 lead agency to assess medical transport needs for these populations.
- Coordinate communication between BOAH/DNR if continued avian influenza exists.

G. Response Operations

See also *Emergency Operations Plan: Incident Command System Policy*

These are the steps that any coalition member should reference during an incident, from incident occurrence through response and recovery.

Stages of Incident Response

Activation of the HCC can occur from a result of the following: this is inclusive but not limited to:

- A request to be activated or monitored by a Coalition member or partner
- Multi-jurisdictional incident or outbreak (Example: H5N1)
- Awareness through open-source media, notification by a partner, notification by a local, state, or Federal entity
- An incident in an area with few resources, such as a low-population county or a county without a hospital
- An incident significant enough to require resource sharing, including:
 - Strategic National Stockpile deployment
 - Epidemiologic investigation
 - Agency Evacuation
- Any substantive alert message requiring action from public health and healthcare (e.g., Indiana Health Alert Network). Possible examples -
 - A natural disaster (e.g., widespread tornado or flooding)
 - A biological attack (e.g., anthrax dispersion)
 - A chemical attack or spill (e.g., train derailment that forces a community evacuation)
 - A biological disease outbreak (e.g., pandemic influenza, H5N1)

- A radiological threat or incident
- A credible terrorist threat or actual terrorist incident

1. Activation

The HCC incident coordination system is activated when an event occurs in or out of the district, affecting members' ability to respond. This activation can happen by one of these two means.

1. A participating member requesting assistance provided they have activated their own Emergency Response Plan.
2. By standby activation due to current knowledge of an event that may affect the member in a manner that will require HCC support. Deployment of resources will not occur until the HCC receives a written request.
3. District 2 Activation Levels:
 - a. Level IV
 - i. A situation has occurred requiring the HCC board officer(s) to be alert for an event's potential escalation.
 - ii. This is the lowest level of activation. The board will likely not need to coordinate actively unless they are pre-staging for a planned event.
 - iii. Once the board gains situational awareness, information will be communicated to the partnering agencies.
 - b. Level III
 - i. A situation has occurred requiring assistance from the HCC board.
 - ii. Once the board gains situational awareness, information will be communicated to the partnering agencies.
 - c. Level II
 - i. A situation has occurred that requires only a single operational period to be coordinated by the HCC board.
 - ii. Once the board gains situational awareness, information will be communicated to the partnering agencies.
 - d. Level I
 - i. A situation has occurred requiring full activation of the District 2 HCC Board.
 - ii. This activation level is required for an incident involving multiple operational periods.
 - iii. A staffing rotation will ensure complete HCC board coverage.

2. Notifications

Each member of the organization can contact the HCC during an event, provided they have already activated their Emergency Operations Plan. This notification should be to the HCC Readiness and Response Coordinator (RRC) following the *District Communications Plan*

(Appendix F). Upon notification, based on the scope and magnitude of the incident, the RRC will determine if additional notifications to the membership are warranted.

3. Mobilization

The event will be monitored, and resources will be operationalized through either a virtual response by the HCC or the HCC board member working through the ESF-8 Lead.

4. Incident Operations (See also Emergency Operations Plan: Incident Command System Policy)

i. Initial and Ongoing HCC Actions

1. The District 2 Liaison will evaluate the individual member situation and begin:
 - a. If available, request the Incident Action Plan from the affected partner(s).
 - b. Coordinating district resources to support the response efforts.
 - c. Disseminating information to the other members, Indiana Department of Health (IDOH) Coordination Center, Indiana Department of Homeland Security EOC (SEOC), and other partner organizations.
 - d. Obtaining information from other members to determine resource allocation and movement. This could include bed counts, equipment availability, human resources, etc.
 - e. Maintain open communications with each responding agency until the incident has been cleared or the HCC Coordinator is terminated.
 - f. Maintain a log (NIMS 214) of all communications and requests that come through the HCC.
2. The District 2 Liaison /designee will communicate with the individual Member Coordinator/Member Incident Commander or designee to begin coordinating the use of district resources.
3. Should the incident be larger and affect additional member partners, the same steps shall apply, including communication and situational awareness updates requested by and provided by the HCC Liaison Officer. Resource deployment shall be made based on the decision-making process outlined above.
4. If the Indiana Department of Homeland Security (IDHS) District 2 Unified Command Center is established, the District 2 Liaison Officer will begin efforts to develop communication and coordination with the IDHS D2 JIS as soon as possible.
5. The District 2 Liaison or designee will notify and update the district status to the IDOH Emergency Operations Center (EOC) or SEOC as warranted.

ii. Information Sharing

Reference the *District Communications Plan* and *Annex A Information Sharing*.

iii. Resource Coordination

An Inventory of available HCC assets is in Appendix F. To request an available asset, please provide the request in writing utilizing the ICS Resource Request Form in Appendix D to the HCC for tracking and fulfillment purposes. The following considerations will factor into fulfillment:

- Size of Agency

- Location of Agency
- Impact on the Agency
- Location of assets
- Ability to obtain the asset
- Other factors as deemed appropriate during the response

If the request is approved, it will be up to the requested facility to arrange transport of the asset. If the HCC board is not available for a quorum vote, the final decision rests with the HCC chair or co-chair.

iv. Patient Tracking

For patient tracking during a surge event or evacuation, the individual facility is expected to track the patient upon arrival and through the facility and/or upon evacuation of the facility and arrival to their destination. The HCC will not assist with patient tracking unless called upon to do so if requested by the facility or for family reunification purposes. Appropriate HICS or other best practice documentation is expected to be utilized for patient tracking.

Should the HCC be called upon to assist with family reunification before the Family Assistance Center is established, the following information may be requested from the affected facilities in accordance with HIPAA guidelines: patient names, dates of birth, and sex.

For further information, reference *Annex C HCC Evacuation and Tracking*.

v. Support and Mutual Aid Agreements

Each member agency within the HCC agrees to support other agencies, if possible, during an event.

Each member organization is expected to have in place any MOUs deemed appropriate for their facility. The HCC will not have any established MOUs.

6. Demobilization and Return to Pre-disaster State

The District 2 Liaison Officer will terminate the HCC response when the agency no longer requires assistance beyond what they are able to obtain internally or locally at their facility. To properly terminate the response, the following items must be accomplished.

1. After a reasonable amount of time has passed and requests for assistance or coordination have slowed to the point that the HCC is not productive in continuing the operations, the district may consider terminating.
2. Verify with each agency involved if they no longer need support from the district.
3. Formally announce or inform all agencies that the District 2 Coordination Center is standing down and closing.

4. Gather all documents and logs used/created during the response and retain them for the record.
5. Make two copies of all resource requests and communication logs and provide one copy each to the requesting Agency and the receiving Agency for reconciliation on their part. Keep the original for the HCC records.
6. Facilitate a demobilization meeting with all facilities involved within 48 hours of post-event, not immediately, to ensure resources are returned to proper ownership.
7. Inventory the HCC-owned property to ensure all items are returned, not damaged, and ready for deployment again in the future. Restock as necessary and work with the Agency that used the items for reimbursement.
8. Within 48 hours post-event, schedule an after-action debriefing/summation, including all agencies. Due to the scope of work that must be accomplished, it may be beneficial to contract with a third-party vendor to perform the documentation and dissemination of the information gathered for this After-Action Report.

H. Continuity of Operations

Operations within the district shall follow the succession plan as noted below:

Chair -> Co-Chair ->Coordinators->Executive Board Members -> Other Committee Representative

In addition, Each General, Sub, and Special Committee shall designate one (1) backup person for continuity in an emergency.

Each member agency is expected to have a continuity plan in place for their respective agencies, which includes a succession plan of leadership.

In addition, redundant communications systems are in place per the *Communications Plan* (Annex F) to maintain communications and support activities at the HCC level.

**** Please refer to the *D2 HCC COOP/Continuity/Recovery Annex*****

INDIANA DISTRICT 2 HEALTHCARE COALITION

Information Sharing Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

The notification and information sharing annex is to provide situational awareness regarding the status of the agencies and facilities into the ongoing flow of information to assist with the creation of a common operating picture. This includes providing information to the full spectrum of coalition partners and mitigating potential gaps in healthcare services during a time of a public health emergency. This annex outlines the purposes for which data may be shared amongst organizations. This data sharing will ensure that coalition members and the community receive the support they require.

B. Scope

This plan covers the protocols of notification and information sharing that may occur during an emergency. These communications may occur within the District 2 Healthcare Coalition, Coalition to another Coalition, Coalition to the (IDOH) Indiana Department of Health, (BOAH) Board of Animal Health, (DNR) Department of Natural resources, or other statewide communications.

C. Situations and Assumptions

Information sharing shall occur from the onset of an event, notification from an affected member and/or the coalition becoming aware of the event and reaching out to affected member to gain situational awareness and confirm an event has occurred. Contact with the coalition shall be made once the affected facility’s EOP (Emergency Operations Plan) has been activated.

Assumptions and Limitations

1. It is expected that a facility shall provide situational awareness to Coalition Leadership if their EOP is activated.
2. Bed and resource availability may be requested to be shared amongst member partners
3. Generally, information shared by the HCC should not include protected health information (PHI/ePHI)
4. Depending on the type of crisis that is occurring, there will possibly be communication limitations
5. Protocols to provide information to and from the Coalition should be timely, relevant, and actionable information that can be used to assist with creation of an incident common operating picture related to healthcare organizations
6. See Communications Plan

II. CONCEPT OF OPERATIONS

A. General

Effective response coordination relies on information sharing to establish a common operating picture. Information sharing is the ability to share real-time information related to emergencies, the current state of the health care delivery system, and situational awareness across various response organizations and levels of government (federal, state, local). HCC’s development of information sharing procedures and use of interoperable and redundant platforms is critical to successful response.

Individual HCC members should be able to easily access and collect timely, relevant, and actionable information about their own organizations and share it with the HCC, other members, and additional stakeholders according to established procedures and predefined triggers in accordance with applicable laws and regulations. Multiple employees from each HCC member organization should understand and be able to access HCC’s information sharing platforms to ensure the continuity of information flow and coordination activities. The HCC and governmental partners (including the ESF-8 lead agency) should be engaged when one or more health care organization has lost the capacity or ability to provide patient care or when a disruption to a health care organization necessitates an evacuation.

B. Information Sharing Management

Reference the District Communications Plan.

C. Activation and Alert Notifications

Upon notification from a coalition member that an event has triggered activation of their emergency response plan or if the coalition receives word and confirms that activation of a member’s emergency operations plan has occurred, the HCC will send notifications that they are standing up as the District Healthcare Resource Coordination Center.

Activation and Alert Triggers		
<i>Extreme Weather</i>	<i>Biological Hazard or Disease</i>	<i>Medical Surge</i>
<i>Flooding</i>	<i>Fire</i>	<i>Mass Casualty Incidents</i>
<i>Earthquake</i>	<i>Radiation</i>	<i>Facility Inoperability</i>
<i>Tornado</i>	<i>Hazardous Materials</i>	<i>Supply Shortage</i>
<i>Winter Weather</i>	<i>Explosion</i>	<i>Diversion Status</i>
<i>Avian Influenza</i>		

D. Information Sharing Coordination

Upon activation of the Coalition Liaison position, situational awareness and resource coordination will be conducted at the coalition level and may include Federal and State entities. See Communication Plan and Response Plan.

E. Essential Elements of Information

The following table provides examples of information that could be requested from or for a member of the coalition.

Types of EEI			
<i>Number of Patients</i>	<i>POD status</i>	<i>Evacuation status</i>	<i>Facility operating Status</i>
<i>Severity and types of illnesses</i>	<i>Epidemiological data</i>	<i>Shelter in place status</i>	<i>Facility structural Integrity</i>
<i>Severity and types of injuries</i>	<i>Surveillance data</i>	<i>Diversion status</i>	<i>Critical services status</i>
<i>Bed Availability</i>	<i>School-related data</i>	<i>EMS Status</i>	<i>Medical services status</i>
<i>Medical supply status</i>	<i>Resource needs and requests</i>	<i>Staffing status</i>	<i>Incident Command Structure</i>
<i># of Counties involved</i>	<i>#of flocks/farms</i>		

F. Information Sharing Platform

EMResource, Preparis, Serv-In, and WebEOC will be platforms utilized to share information electronically.

G. Information Validation

The District 2 HCC RRC shall receive resource requests on the required form, validate the request and ensure that the appropriate process for approving requests is followed (See Response Plan). It will be the requesting facility’s responsibility to arrange transport and return of the resource. Reports of an event received from a source other than the affected member facility, the liaison office shall contact the facility to confirm statues and receive situational awareness reports.

H. EHR Alternatives

It will be the affected facility’s responsibility to ensure that appropriate patient information is shared with another receiving facility. They will need to determine if a paper chart or paper documentation is required to be sent. This decision will be made in coordination with any receiving facility prior to transfer of any patients.

III. INFORMATION ACCESS AND DATA PROTECTION PROCEDURES

TBD – IDOH to provide info relating to information sharing platform:

- Access to public or private systems
- Authorization to receive and share data
- Types of information that can and will be shared (e.g., EEIs)
- Data use and re-release parameters for sensitive information
- Data protections
- Legal, statutory, privacy, and intellectual property issues, as appropriate
- Reporting notifications to BOAH, DNR

IV. INTERNAL COMMUNICATIONS AND NOTIFICATIONS

Sharing accurate and timely information is critical during an emergency. Health care organizations should have the ability to rapidly alert and notify their employees, patients, and visitors to update them on the situation, protect their health and safety, and facilitate provider-to-provider communication.

A. Clinical Information Acquisition and Sharing

The HCC, in coordination with its public health agency members, will collect and share information as deemed necessary during an event. It is expected that member agencies and the coalition share a bi-directional flow of information regarding status, patients, special information (to include CBRNE or epidemiological information) related to the event. Utilizing the communications platforms available and providing situational awareness updates in a time manner, the coalition can appropriately assist with resource sharing.

INDIANA DISTRICT 2 HEALTHCARE COALITION

Medical Surge Coordination Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

This annex shall address the responsibilities of the HCC and coalition members during a medical surge event.

B. Scope

This annex applies to each member agency of the HCC. This annex will be activated upon notification to the HCC of the need for resources, or should the HCC confirm an event has occurred and a member agency is affected. This annex does not supersede any agency plan or local jurisdiction.

C. Situations and Assumptions

The following situations and assumptions apply to this annex.

Assumptions and Limitations

1. Indiana's Healthcare Coalitions are involved in ongoing preparedness activities
2. Activation is dependent upon the locality or jurisdiction of where the incident occurs
3. Activation of this annex shall only occur if the affected agency has activated their EOP.
4. The medical surge plan applies to an event that results in a number or type of patients that overwhelm the day-to-day capacity of hospitals
5. It is impossible to plan for every type of disaster
6. Member agencies shall have in place a surge plan to address influx of patients, discharge, specialty populations, patient tracking procedures
7. Member agencies shall have within their EOPs plans to conserve/ration supplies or activate any crisis standards of care plans
8. Each member agency will provide bed and resource availability in a timely manner
9. Agencies that provide inpatient or outpatient services will have an emergency credentialing policy
10. Each individual facility is responsible for formulating their own respective surge plan to include alternate care sites and crisis standards of care plans
11. HCC and each member agency will provide bi-directional situational awareness updates
12. Local response may be overwhelmed by the time regional, or state response is active
13. An event that causes a medical surge situation often has far-reaching consequences and can impact the entire Coalition

II. CONCEPT OF OPERATIONS

A. General

Healthcare organizations can most effectively implement and manage medical surge when appropriate information sharing systems and procedures have been established, appropriate plans for all levels of care and populations have been developed, and personnel have been trained and exercised in their use.

An emergency event will require the HCC and its members to share information, attain and maintain situational awareness, and manage and share resources, at a minimum. The HCC may help facilitate patient and resource distribution (or re-distribution) during a surge emergency. The healthcare organization’s Emergency Operations Plan (EOP) will help inform these efforts.

B. Strategies and Resource Summary

The HCC will expect member agencies to enact their surge plans should an event result in an influx of patients on their facility. Upon activation of either the surge plan or the EOP, it is expected that the HCC be notified and provided a situational report on the event. The HCC will make the decision to notify the other member agencies and request bed availability or other resources as deemed appropriate or requested by the affected facility. The HCC will then follow the process defined in the Response Plan and related annexes and appendices.

1. Emergency Department and Inpatient Services

The HCC would expect that each member agency that provides inpatient or outpatient care at their facility to have a plan that addresses the items in this table should a surge event occur.

Strategies to Develop ED and Inpatient Medical Surge Capacity and Capability	
Area	Area Description
Emergency Department	<ul style="list-style-type: none"> Make beds and surge spaces rapidly available for initial triage and stabilization, and obtain additional staff, equipment, and supplies
General medical, general surgical, and monitored beds	<ul style="list-style-type: none"> Ensure IBA (at least 20 percent additional acute hospital inpatient capacity within the first four hours following an emergency) by rapidly prioritizing patients for discharge, maximizing the use of staffed beds, and using non-traditional spaces (e.g., observation areas)
Critical care	<ul style="list-style-type: none"> Rapidly expand capacity (for those facilities that provide it) by adapting procedural, pre- and post-operative, and other areas for critical care Assess staff, equipment, and supply needs for these spaces to facilitate requests
Surgical intervention	<ul style="list-style-type: none"> Secure resources, such as operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment

	and supplies to provide time-sensitive, immediate surgical interventions to patients with life threatening injuries
Clinical laboratory and radiology	<ul style="list-style-type: none"> • Rapidly expand basic laboratory services (e.g., hematology, chemistries, Gram stain, blood cultures), including mechanisms for staff augmentation and rapid reporting • Consider use of point-of-care testing • Rapidly expand radiology services (e.g., diagnostic radiology, ultrasound, computed tomography [CT]), including mechanisms for staff augmentation and rapid reporting
Staffing	<ul style="list-style-type: none"> • Call back clinical and non-clinical staff; utilize staff in non-traditional roles • Adjust staffing ratios and shifts as required, and implement HCC member staff sharing plans
Healthcare volunteer management	<ul style="list-style-type: none"> • Identify situations that would necessitate the need for volunteers in hospitals • Identify processes to assist with volunteer coordination • Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility • Identify and address volunteer liability issues, scope of practice issues, and third-party reimbursement issues that may deter volunteer use • Leverage existing government and non-governmental volunteer registration programs (e.g., State Emergency Registry of Volunteers for Indiana [SERV-IN] and Medical Reserve Corps [MRC]) • Develop rapid credential verification processes to facilitate emergency response
Equipment and supplies	<ul style="list-style-type: none"> • Implement emergency equipment, supplies and stocking strategies, and HCC resource sharing agreements

2. Emergency Medical Services Surge

The HCC would expect that local EMS providers have a plan to address the items in this table:

Medical Surge Elements to Incorporate into EMS Operations Plans	
Area	Area Description
Dispatch	<ul style="list-style-type: none"> • Identify procedures to: <ul style="list-style-type: none"> – Alert hospitals of an emergency per local protocol – Communicate hospital capacity and capability to EMS providers

	<ul style="list-style-type: none"> – All EMS surge requests utilize mutual aid response plans per local protocol.
Response	<ul style="list-style-type: none"> • Match appropriate specialized providers and equipment with the nature of the emergency (Example: flooding, hazardous materials incident, avian influenza) • Consider surge strategies such as changing shift lengths or crew configurations, using alternate vehicles, using community paramedicine, or other non-ambulance responses in coordination with dispatch priorities
Pre-hospital triage and treatment	<ul style="list-style-type: none"> • Implement disaster triage procedures and other standard operating procedures (e.g., eliminate requirement for verbal orders) • Consider processes that allow for expanded scope of practice • Plan for specialty responses, such as HAZMAT, highly infectious disease, mass burn, mass trauma, and mass pediatric emergencies
Transportation	<ul style="list-style-type: none"> • Identify procedures to surge the numbers of patients transported per vehicle or aircraft • Identify procedures for changing preferred destination facilities (e.g., trauma center, pediatric hospital) or not using the closest hospital • Identify procedures for type and level of pre-hospital care delivery and mode of transport (ground and air medical) • Develop and implement EMS patient distribution strategies to avoid overloading any single hospital • Identify procedures for transporting patients to alternate care sites
Supplies and Equipment	<ul style="list-style-type: none"> • Utilize physical resources including supplies, equipment, and cached materials to support a medical surge

3. Out of Hospital Surge Response

Patient care settings outside of hospitals may be impacted during an emergency. For example, structural impacts from natural disasters or increased demand during epidemics may compromise an outpatient clinic’s ability to provide care. If not adequately addressed, the demand for out-of-hospital care will usually fall on hospitals and EMS, further overloading an already burdened system. Safe, continued operations of a community’s out-of-hospital care resources are critical to an effective medical surge response.

During a surge event that affects the District, the HCC Logistics Coordinator would send notifications to each member agency with a situational awareness report. Resources and assets may be requested from any agency. Each member that provides inpatient or outpatient care should have an emergency credentialing policy in order to be able to use staffing resources from other agencies. The HCC will assist in coordinating contact between the requesting agency and the resources.

4. Alternate Care Systems

An alternate care system – the utilization of non-traditional settings and modalities for health care delivery – may be required when demand overwhelms a regions or the nation’s health care delivery system for a prolonged period, or an emergency has significantly damaged infrastructure and limited access to health care.

When it is determined that alternate care sites will be established, the HCC may be contacted through the EOC to request staffing and resources from the HSS member agencies. HCC would not be responsible for delivery of any durable resources to the alternate care site, instead they would function as an intermediary solely requesting resources for the alternate care site.

The following recommendations are made to any member agency considering establishing an alternative care site:

Key Considerations to Develop an Alternate Care System	
Area	Area Description
Telemedicine/virtual medicine	<ul style="list-style-type: none"> Use telephone, internet, telemedicine consultations, or other virtual platforms to provide consultation between providers Provide access to specialty care expertise where it does not exist within the HCC to allow for remote triage and initial patient stabilization Establish call centers to offer scripted patient support
Screening/early treatment	<ul style="list-style-type: none"> Ensure that section 1135 of the Social Security Act waiver is in place if required; 1135 waivers will be requested at the hospital level by each individual facility. Establish assessment and screening centers that allow the health care delivery system to respond to increased demand for screening and early treatment (e.g., during a pandemic) Preferentially manage patients with minor symptoms and those who might require limited medical intervention as these patients might otherwise overwhelm emergency departments
Medical care at shelters	<ul style="list-style-type: none"> Provide medical care support at community-established shelters (may involve SERV-IN, MRC, nursing home staff, or a variety of ambulatory care providers)
Disaster alternate care facilities selection and operation	<ul style="list-style-type: none"> Be able to provide non-ambulatory care for patients when hospital beds are not available Select sites for out-of-hospital patient care management based on recommended guidance Identify the process to assist with multiagency volunteer coordination to organize, assemble, dispatch, and properly out-process volunteers (e.g., Volunteer Reception Center)

	<ul style="list-style-type: none">• Integration with Federal Medical Stations (FMS)
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C. Patient Tracking

Patient tracking refers to several types of processes and documentation across patient movement. These types consist of:

1. Pre-Hospital Patient Tracking

Currently, EMS within District 2 tracks patients via paper methods during a surge event. There is not an established or consistent process in place.

2. Patient Movement Tracking

Each agency providing inpatient, or outpatient care shall establish a means for tracking patients both within their facility and include a method for tracking when a patient is transferred from the facility.

See Annex C: **Evacuation and Tracking** for additional information.

3. Unidentified Patient Tracking

Each member agency should have in place a method for tracking and identifying those patients who arrive and are non-communicative or have no identification.

The HCC may be asked to assist with Family Reunification and shall work collaboratively with the EOC and ESF-8 Officer/Coordinator to assist if a Family Assistance Center is established. The HCC may also request lists of patient names in accordance with HIPPA from member agencies to assist with family reunification.

D. Patient Distribution

Patient distribution will be left to the discretion of the local jurisdiction’s transport manager working in conjunction with the local EOC. Bed and Emergency Department availability may be requested from the local hospitals and/or the HCC coordinator to allow for distribution of patients.

E. Definitive Patient Movement

Should the size and scale of the event overwhelm the member agencies and resources of District 2, the D2 Liaison officer should contact IDOH to assist with activations of other districts and State resources, and the transfer of patients to other districts within the state. The HCC in coordination with local EOC’s and ESF-8 Officer/Coordinator may assist with movement of patients to rallying points or shelters for transfer outside the district.

IDOH works directly with the U.S. Department of Defense (DoD) or U.S. Department of Veterans Affairs (VA) Federal Coordinating Centers (FCCs), including the establishment of aerial ports of embarkation and debarkation for patient movement (e.g., deployable U.S. Department of Health and Human Services [HHS] response teams, definitive medical care in National Disaster Medical System [NDMS] civilian hospitals)

F. Coalition Joint Decision-Making Process

Decisions made by the HCC will be voted on by a quorum of the executive team. If a quorum is not available, the decision rests with Chair and Co-chair. Should a joint decision need to be made, the HCC executive team shall work collaboratively with the local jurisdictional partners to determine resource allocation or other response activities.

III. SPECIALTY CARE

The following tables are representative of specialty hospitals or care within the region or within the state. HCC will serve to assist with bed availability and resource sharing with these facilities. Trauma Capability

HCC and its members should coordinate a response to large-scale trauma emergencies with all trauma system partners. All hospitals should be prepared to receive, stabilize, and manage trauma patients. However, given the limited number of trauma centers, an emergency resulting in large numbers of trauma patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from trauma services receive priority for transfer. Health care facilities should ensure sufficient availability of operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide immediate surgical interventions to patients with life threatening injuries.

During any event, the HCC serves as a situational awareness and resource coordinator. HCC would send out alerts to the members and ask for information regarding resource availability.

The following table lists the trauma centers of the district:

Trauma Centers			
Name	Location	ACS Trauma Level	Capabilities
Memorial Hospital	615 N Michigan Street, South Bend 46601	2	
Elkhart General Hospital	600 East Boulevard, Elkhart 46514	3	

G. Burn Capability

All hospitals should be prepared to receive, stabilize, and manage burn patients. However, given the limited number of burn specialty hospitals, an emergency resulting in large numbers of burn patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from burn specialty services receive priority for transfer. Additionally, burn surgeons may be able to help identify patients who do not require burn center care and who are appropriate for transfer to other health care facilities.

District 2 does not have any facilities that treat burn victims. The table lists the 2 closest facilities that do receive burn victims. *See also the **District 2 Burn Surge Response Annex**.

Burn Treatment			
Name	Location	ABA Verified Center (y/n)	Capabilities
Lutheran Hospital	700 Broadway, Ft. Wayne 46802	No	
Bronson Methodist Hospital	601 John St, Kalamazoo, MI 49007	No	

H. Pediatric Capability

All hospitals should be prepared to receive, stabilize, and manage pediatric patients. However, given the limited number of pediatric specialty hospitals, an emergency affecting large numbers of children may require HCC and ESF-8 lead agency involvement to ensure those children who can most benefit from pediatric specialty services receive priority for transfer. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. EMS resources, including providers with appropriate training and equipment, should be prepared to transport pediatric patients. The HCC should promote its members’ planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that are able to stabilize and/or manage pediatric medical emergencies.

The following table lists the pediatric centers of the district:

Pediatric Centers		
Name	Location	Capabilities
Memorial Hospital	615 N Michigan Street, South Bend 46601	NICU, PICU
Elkhart General Hospital	600 East Boulevard, Elkhart 46514	NICU
St. Joseph Health	5215 Holy Cross Pkwy, Mishawaka 46545	NICU

I. Psychiatric Capability

See Annex E – HCC Disaster Behavioral Health for resources.

IV. ADDITIONAL SURGE ELEMENTS

A. Chemical or Radiation Events

Communities should be prepared to manage exposed or potentially exposed patients during a chemical or radiation emergency. During such events, individuals may go to various healthcare facilities, police and fire stations, and other locations for assistance.

HCC members should be prepared and have plans to address the following:

HCC Members Recommended Actions
Provide wet and dry decontamination by personnel trained and equipped according to the Occupational Safety and Health Administration (OSHA) guidance for first receivers and the <i>Patient Decontamination in a Mass Chemical Exposure Incident: National Planning Guidance for Communities</i>
Ensure involvement and coordination with regional HAZMAT resources, including EMS, fire service, health care organizations, and public health agencies
Distribute and administer available antidotes, including mobilization of CHEMPACKs when necessary
Screen to differentiate exposed to unexposed patients, especially in radiation emergency events
Develop a process for radiation triage, treatment, and transport (RTR response)
Manage behavioral health consequences for these types of emergency events

The following table is a list of Chempack containers placed within the district:

Chempack		
Location Name	Container Type	Contact
Memorial Hospital of South Bend	Hospital Chempack	
St Joseph Health Mishawaka	Hospital Chempack	
Kosciusko County	EMS Chempack	

Enhanced Infectious Disease Preparedness and Surge Response

Both health care organizations and the HCC have roles in planning for and responding to infectious disease outbreaks that stress either the capacity and/or capability of the health care delivery system.

See also: **District 2 Emerging infectious Disease Plan.**

HCC members should be prepared and have plans to address the following:

Healthcare Recommendations for Infectious Disease
Screen patients for signs, symptoms, and relevant travel and exposure history
Support treatment protocol and algorithm use in clinical care by deploying clinical decision support (CDS) where electronic health records (EHRs) are in use
Document exposure information in EHRs, and ensure it is communicated to the entire care team and state and local health departments (by electronic means, if available)
Rapidly isolate patients
Provide personal protective equipment (PPE) and prophylaxis to their employees and visitors while awaiting either comprehensive evaluation, definitive diagnosis, or transfer
Utilize tertiary care facilities, when possible, or designated facilities to assess, manage, and treat patients with suspected highly pathogenic transmissible infections (e.g., severe acute respiratory syndrome [SARS]/Middle East respiratory syndrome [MERS]) or non-transmissible infections (e.g., anthrax)
Define and implement visitor policies for infectious disease emergencies, in collaboration with the HCC, to ensure uniformity

Should an infectious disease affect District 2, the ESF-8 Lead agency will collaborate with the District 2 Liaison officer as needed to complete the following table and information reference Communication Plan and Information Sharing Annex.

Completed (Y/N)	HCC Infectious Disease Checklist for Surge
	Expand existing Ebola concept of operations plans (CONOPs) to enhance preparedness and response for all infectious disease emergencies that stress the health care delivery system
	Ensure jurisdictional public health infection control and prevention programs (including healthcare-associated infection [HAI] programs) participate in developing infectious disease response plans, and include HCC members for management of individual cases and larger emerging infectious disease outbreaks

	Develop HCC and regional training and strategies for the consistent use of PPE
	Manage PPE resources, including stockpiling considerations, vendor managed inventory, and the potential reuse of equipment. This includes consistent policies regarding the type of PPE necessary for various infectious pathogens and sharing information about PPE supplies across HCCs, EMS, public health agencies, and other HCC members
	Include HAI coordinators and quality improvement professionals at the facility and jurisdiction levels in HCC activities, including planning, training, and exercises/drills; include HCC leaders in state HAI coordination work groups
	Develop and/or integrate a uniform process of continuous screening, integrated with EHRs where possible, throughout HCC member facilities and organizations
	Coordinate patient distribution for highly pathogenic respiratory viruses and other highly transmissible infections when tertiary care facilities or designated facilities are not available
	Provide real-time information through coordinated HCC and jurisdictional public health information sharing systems
	Partner with relevant public health and health care delivery system informatics initiatives, including electronic laboratory reporting, electronic test ordering, electronic death reporting, and syndromic surveillance as it relates to the submission of emergency department visit data to the public health agency
	Identify, utilize, and share leading practices to optimize infectious disease preparedness and response; support the use of these practices with CDS in EHRs whenever possible

B. Medical Countermeasures during Surge Response

In coordination with public health agencies, HCC and its member organizations should be prepared to receive and dispense medical countermeasures (MCMs) to patients, responders, and employees and their household members during a medical surge emergency (e.g., radiation, botulism, anthrax, and other category A bioterrorism agents). Where possible, health care organizations should coordinate with local public health agencies prior to an emergency to establish a closed point of dispensing (POD) in their facility. In the event of a public health emergency requiring mass dispensing of MCMs to local populations, available MCMs may exist in HCC or individual HCC member’s caches or be provided by local public health agencies to established closed PODs. Establishing closed PODs prior to an emergency allows for organized and timely distribution of medication or vaccines to hospital patients, employees, and their families.

See also: Your **County Closed POD Plan**.

C. Scarce Resources and Crisis Care

The term Crisis Standards of Care (CSC) refers to the adjustment of medical care under catastrophic disaster conditions. The standards of care proposed under the delivery of such conditions must represent a “reasonable” approach to healthcare service delivery, albeit under some unique and challenging conditions that simply do not exist under conventional disaster conditions.

HCC will be responsible for resource allocation based upon the requesting facilities specific information, See also Response Plan. The HCC leadership will fulfill resource requests based upon a quorum of votes with the executive team. If a quorum is not available, the decision rests with the Chair and Co-chair.

It will be each member’s responsibility to establish and activate a plan for crisis standards of care. The HCC will not make the decision to implement crisis standards of care; this will remain a localized decision.

V. MASS FATALITY SUPPORT

Mass fatality management may involve emergency management organizations, public health agencies, coroners, medical examiners, and other stakeholders depending on the nature of the emergency. Hospitals should be able to manage an increase in dependents at their facilities. Hospitals should be aware of community plans and authorities for an emergency resulting in mass fatalities.

Healthcare organizations, in collaboration with public health agencies and other stakeholders, should:

Healthcare Organization Mass Fatality Recommendations
Prepare for a surge in initial storage of decedents, including those who will not become medical examiner cases (e.g., pandemic)
Manage large numbers of family members and friends of decedents who may come to the hospital
Facilitate the identification of temporary, ad hoc mass fatality storage sites in the community (e.g., parking decks, ice rinks) when refrigerated trailers and other conventional storage means are not immediately available
Manage contagious, chemically, or radiologically contaminated remains

VI. COALITION MEDICAL SURGE SUPPORT

The table below is an example of how the Coalition’s support can be organized. Under “Coalition Support,” other policies documents, such as annexes specifically related to the topic, should be named and briefly summarized. These do not need to be documents that the Coalition has created; they simply need to be accessible by the Coalition. This is by no means a complete list and should be added to reflect the specific needs of your Coalition.

Medical Surge Support	
Situation	Support Documents
Emergency Department, Inpatient and Outpatient Facilities	See also District 2 Surge Plan, Evacuation and Tracking Annex, District 2 Communication Plan
Infectious Disease Response	See District 2 Emerging Infectious Disease Plan
Behavioral Health Needs	See Behavioral Health Annex
Enhance Infectious Disease Preparedness	See District 2 Emerging Infectious Disease Plan
Distribute Medical Countermeasures	See your County Closed POD Plan
EMS Mass Casualty Incidents	See District 2 Surge Annex

INDIANA DISTRICT 2 HEALTHCARE COALITION

Evacuation and Tracking Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

This annex addresses how the HCC and member agencies shall support each other during an evacuation event and the expectations for patient tracking.

B. Scope

This annex applies to each member agency that provides either inpatient or outpatient care. It shall be activated upon the HCC being alerted that a facility requires evacuation. The HCC will then activate the Readiness and Response Coordinator, requesting situational awareness information from member agencies. In all cases, HIPPA standards will be adhered to for patient tracking.

C. Situations and Assumptions

HCC's role during evacuation will be to provide situational awareness, collect bed availability, and address any resource requests.

Assumptions and Limitations

1. The evacuation and tracking plan apply to an event that results in a number or types of patients that overwhelm the day-to-day capacity of hospitals, healthcare, long-term care facilities etc.
2. Inter-agency collaboration will be necessary.
3. Execution of this plan will take a whole community approach.
4. Every region comes with unique environmental challenges and limitations.
5. Local response may be overwhelmed when regional or state response is active.
6. Each member agency providing patient care is responsible for maintaining and exercising an evacuation plan.
7. The evacuating agency is expected to track patients during an evacuation.
8. The evacuating agency is expected to place their patients according to their care level.
9. The evacuating agency is expected to contact appropriate levels of transportation (the HCC can assist with resources upon request).
10. Member agencies are expected to plan for specialty populations (i.e., behavioral, pediatric, geriatric, etc.).

II. CONCEPT OF OPERATIONS

A. General

Healthcare organizations should evacuate or relocate when continuity planning efforts cannot sustain a safe working environment or when a government entity orders them to evacuate. The HCC and its members should prepare to be able to evacuate or relocate with little or no warning. Evacuation and relocation plans assist healthcare organizations with the safe and effective care of patients, use of equipment, and utilization of staff when relocating to another part of the Agency or when evacuating patients to another location.

B. Evacuation and Relocation Plans

The HCC shall support an evacuating agency by assisting with resource allocation. If a single facility is evacuated, the HCC may be able to provide patient tracking assistance; however, ultimately, it is the responsibility of the affected agency to ensure patient tracking is completed and documented.

During an evacuation, the HCC Liaison Officer shall be in contact with the activated EOC and work collaboratively with them. The evacuating Agency is expected to work collaboratively with the activated EOC.

Evacuation Planning Considerations
Establish authorities for decision-making processes, including triggers for evacuation - at the entity level.
Ensure internal and external communications – at entity, HCC, and EOC levels.
Identify appropriate relocation and evacuation staging areas within the Agency - at the entity level.
Identify situations for early discharge - at the entity level.
Identify available destination facilities and their ability to expand existing services to receive patients from evacuating facilities. Bed counts are at the HCC level; up to the Agency specific to place patients and provide patient handoff.
Identify available evacuation assistance devices and where they are located – at the entity level; and HCC to coordinate, but the entity to establish means to obtain the devices.
Establish processes for when patients cannot be moved – at the entity level, shelter in place.
Establish procedures for Agency closure – at the entity level. (Face sheets, medications, pets etc).

The HCC RRC, in conjunction with the EOC, shall facilitate the following:

Evacuation and Relocation Considerations
Prioritize the order and category of patients chosen for evacuation and relocation – at the entity level.

Obtain section 1135 of the Social Security Act waivers – at the entity level in coordination with Public Health.
Match patient needs with available transport resources (including non-EMS transportation assets) – at the entity level.
Move and track patients and their belongings, staff, and medical records; ensure vital patient medications and equipment (e.g., mechanical ventilators, monitors, intravenous [IV] poles, etc.) are brought with the patient during patient transport and are returned to the Agency of origin – at entity level
Notify families and facilitate reunification – at the entity level.

Planning, training, and exercising these activities are critical to the success of evacuation and relocation. High-risk patients should be given special consideration during evacuation and relocation. These patients include adults, children, neonates in critical care units, current operative cases, psychiatric (including memory/dementia care) patients (to include information regarding sending staff with the patients, etc.), and other patients who may need specialized care during evacuation and relocation.

C. Evacuation Transportation Plans

The HCC and its members, in collaboration with the ESF-8 lead agency, should develop and implement transportation plans for evacuating patients from one healthcare Agency to another due to an Agency evacuation or mass casualty incident. – Reference county transport and route plan.

1. HCC Coordination

The HCC shall assist with resource requests and provide situational awareness updates. The HCC may assist with coordinating EMS resources through the EOC if activated.

2. Transport Manager

EMS will coordinate with the local transport manager assigned at the entity level.

The HCC can activate a transport manager position upon request.

3. Coordinating Entity

The local transport manager will coordinate with EMS for ground and air transport as transportation needs and patient acuity are assessed.

4. Transportation Assets

See attachment for transportation assets within the district (Page 5).

5. ESF-8 Requests

For specialized resources and assets, the local jurisdiction shall contact the EOC and make a request through the ESF-8 officer.

6. Specialized equipment needs

In an evacuation, the evacuating Agency must assess any specialized equipment needs, such as age-related devices, bariatric devices, ventilators, or dialyzed patients, and ensure the appropriate equipment and transportation assets are obtained. The Agency or the HCC may make these requests on behalf of the Agency through the local EOC.

7. Patient tracking during transport

The evacuation agency is responsible for tracking all patient movements from when they leave the agency until they arrive at the destination Agency. It is recommended that facilities utilize the HICS forms provided in Appendix D. If available, the HCC Liaison officer may assist or provide resources to assist the Agency with patient tracking.

8. Transport Communications

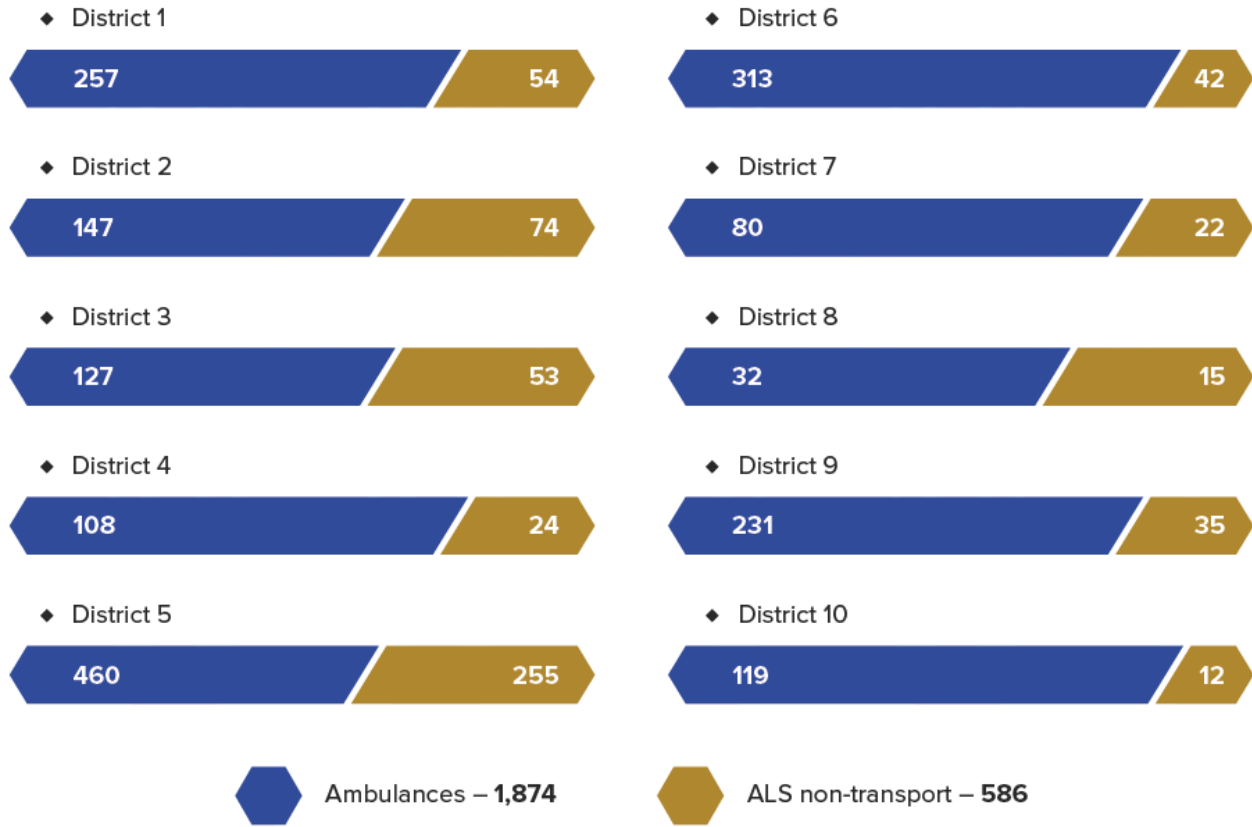
Communications during transport will follow the Communications Plan.

9. Patient and Family Communications

The evacuating Agency is responsible for contacting the next of kin and informing them of the decision to evacuate and the location of their family members. The HCC Liaison Officer may be able to assist or provide resources to help upon the Agency's request.

State Transportation Assets

TOTAL CERTIFIED GROUND VEHICLES BY DISTRICT



INDIANA DISTRICT 2 HEALTHCARE COALITION

Public Information Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

This plan will address the Public Information Officer (PIO) role by listing resources available throughout the district. The District 2 Healthcare Coalition will not have a PIO and will rely on its partners to release statements as deemed necessary, with input from the Healthcare Coalition when requested and appropriate.

B. Scope

This plan will address all coalition members.

C. Assumptions and Limitations

Reference other plans to include but not limited to District 2 Response Plan, District 2 Communications Plan, and District 2 Resource Plan. *Coalition background/governance- refer to the HCC Preparedness Plan or other base documents for specifics as pertinent*

Assumptions and Limitations

1. Each county jurisdiction maintains policies and procedures regarding public information and media relations, operating independent joint information systems.
2. Individual organizations may have individual policies and procedures regarding public information and media relations.
3. Jurisdictional public health has health officers and spokespersons regarding public information and media relations.
4. The District HCC's role in public information is primarily coordination, not direct delivery or dissemination of information to the media.
5. The District HCC will not release information directly to the public or media.
6. The District HCC can assist with notification to authorities in the event of an emergency (IDOH, IDHS, BOAH, DNR).

II. CONCEPT OF OPERATIONS

A. General

Health care organizations, HCCs, and public health departments should work with their community's Joint Information Center (JIC) to ensure information is accurate, consistent, linguistically and culturally appropriate, and disseminated to the community using one voice during an emergency.

The District 2 HCC does not employ a PIO and would like to rely upon the counties or local jurisdiction's PIO to disseminate an appropriate message on behalf of the coalition. The HCC shall establish contact through the local Emergency Operations Center (EOC) should communication be deemed necessary. The HCC shall not provide information to the local Joint Information Center (JIC) on behalf of a singular member of the HCC, but it is the expectation that each agency represents itself at an established JIC or JIS. The HCC can assist with notifications to required authorities as needed. (Example: Avian Influenza-IDOH, BOAH, DNR)

B. Joint Information Systems

The Joint Information System (JIS) provides the mechanism to organize, integrate, and coordinate information to ensure timely, accurate, accessible, and consistent messaging across multiple jurisdictions and disciplines with nongovernmental organizations and the private sector.

HCC members should coordinate relevant health care information with the community's JIS to ensure information is accurate, consistent, linguistically and culturally appropriate, and disseminated to the community using one voice. Coordinated health care information that could be shared with the JIS includes but is not limited to:

- Current healthcare Agency operating status
- When and where to seek care
- Alternate care site locations
- Screening or intervention sites
- Expected health and behavioral health effects related to the emergency
- Information to facilitate reunification of families
- Other relevant healthcare guidance, including preventive strategies for the public's health

C. Joint Information Center

The JIC is a central location that facilitates the operation of the JIS, where personnel with public information responsibilities perform critical emergency information functions, crisis communications, and public affairs functions.

JICs may be established at various government levels or at incident sites or can be components of Multiagency Coordination (MAC) Systems (e.g., MAC Groups or EOCs). A single JIC location is preferable, but the system is flexible and adaptable enough to accommodate virtual or multiple JIC locations, as required.

D. HCC Public Information Considerations

If the HCC deems a message necessary, the executive board shall approve a message by a quorum to be disseminated to the JIC/JIS. For example:

1. HCC Press Releases and Media Relations

The HCC will not speak directly with the press or media. Individual members shall follow their policies regarding messaging to the media.

2. HCC Spokesperson

If it is deemed necessary to provide a statement, the executive board shall designate a board member with PIO training to work with the JIC/JIS to release statements.

3. HCC Public Information Membership Approval

The executive board shall vote on the messaging for approval; a quorum must be obtained. If a quorum is unavailable, the chair and co-chair of the HCC will decide whether the messaging should be shared with the JIC or JIS.

E. External Affairs and Social Media

The HCC maintains a website that the District Webmaster operates. Messaging on this website is limited to what is approved for public consumption as this is not a “members only” or private website. Specific event information will not be shared on this page.

III. STATE PUBLIC INFORMATION RESOURCES

A. Indiana State Department of Health

The Indiana Department of Health (IDOH) Office of Public Affairs (OPA) promotes trained PIOs, maintains the IDOH Crisis Emergency Risk Communication (CERC) plan, designates IDOH spokespersons, and oversees the development of press releases and external affairs with the public and media.

During a public health/bioterrorism emergency or incident, the IDOH OPA will coordinate and deliver public health information using risk and crisis communication theory and best practices to the public through every available channel, including:

- The media (through a JIC, if activated);
- The IDOH website;
- The IDOH phone bank;
- Community meetings;
- Distributed flyers;
- Through partners/stakeholders; and
- Social media websites

These operations will be accomplished in close coordination with the Governor’s Press Office, the Indiana Department of Homeland Security (IDHS) PIO, other appropriate State agency PIOs, and local health department officers or administrators by federal, state, and local emergency plans.

B. Indiana Joint Information Center (JIC)

The Indiana JIC is located and managed by the IDHS. It includes representatives from multiple agencies and organizations collaborating to provide the public with a unified message regarding response and recovery efforts. The JIC communicates information regarding the provision of assistance in an accessible format. The IDOH participates with the State JIC in incidents where multiple jurisdictions or multiple levels of public health information are required. The JIC additionally coordinates with ESF-15 External Affairs within the State EOC when activated and staffed.

C. Public Information Officer Training

The HCC does not provide PIO training; however, the following courses may be referenced.

Recommended PIO and JIS Related Training	
Course	Provider
NIMS IS-100,200,700, 800	FEMA Independent Study/Elkhart County EMA
NIMS Public Information Systems IS-702	FEMA Independent Study
CDC Crisis and Emergency Risk Communication	CDC Online Training
Optional Advanced or Additional Training	
Course	Provider

NIMS IS-300	State Delivered
Public Information Officer Awareness IS-29	FEMA Independent Study
Social Media in Emergency Management IS-42	FEMA Independent Study
Basic Public Information Officer G290	State Delivered / Emergency Management Institute
JIS/JIC Planning for Tribal, State, and Local PIOs G291	State Delivered / Emergency Management Institute
Working with the Media AWR 209	State Delivered/TEEX
Public Information in an All-Hazards Incident MGT-318	State Delivered/TEEX

III. RESOURCES

A. County Public Information Officers

County Public Information Officers				
Organization	Name	Title	Phone	Email
SJCEMA	Al Kirsits	Director	574-360-9345	akirsits@sjcindiana.com
SJCEMA	Jim Lopez	Deputy	574-876-6737	James.lopez@sjcindiana.com
Marshall County	Stan Klotz	President Board of Commissioners	Confidential	klotzleasinginc@hotmail.com
Marshall County	Kevin Overmyer	Board of Commissioners	Confidential	kgovermyer@gmail.com
Marshall County	Jack Garner	EMA Director	574-341-4536	ema@co.marshall.in.us
Elkhart County	Jennifer Tobey	Elkhart County EMA Executive Director	574-238-0144	jtobey@elkhartcounty.com
Fulton	Bryan Lewis	President Board of Commissioners	Confidential	blewis@co.fulton.in.us
Fulton	Richard Ranstead	Vice-President Board of Commissioners	Confidential	rrandstead@co.fulton.in.us
Fulton	David Sommers	Board of Commissioners	Confidential	dsommers@co.fulton.in.us
Fulton	Dawn Sewell	Fulton County EMA Director	574-835-0191	ema@co.fulton.in.us
Kosciusko	Kip Shuter	Kosciusko EMA Director	574-371-2602	kshuter@kosciusko.in.gov
Kosciusko	Doug Light	PIO	(574) 265-5012	dlight@kcgov.com
Starke County	Victoria Chessor	EMA Director	219-205-2057 or 574-806-1838	V.chessor@starke.in.gov
Pulaski County	Richel Fox	EMA Director	(574) 946-6391 (574) 242-2508	Pulaskiema@pulaskicounty.in.gov

B. Health Department Spokespersons

Health Department Spokespersons				
Organization	Name	Title	Phone	Email
Elkhart County Health Department	Melanie Sizemore	Health Officer	574-276-1197	msizemore@elkhartcounty.com
Marshall County Health Department	Brian Holm	Health officer	C: 574-286-0200	Bholm@lifeplexmedical.com
Marshall County Health Department	Ryan Begg	Administrator	219-210-2218	healthadmin@co.marshall.in.us
Pulaski County Health Department	Dr. Day	Health Officer	574-946-6080	tday@pulaskicounty.in.gov
St. Joseph County Dept of Health	Matthew Gotsch	Communications and Events Specialist	O: 574-235-9750 x7962 C: 574-876-1995	mjgotsch@sjcindiana.com
Fulton County Health Department	David Kevin Reyburn, MD	Health Officer	574-835-1183	kreyburn@woodlawnhospital.com
Fulton County Health Department	Allison Foster	PHN/Administrator	574-223-5152	afoster@co.fulton.in.us
Kosciusko County Health Department	Dr Eric Waldo	Health Officer	765-717-9619	ewaldo@iuhealth.org
Kosciusko County Health Department	Thomas Howard, DO	Board of Health Member	574-269-5329	tzhder@comcast.net
Starke County Health Department	Frank Lynch	Nurse/Administrator	574-772-9137	flynch@starke.in.gov

C. Healthcare Organization Public Relations

Healthcare Organization Public Relations				
Organization	Name	Title	Phone	Email
Beacon	Heidi Prescott	SR Media Relations Specialist	(574) 807 –2884	hprescott@beaconhealthsystem.org
Beacon	Cheryl Kennison	VP Marketing	(937) 974-4614	ckennison@beaconhealthsystem.org
Goshen Health	Liz Fisher	Marketing Specialist	O: 574-364-2776 C: 574-238-4556	lfisher2@goshenhealth.com
St Joseph Health System Mishawaka and Plymouth Campuses	Thomas VanNevel	PIO	574-404-1048	Thomas.VanNevel@sirmc.com
Lutheran Kosciusko Hospital	Laura Cormody	Director of Marketing	260-435-6798	lcormody@lhn.net
Parkview Kosciusko Hospital	Jessica Foor	Communications Director	260-602-9222	Jessica.Foor@parkview.com
Pulaski Memorial Hospital	Brian Ledley	Director of Communications	574-946-2148	bledley@pmhnet.com
Northwest Health Starke Hospital	Kelly Credit	Market Director- Marketing and Community Relations	O: 219-983-8586 C: 219-510-2222	Kelly.credit@nwhealthin.com
Northwest Health Starke Hospital	Karen Keltner-Karolzak	Regional Manager – Marketing	O: 219-983-8630 C: 219-242-2026	Karen.keltnerkarolzak@nwhealthin.com
Unity Hospital	Jennifer Medich	PIO	574-231-6134	Jennifer.medich@umsh.net
Woodlawn Hospital	Khrista Boster	Director of Marketing		kboster@woodlawnhospital.com
Woodlawn Hospital	Alan Fisher	Hospital CEO		afisher@woodlawnhospital.com
Woodlawn Hospital	Paula McKinney	Chief Nursing Officer	574-224-1171	pmckinney@woodlawnhospital.com
Woodlawn Hospital	Troy Phillipy	Director Emergency Department	574-224-1136	tphillipy@woodlawnhospital.com

D. County Joint Information Centers

County Joint Information Centers				
Jurisdiction	Location	JIC Contact	JIC Phone	JIC Email
St Joseph	EMA	Al Buddy Kirsits	574-360-9345	ajirsits@sjcindiana.com
St Joseph	EMA	Jim Lopez	574-876-6737	James.lopez@sjcindiana.com
Marshall County	Marshall County Building Room 207 112 W. Jefferson Street Plymouth, IN	Jack Garner	574-341-4536	ema@co.marshall.in.us
Kosciusko	221 W Main St. Warsaw	Doug Light	574-265-5012	dlight@kcgov.com
Elkhart County EMA	26861 Cr 26 Elkhart, IN 46517	Jennifer Tobey	574-238-0144	jtobey@elkhartcounty.com
Fulton County EMA	1728 E SR 14 Rochester IN	Dawn Sewell	O: 574-223-6611 C: 574-835-0191	ema@co.fulton.in.us
Starke County EMA	53 E. Mound ST. Knox, IN 46534	Victoria Chessor	219-205-2057 or 574-806-1838	V.chessor@starke.in.gov
Pulaski County	108 N. Franklin St. Winamac, IN 46996	Richel Fox	(574) 946-6391 (574) 242-2508	pulaskiema@pulaskicounty.in.gov

INDIANA DISTRICT 2 HEALTHCARE COALITION

Disaster Behavioral Health Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

This plan describes the District 2 Healthcare Coalition's (HCC) role in Disaster Behavioral Health and lists resources available to assist coalition members in responding to incidents.

B. Scope

This plan applies to all coalition members and should be utilized after activating the affected facility's Emergency Operations Plan and when its resources are in use and additional resources are necessary. Depending on the situation, it will be the facility's responsibility to arrange for resource assistance unless requesting the assistance of the coalition's leadership.

C. Assumptions and Limitations

Reference the D2 HCC Response and Communication Plans for information on activating the coalition to assist with coordination. Those documents state that the affected Agency will ultimately be responsible for activating its plan, requesting the coalition activate, and organizing its resources.

Assumptions and Limitations

1. Each county within the District may have various community mental health centers, psychiatric residential facilities, or other behavioral and mental health services or groups that can provide additional behavioral health services.
2. Many healthcare organizations may have behavioral health services as part of their regular provision of services.
3. Several public safety organizations may have chaplaincy programs within the organization.
4. Many jurisdictions may have faith-based or other non-governmental organizations that assist with behavioral and mental health.
5. Jurisdictional public health may support behavioral health services and resources as the ESF-8 coordinating agency for the jurisdiction.
6. The HCC's role in behavioral health services is primarily coordination, not direct provision of service.

II. CONCEPT OF OPERATIONS

A. General

Disaster behavioral health provides mental health, substance abuse, and stress management services to disaster survivors and responders. Following an event, it is common for individuals, families, and disaster responders to experience distress and anxiety about safety, health, and recovery. Behavioral health professionals trained in disaster response often work in shelters and medical and psychiatric facilities or may engage in community outreach and educational activities to facilitate the resiliency and recovery of survivors and responders.

The HCC will assist member facilities in accessing resources available within the district. It will be the affected facility's responsibility to organize the space and times for resource utilization.

B. Behavioral Health Needs

Emergencies may cause severe emotional impacts on survivors, their families, and responders and may additionally cause substantial destabilization of patients with existing behavioral health issues. Behavioral health organizations are valuable HCC members and can support survivors, responders, and people with pre-existing behavioral health concerns.

C. Behavioral and Mental Health Information

The HCC will work with local Emergency Operation Centers (EOCs) and local media through a Joint Information Center to provide information regarding Behavioral Assistance available in the District during an event. The HCC will work with providers and public health to draft statements regarding acute stress symptoms but will not be responsible for disseminating such information.

D. Behavioral and Mental Health Service Surge

1. Agency Surge

During a surge of patients at behavioral health facilities, the coalition may be able to assist with contacting resources to obtain bed counts and other resource information. However, it will be the affected Agency's responsibility to arrange for placement at the appropriate level of care and consider the age of the patient. In addition, the HCC may be able to assist with organizing transport resources and contacting transport agencies. The affected Agency will be responsible for patient tracking to ensure prompt departure and arrival.

2. Community Surge

In the event of a community-wide surge of behavioral health needs, the HCC will work with the local EOC to assist in organizing resources. The coalition will not be responsible for arranging space or shelter; it will only assist with resources to provide mental health support.

Mobile Integrated Health Teams

Organization	County	Services Provided and Age Range	Capacity (# of beds, etc.)	24/7 Contact	Phone	Email
Goshen Fire Department	Elkhart	Outpatient mental health and addiction – all ages		911	574-533-7878	andrewpriem@goshencity.com
Oaklawn	Elkhart & St Joseph	Outpatient mental health and addiction – all ages (both counties)		On-Call (574 533-1234	Emily Neufeld (574) 533-1234	Emily.neufeld@oaklawn.org

Behavioral and Mental Health Teams

This section will identify hospitals, teams, and other behavioral health providers that are participating in the district.

Organization	County	Services Provided and Age Range	Capacity (# of beds, etc.)	24/7 Contact	Phone	Email
Epworth Hospital	St. Joseph	Ages 13 – geriatric aged patients. Inpatient mental health care.	126 beds	(574) 274-3330 House Supervisor	Memorial Switchboard (574) 647-1000	N/A
Elkhart General Center for Behavioral Medicine	Elkhart	18 or older, whose mental condition warrants acute inpatient psychiatric care and who can emotionally, behaviorally, and physically (to the extent that their illness allows) participate in the program and can be expected to profit from the therapeutic,	12	(574) 274-3330 (Epworth House Supervisor)	Elkhart General Switchboard (574) 294-2621	N/A

		diagnostic , evaluative , and treatment services offered.				
Michiana Behavioral Health Center 1800 North Oak Drive, Plymouth IN 46563	Marshall	51 inpatient beds – children, adolescents, adult psych, adult detox 29 residential beds (PRTF) – children, adolescents	51 inpatient beds 29 residential beds			
Oaklawn Psychiatric Center, Inc.	St. Joseph & Elkhart	Outpatient mental health and addiction – all ages (both counties)		On-Call (574) 533-1234	Emily Neufeld (574) 533-1234	Emily.neufeld@oaklawn.org
		Youth residential (Mishawaka)	100 beds			
		Adult inpatient (Goshen)	16 beds			
		Adult group homes (South Bend, Goshen)	39 beds			
Bowen Center	Kosciusko	Inpatient Hospital	20 Beds	Desk Nurses at IPH	1-800-342-5653	Dan.carey@bowncenter.org

Corporate Offices: 2621 E Jefferson Street, Warsaw, IN, 46580		(Kosciusko) 3 adult transitional living facilities – 30 total beds 2 Primary Care Health clinics (Kosciusko and Marshall) 1 Community Center with before and after school youth programs and resale store that provide work opportunities for the underserved areas (Kosciusko).	30 Beds total	or Dan Carey, Sr. VP Health Care Quality Elizabeth Bearman, Quality Manager	574-269-0564 Direct Line 574-269-0574 Direct line	elizabeth.bearman@bowencenter.org
	Allen	1 MAT Facility				
	Multiple Counties (Allen, DeKalb, LaGrange , Steuben,	12 outpatient facilities and primary care				

	Noble, Whitley, Kosciusk o, Marshall, Wabash, Huntingt on)	health clinics				
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III. PSYCHOLOGICAL FIRST AID

Psychological First Aid (PFA) is an evidence-informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Individuals affected by a disaster or traumatic incident, whether survivors, witnesses, or responders to such events, may struggle with or face new challenges following the event. PFA was developed by the National Child Traumatic Stress Network and the National Center for PTSD, with contributions from individuals involved in disaster research and response.

PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. PFA does not assume that all survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (e.g., physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.

Free online training is available at the National Child Traumatic Stress Network:

<https://learn.nctsn.org/>

The HCC encourages its member organizations to have staff members trained in PFA or other Incident Stress Debriefing methods.

IV. RESILIENCE AND EMOTIONAL SUPPORT (REST) TEAMS

The Indiana Family and Social Services Administration (FSSA) coordinates REST Teams nationwide. These teams are staffed by a coalition of the Community Mental Health Centers in each district and can be activated by the Emergency Management Agency or FSSA.

REST Teams provide short-term emotional intervention focusing on practical needs PFA and referrals for further support.

District 1 and 2 Coordinator: Ryan Begg 317-617-0627

Community REST (Resilience and Emotional Support Teams) Centers:

Counties	Organization	Contact	Email	Phone
<i>Marshall Kosciusko</i>	<i>Bowen Center</i>	<i>Tim Nussbaum Dan Carey Elizabeth Bearman</i>	Tim.nussbaum@bowncenter.org Dan.carey@bowncenter.org Elizabeth.bearman@bowncenter.org	574-269-0592 574-269-0564 574-269-0574
<i>Elkhart St Joseph</i>	<i>Oaklawn Psychiatric Center, Inc.</i>	<i>Emily Robinson</i>	emily.robinson@oaklawn.org	(574) 533-1234

<i>Fulton Pulaski</i>	<i>Four County Counseling Center</i>	<i>Hope Kerns</i>	<u>hkerns@fourcounty.org</u>	<i>(574) 870- 5697</i>
<i>Starke</i>	<i>Porter Starke Services</i>	<i>Sandy Carlson</i>	<u>scarlson@porterstarke.org</u>	<i>(219) 476-4557</i>
<i>St Joseph</i>	<i>Meridian Health Services</i>	<i>Amy Schemoel</i>	<u>Amy.shemoel@meridianhs.org</u>	<i>(219) 688-1455</i>

INDIANA DISTRICT 2 HEALTHCARE COALITION

Communications Plan Annex



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

I. INTRODUCTION

A. Purpose

This annex will provide communication priorities and systems for use during an emergency event.

B. Scope

This annex applies to all District 2 Healthcare Coalition (HCC) member agencies, local authorities, State, and Federal. This annex shall be activated by notification to the HCC or confirmation by the HCC that an event has occurred, and facilities are affected by the event. This annex does not supersede any member agency’s plan or local jurisdiction plans.

C. Situations and Assumptions

This annex shall be activated when the HCC Liaison Officer position activates, at that time situational awareness updates may be requested or shared via a communication platform described in the next section.

Assumptions and Limitations

1. Communications equipment and access may greatly vary among the HCC membership.
2. Many systems utilized by the HCC are administered by the State.
3. Some methods of communication, such as Radio, are impractical on a district-wide geographical boundary.
4. Each member agency will be responsible for ensuring they have the appropriate means of communication available.
5. Each member agency is responsible for communication within their own facility.
6. Member agencies are expected to participate in communications testing.

II. CONCEPT OF OPERATIONS

A. General

The capability to exchange verbal and written (documented) information is essential to incident response. The ability of the HCC to rapidly transition to a response state requires that some baseline communications capabilities are functional 24/7/365. However, some communications systems and technologies will only be relevant or available during a disaster or other public health emergency. This annex will cover both those modalities and systems that are regularly in use and those that are only used during an emergency.

B. Information Systems and Platforms

The following platforms identify redundant communication systems to be utilized within the HCC.

State Communication Systems Utilized		
System	Provider	Access
Telephone (Cell and Land Line)	Multiple	All HCC members
Email	Multiple	All HCC members
700/800 P25 SAFE-T Network Base Template*	IPSC	All public safety, public health, hospitals, emergency management, and government
700/800 MHz P25 SAFE-T Network, IDOH Template*	IDOH (via IPSC)	State Health, Local Health, Hospitals
UHF/VHF Radio	IDHS	Public Safety
HAM Radios	Multiple	All HCC members
WebEOC	IDHS	All public safety, public health, hospitals, emergency management, and government
EMResource	IDOH	All public health, healthcare, emergency management, and participating in public safety and PSAP
Preparis	D2	All HCC Members
Indiana Health Alert Network (IHAN-IN)	IDOH	All public health, healthcare, public safety, emergency management, and other
State Emergency Registry of Volunteers for Indiana (SERV-IN)	IDOH	All public health, healthcare, and others utilizing volunteers

* Reference IDOH P25 Radio Reference for State Talk group designations

C. Communication Utilization

The coalition shall use redundant means to communicate situational awareness with the coalition membership. For example, notifications can occur using the mass notification system, situational awareness may be shared via mail or additional mass messaging. Communications tests shall occur to ensure the functionality of equipment and operator familiarity with the systems.

D. Communications Continuity

The HCC shall rely primarily upon phone communications when available. Should the primary means fail, the following list describes the order in which communication systems shall be utilized:

- a. Cellular telephone and text messaging
- b. E-Mail
- c. Preparis/Serv-In
- d. Web EOC (<https://eoc.in.gov/eoc7/>) - refer to WebEOC User Guide
- e. EMResource
- f. 800 MHz Radio
- g. Facsimile
- h. Ham Radio (County Emergency Management Agency (EMA) Resource)

Should a system be determined to be ineffectual during an event, the HCC shall communicate the alternate system to ensure situational awareness and support is not affected.

E. Communications Testing:

- 1. Indiana District 2 HCC will test its communications plan monthly.
- 2. The testing method will be comprised of 800 MHz radio testing and a mass communications platform (Preparis, Serve-In).

HEALTHCARE COALITION PEDIATRIC SURGE ANNEX-G

Indiana District 2 Healthcare Coalition

January 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
6/13/23	3 4	Added this record of changes page. Table of contents	Jennifer Tobey
6/2024	Random	Grammatical corrections	Jennifer Tobey
5/2025	Random	Review/update	Jennifer Tobey
1/2026	Random	Whole plan review	Jennifer Tobey

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INTRODUCTION

A. PURPOSE

This annex applies to a mass casualty event with many pediatric patients. It supports the (HCC) Healthcare Coalition Response Plan by addressing specific needs of children and supporting appropriate pediatric medical care during a disaster. This plan is intended to support, not replace, any existing facility or agency policy or plan by providing uniform response actions in the case of an emergency that involves (or could involve) significant numbers of children.

B. SCOPE

The HCC Pediatric Surge Annex provides guidance to District 2 healthcare coalition members in relation to pediatric surge trauma needs. This annex also takes into consideration the national best practices and lessons learned while leveraging District 2's specific strengths and weaknesses.

C. SITUATIONS AND ASSUMPTIONS

The following situations and assumptions apply to this annex:

1. Indiana's Healthcare Coalitions are involved in ongoing preparedness activities.
2. Activation depends upon the locality or jurisdiction of where the incident occurs.
3. Activation of this annex shall only occur if the affected agency has activated their Emergency Operation Plan (EOP).
4. The medical surge plan applies to an event that results in a number or type of patients that overwhelm the day-to-day capacity of hospitals.
5. It is impossible to plan for every type of disaster.
6. Member agencies shall have in place a surge plan to address influx of patients, discharge, specialty populations, and patient tracking procedures.
7. Member agencies shall have within their EOPs plans to conserve/ration supplies or activate any crisis standards of care plans.
8. Each member agency will provide bed and resource availability in a timely manner.
9. Agencies that provide inpatient or outpatient services will have an emergency credentialing policy.
10. Each individual facility is responsible for formulating their own respective surge plans to include alternate care sites and crisis standards of care plans.
11. The HCC and each member agency will provide bi-directional situation awareness updates.
12. Local response may be overwhelmed by the time regional, or state response is active.
13. An event that causes a medical surge situation often has far-reaching consequences and can impact the entire HCC.

D. BACKGROUND OF EMSC AND PEDIATRIC READINESS

Enhancing the pediatric readiness of Emergency Departments (EDs) and Emergency Medical Services (EMS) agencies is vital to improving the quality of care and outcomes for ill and injured children. To achieve this goal, the U.S. Health Resources and Services Administration (HRSA), EMS for Children (EMSC) Program and the EMSC Innovation and Improvement Center (EIIC) have partnered with the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association to support quality improvement.

At the state-level, Indiana Emergency Medical Services for Children (IEMSC) focuses on improving the quality of emergency care for children with serious injuries and illnesses by integrating the unique needs of children into the existing hospital and EMS system. IEMSC advocates for child-specific medical concerns within the healthcare community, working to ensure that children throughout Indiana have access to timely and appropriate emergency medical care. More information is available at <http://www.indianaemsc.org/>.

IEMSC offers a voluntary program, Indiana Facility Recognition for Pediatric Readiness, which recognizes hospitals that have demonstrated their ability to provide advanced pediatric care for most pediatric medical emergencies, including illnesses and injury. Two levels of recognition are achievable by hospitals – Pediatric Ready and Pediatric Advanced. This voluntary facility recognition program identifies hospitals which meet specific criteria for personnel training, equipment, and facilities that support optimal care for ill or injured infants, children, and adolescents.

Nationwide, there is a renewed focus on ensuring that hospitals have pediatric-specific care available. The National Pediatric Readiness Project (NPRP) is a multi-phase quality improvement initiative to ensure that all U.S. emergency departments have the essential guidelines and resources in place to provide effective emergency care to children.

E. ACCESS AND FUNCTIONAL NEEDS

The D2 HCC *At-Risk Individuals with Access and Functional Needs Plan* provides detailed demographic data about the pediatric population with access and functional needs.

Pediatric disabilities by age groups with the D2 HCC are:

Individuals with Disabilities in Indiana D2 Counties (2024 Estimate) ¹								
DISABILITY	ELKHART	PULASKI	ST JOSEPH	FULTON	KOSCIUSKO	MARSHALL	STARKE	
Under 5 years								
Hearing Difficulty	572.5	24	643	45	194	111	49	
Vision Difficulty	371	16	418	29	126	72	32	
5-17 years								
Hearing Difficulty	7,062	432	9,414	694	2,746	1,600	802	
Vision Difficulty	4580	281	6,106	450	1,781	1,038	520	
Cognitive Difficulty	10,688	655	14,248	1,050	4,156	2,422	1,213	
Ambulatory Difficulty	13,933	854	18,573	1,369	5,418	3,157	1,581	
Self-Care Difficulty	5,153	316	6,870	506	2,004	1,168	585	

The HCC Emergency Management Agency members have identified locations of generators and plans to tap local resources in the event electricity is all that is needed to charge equipment. This will reduce surge on the hospitals if there is no medical necessity.

The HCC has resources that can help support pediatric mental and behavioral health:

Tele-psych services are available through some providers and facilities.

The HCC works with ancillary member organizations and providers, such as daycares and educational facilities, to consider how they can keep special education children safe during an incident and/or public health emergency, and provide care and services to injured, ill and well children to reduce surge on the hospitals if there is no medical necessity.

¹ <https://data.census.gov>

Special Education (2024) ²	
District 2	
Elkhart	4992
St Joseph	6333
Kosciusko	1851
Marshall	944
Pulaski	330
Fulton	359
Starke	468

F. DESIGNATED PEDIATRIC TRAUMA CENTER

All hospitals should be prepared to receive, stabilize, and manage, pediatric patients. However, given the limited number of pediatric specialty hospitals, an emergency affecting large numbers of children may require HCC and ESF-8 lead agency involvement to ensure those children who can most benefit from pediatric specialty services receive priority for transfer. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. EMS resources, including providers with appropriate training and equipment, should be prepared to transport pediatric patients. The HCC should promote its members' planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that are able to stabilize and/or manage pediatric medical emergencies.

The following table lists the pediatric centers of the district:

Pediatric Centers		
Name	Location	Capabilities
Memorial Hospital	615 N Michigan Street, South Bend 46601	NICU, PICU
Elkhart General Hospital	600 East Boulevard, Elkhart 46514	NICU
St. Joseph Health	5215 Holy Cross Pkwy, Mishawaka 46545	NICU

² <https://datacenter.kidscount.org/data/tables/1178-special-education-students?loc=16&loct=5#detailed/5/2292-2383/false/871,870,573,869,36,868,867,133,38,35/any/2563>

CONCEPT OF OPERATIONS

G. ACTIVATION

When an incident occurs resulting in pediatric victims, the initial response should follow local surge plans. Local hospitals and EMS agencies should access:

- Scope and magnitude of the incident,
- Estimate the influx of patients and the real or potential impact on the local health care system,
- Any special response needs (e.g., infectious disease, hazardous materials, etc.), and
- Internal response plan activation(s).

H. NOTIFICATIONS

The HCC would expect that local EMS providers have a plan to address the items in this table:

Medical Surge Elements to Incorporate into EMS Operations Plans	
Area	Area Description
Dispatch	<ul style="list-style-type: none">• Identify procedures to:<ul style="list-style-type: none">– Alert hospitals of an emergency per local protocol– Communicate hospital capacity and capability to EMS providers– All EMS surge requests, utilize mutual aid response plans per local protocol.
Response	<ul style="list-style-type: none">• Match appropriate specialized providers and equipment with the nature of the emergency (e.g., hazardous materials [HAZMAT] trained crews during a chemical spill)• Consider surge strategies such as changing shift lengths or crew configurations, using alternate vehicles, using community paramedicine, or other non-ambulance responses in coordination with dispatch priorities
Pre-hospital triage and treatment	<ul style="list-style-type: none">• Implement disaster triage procedures and other standard operating procedures (e.g., eliminate requirement for verbal orders)• Consider processes that allow for expanded scope of practice• Plan for specialty responses, such as HAZMAT, highly infectious disease, mass burn, mass trauma, and mass pediatric emergencies

Transportation	<ul style="list-style-type: none"> • Identify procedures to surge the numbers of patients transported per vehicle or aircraft • Identify procedures for changing preferred destination facilities (e.g., trauma center, pediatric hospital) or not using the closest hospital • Identify procedures for type and level of pre-hospital care delivery and mode of transport (ground and air medical) • Develop and implement EMS patient distribution strategies to avoid overloading any single hospital • Identify procedures for transporting patients to alternate care sites
Supplies and Equipment	<ul style="list-style-type: none"> • Utilize physical resources including supplies, equipment, and cached materials to support a medical surge

I. ROLES AND RESPONSIBILITIES

Health care organizations can most effectively implement and manage pediatric surge when appropriate information sharing systems and procedures have been established, appropriate plans for all levels of care and populations have been developed, and personnel have been trained and exercised in their use.

An emergency event will require the HCC and its members to share information, attain and maintain situational awareness, and manage and share resources, at a minimum. The HCC may help facilitate patient and resource distribution (or re-distribution) during a surge emergency. The healthcare organization’s Emergency Operations Plan (EOP) will help inform these efforts. The HCC will expect member agencies to enact their surge plans should an event result in an influx of pediatric patients to their facility. Upon activation of either the surge plan or the EOP, it is expected that the HCC be notified and provided a situational report on the event. The HCC will make the determination to notify the other member agencies and request bed availability or other resources as deemed appropriate or requested by the affected facility. The HCC will then follow the process defined in the Response Plan and related annexes and appendices.

- Initial coordination mechanism and information gathering to determine impact and specialty transportation and inpatient needs. This should include essential elements of information to be gathered on all patients according to coalition needs (e.g., name, age, weight, injuries/diagnosis, and care requirements for transport [e.g., IV drip medications, oxygen/vent support], and whether the minor has identified parents or a guardian).
- Documentation of available local, state, and interstate resources and activation procedures that can support the specialty response as well as key resource gaps that may require external support (including inpatient and outpatient resources). This should also include behavioral health support for patients, families, and staff.
- Access to local, regional, and national sub-specialty SMEs. (Note: this is not the same as the assigned pediatric SMEs that support response operations).

J. LOGISTICS

Strategies to Develop ED and Inpatient Pediatric Surge Capacity and Capability	
Area	Area Description
Emergency Department	<ul style="list-style-type: none"> • Make beds and surge spaces rapidly available for initial triage and stabilization, and obtain additional staff, equipment, and supplies.
General medical, general surgical, and monitored beds	<ul style="list-style-type: none"> • Ensure IBA (at least 20 percent additional acute hospital inpatient capacity within the first four hours following an emergency) by rapidly prioritizing patients for discharge, maximizing the use of staffed beds, and using non-traditional spaces (e.g., observation areas).
Critical care	<ul style="list-style-type: none"> • Rapidly expand capacity (for those facilities that provide it) by adapting procedural, pre- and post-operative, and other areas for critical care. • Assess staff, equipment, and supply needs for these spaces to facilitate requests.
Surgical intervention	<ul style="list-style-type: none"> • Secure resources, such as operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide time-sensitive, immediate surgical interventions to patients with life threatening injuries.
Clinical laboratory and radiology	<ul style="list-style-type: none"> • Rapidly expand basic laboratory services (e.g., hematology, chemistries, Gram stain, blood cultures), including mechanisms for staff augmentation and rapid reporting. • Consider use of point-of-care testing. • Rapidly expand radiology services (e.g., diagnostic radiology, ultrasound, computed tomography [CT]), including mechanisms for staff augmentation and rapid reporting.
Staffing	<ul style="list-style-type: none"> • Call back clinical and non-clinical staff; utilize staff in non-traditional roles. • Adjust staffing ratios and shifts as required and implement HCC member staff sharing plans.
Health care volunteer management	<ul style="list-style-type: none"> • Identify situations that would necessitate the need for volunteers in hospitals. • Identify processes to assist with volunteer coordination. • Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility.

	<ul style="list-style-type: none"> • Identify and address volunteer liability issues, scope of practice issues, and third-party reimbursement issues that may deter volunteer use. • Leverage existing government and non-governmental volunteer registration programs (e.g., State Emergency Registry of Volunteers for Indiana [SERV-IN] and Medical Reserve Corps [MRC]). • Develop rapid credential verification processes to facilitate emergency response
Equipment and supplies	<ul style="list-style-type: none"> • Implement emergency equipment, supplies and stocking strategies, and HCC resource sharing agreements.

K. SPECIAL CONSIDERATIONS

The following tables are representative of specialty hospitals or care within the region or within the state. The HCC will serve to assist with bed availability and resource sharing with these facilities.

Trauma Capability:

The HCC and its members should coordinate a response to large-scale trauma emergencies with all trauma system partners. All hospitals should be prepared to receive, stabilize, and manage trauma patients. However, given the limited number of trauma centers, an emergency resulting in large numbers of trauma patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from trauma services receive priority for transfer. Health care facilities should ensure sufficient availability of operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide immediate surgical interventions to patients with life threatening injuries.

During any event, the HCC serves as a situational awareness and resource coordinator. The HCC would send out alerts to the members and ask for information regarding resource availability.

The following table lists the trauma centers of the district:

Trauma Centers			
Name	Location	ACS Trauma Level	Capabilities
Memorial Hospital	615 N Michigan Street, South Bend 46601	2	
Elkhart General Hospital	600 East Boulevard, Elkhart 46514	3	

1. Behavioral Health

See Behavioral Health Decontamination

2. Evacuation

See District 2 Surge Plan, Evacuation and Tracking Annex.

3. Special Pathogens

See District 2 Emerging Infectious Disease Plan.

4. Security

The District 2 HCC will ensure that each facility has a detailed plan for resources for increased security at hospitals and should include planning for pediatric safe areas, family reunification sites, and the incident scene when children are present, as well as liaisons and resources provided by local law enforcement. Detailed plans for security at the facility / agency level should also consider protecting children against kidnapping and predation and include checklists for childproofing areas that are not intended for pediatrics.

L. OPERATIONS –COMMAND, CONTROL AND COORDINATION

- When the facility disaster plan is activated for a pediatric event the Pediatric Emergency Team (PET) should be activated by Click or tap here to enter text. This team consists of providers with pediatric-specific training.
- The following HICS positions may be assigned (in addition to usual HICS positions – assure that Mental Health Branch Director, PIO, and Liaison Officer are appointed to manage family and information issues):
 - Pediatric Technical Specialist (See Appendix A for template Job Action Sheet)
 - Pediatric Services Supervisor (See Appendix B for template Job Action Sheet)
 - Pediatric Safe Area Unit Leader (See Appendix C for template Job Action Sheet)
- The following HICS positions have pediatric-specific considerations in their Job Action Sheet:
 - Inpatient Unit Leader
 - Outpatient Unit Leader
 - Clinical Support Services Unit Leader
 - Nutrition/Food Services Unit Leader
 - Mental Health Branch Director
 - Victim Decontamination Unit Leader
 - Family Support Unit Leader
 - Access Control Unit Leader

1. Triage

Children may not evidence signs of shock until later than adults—careful evaluation is required. There is a tendency to ‘over-triage’ children, especially when they have visible significant wounds and/or are extremely distressed

Be careful not to over-commit resources because of first impressions of distress/wound appearance

- This may divert resources from patients that are more critical (less external ands, lethargic, etc.)

Pediatric providers should target care of those <8 years of age as they are most likely to benefit from specialty care.

2. Treatment

This section should include specific, actionable information on plan-specific pediatric needs and partnerships. Pediatric needs must be considered during the formation of all plans. However, if this section is not relevant to the plan it may be deleted.

This section should include considerations for treatment of pediatric patients, including how information on patients will be shared and transfers prioritized when the demand for specialty services or transport exceeds supply. It should also include how pediatric specialty consultation will be obtained by hospitals that are temporarily caring for complex patients and/or many pediatric patients to ensure the best care possible (e.g., telemedicine, or in some cases bringing specialty providers from a referral facility for consultation). Establish a process for regional level clinical management that addresses how information from SMEs, poison centers, and other specialists can be shared during an incident with hospitals, community clinicians, and others to aid in caring for children throughout the affected area. Rehabilitation services and coordination of continued care following the surge event should be discussed, including procedures for repatriation of any patients transferred out of the area.

M. TRANSPORTATION

Neonatal and some specialty patients may require specialized transport teams. Patients that require a referral that can sit may require car seats. The Transport Officer or designee is responsible for assuring that following car seats are safely installed, and children are appropriately restrained in the seat prior to transport.

Hospital Command Center will work with EMS and/or the District 2 Healthcare Coalition to coordinate appropriate transportation assets and staffing. Pediatric Technical Specialists should assist Command Center with patient lists and priorities.

In collaboration with the Emergency Nurses Association (ENA) and the Society of Trauma Nurses (STN), the “Inter-facility Transfer Toolkit for the Pediatric Patient” was created. This toolkit is a resource for facilities needing assistance in developing inter-facility transfer agreements and guidelines that integrate the needs of children and families as a requirement of being pediatric ready. The toolkit may be found at: <https://emscimprovement.center/education-and-resources/toolkits/interfacility-transfer-toolbox/>.

N. TRACKING

Patient tracking refers to several types of processes and documentation across patient movement. These types consist of:

- **Pre-Hospital Tracking**
Currently, EMS within District 2 tracks patient via paper methods during a surge event. There is not an established or consistent process in place.
- **Patient Movement Tracking**
Each agency providing inpatient, or outpatient care shall establish a means for tracking patients both within their facility and include a method for tracking when a patient is transferred from the facility.
- **Unidentified Patient Tracking**
Each member agency shall have in place a method for tracking and identifying those patients who arrive and are non-communicative or have no identification.
The HCC may be asked to assist with Family Reunification and shall work collaboratively with the EOC and ESF-8 officer to assist if a Family Assistance Center is established. The HCC may also request lists of patient names in accordance with HIPPA from member agencies to assist with family reunification.

O. REUNIFICATION

- Parents with colored bands matching may retrieve the child from the pediatric safe area when they can do so or work with the coordinator to arrange a safe place to stay if they require hospitalization and are unable to care for the child.
- Children with colored bands should have an Unaccompanied Child Form filled out and a digital photo taken. This information should be collected and shared with the Hospital Command Center.
- Hospital Command Center will establish a Hospital Support Center location.

- Family Support Center will determine ‘matches’ for children in the Safe Area. Parents should be able to produce a picture of the child with them or other concrete identifiers prior to any reunion/release if the child is not able to identify their parent and provide assent.
- Hospital support center should plan to demobilize the safe area and work with local Emergency Operations Center (EOC) to determine plans for children remaining unaccompanied after 12 hours.
- Any child without an apparent match at 12 hours should be reported to the clearinghouse of the National Center for Missing and Exploited Children as well as the Hospital Command Center, jurisdictional EOC, and Red Cross or other assisting community agencies. At this time, the child should undergo a physical and behavioral health screening per usual facility policy. Deactivation and Recovery.
- Disclaimer: This can be specific Facility requirements and onsite plan.

APPENDIX A: Pediatric Technical Specialist Job Action Sheet

Table A.1: Brief Job Description

Position Description:	The Pediatric Technical Specialist will provide guidance and develop policy on pediatric triage, treatment, transportation, and referrals/consultation during an incident with significant number of pediatric patients.
Reports to:	To be determined by individual hospital HICS framework. (Incident Commander or Planning Section Chief)
Minimum Required Qualifications:	<ul style="list-style-type: none"> • Pediatric specialist. • Completion of internal HICS training. • Knowledge of the Pediatric Surge Plan and internal hospital surge plans.

*****Read This Entire Position Checklist Before Acting*****

Immediate (0-2 hours)

___ Read this entire Job Action Sheet and review organizational chart.

___ Follow facility ICS process.

___ Maintain situational awareness of evolving incident. Obtain briefing from the Incident Commander or Operations Section Chief or another assigned individual.

___ Document any decisions and actions made during the response that will be vital in compiling an after report/improvement plan. (ICS 214)

___ Gather information from Casualty Care Supervisor/ED Charge Nurse regarding:

- Number of expected pediatric patients and their conditions

- Hazardous materials or decontamination issues
- Equipment, staff, or medication shortages/issues

___ Determine number of patients that may require transfer.

___ Determine patients that may be cared for at the facility and assure appropriate staffing and location with Inpatient Area Supervisor.

___ Determine additional staff or materials needed based on expected patient volume and communicate with Logistics Section Chief as required.

___ Liaison with community EOC or Regional Healthcare Preparedness Coordinator if multiple hospitals affected to determine transportation resources and timeline.

___ Determine best use of pediatric-capable staff with Pediatric Services Supervisor.

___ Coordinate referral consultation with Casualty Care Supervisor and other pediatric inpatient locations and assist with arranging inpatient transfers and transportation.

___ Provide expert input into decisions about priority for transfer to referral facility when transportation/referral capacity is limited.

Intermediate (2-12 hours)

___ Assess on-going staff and materials needs based on patient status reports

___ Assist Logistics and Planning Section Chiefs in detailing/obtaining additional resources:

- Recommend substitutions and adaptations as required.
- Provide policy guidance when pediatric resources must be triaged due to patient volumes or resource shortfalls.

___ Provide talking points to Public Information Officer to share with media and parents relative to the incident, victim care, decontamination/infection control, or other relevant issues.

___ Provide guidance on any just-in-time training required.

____ Ensure pediatric identification and tracking systems are implemented with Pediatric Services Supervisor.

____ Coordinate with Logistics and Planning Section Chiefs to expand/create additional Pediatric Patient Care areas, if needed.

____ Facilitate referrals and consultations as required with other facilities.

____ Continue to prioritize and assist with transfer coordination including priority for transfer, safe means of transport, staffing requirements, and in-transit care requirements.

____ Determine, with pharmacy, if any pediatric-specific dosing or formulation issues require action and provide guidance to address these issues.

____ Provide guidance and support as needed to clinical areas caring for pediatric patients.

Extended (>12 hours)

____ Participate in planning meetings and briefings as required by the Incident Commander or Planning Section Chief.

____ Continue to support facility needs for clinical policies and guidance.

____ Monitor and anticipate staff and supply issues and work with Logistics and Planning Section Chiefs to remediate issues.

____ Monitor and provide support for any ongoing transportation/transfers.

____ Provide support for on-site pediatric care issues and consultations.

____ Work with Public Information Officer on messages for the public, families, staff, and patients.

____ Assure rest, nutrition, and psychological support are available for staff, families, and patients.

____ Coordinate with Mental Health Branch Director for support and, if needed, evaluations of mental health of volunteers and children.

____ Track issues (successes and opportunities) for after-action analysis.

____ Upon shift change - brief your relief - including situation update, actions taken, issues and problems to be addressed, key contacts, and anticipated actions for the subsequent operational period.

Demobilization/Recovery

____ Return all assigned HICS equipment.

____ Upon deactivation of your position, ensure all documentation and operational logs (ICS 214) are submitted to the Operations Section Chief or Incident Commander as appropriate.

____ Brief the Operations Section Chief or Incident Commander as appropriate on problems, outstanding issues, and follow-up requirements.

____ Submit comments to Operations Section Chief or Incident Commander, as appropriate for discussion and possible inclusion in the after-action report. Topics include:

- Review of pertinent positions descriptions
- Operation checklist
- Recommendation for procedure changes
- Section accomplishments and issue

APPENDIX B: Pediatric Service Supervisor Job Action Sheet

Table B.1: Brief Job Description

Position Description:	The Pediatric Services Supervisor ensures the pediatric treatment and holding areas are properly assigned, equipped, and staffed during an emergency.
Reports to:	Operations Section Chief
Minimum Required Qualifications:	<ul style="list-style-type: none">• Pediatric specialist• Completion of internal HICS training• Knowledge of the Pediatric Surge Plan and internal hospital surge plans.

*****Read This Entire Position Checklist Before Acting*****

Immediate (0-2 hours)

___ Read this entire Job Action Sheet and review organizational chart.

___ Follow facility ICS process.

___ Maintain situational awareness of evolving incident. Obtain briefing from the Incident Commander or Operations Section Chief or another assigned individual.

___ Document any decisions and actions made during the response that will be vital in compiling an after report/improvement plan. (ICS 214)

___ Gather information from Casualty Care Supervisor/ED Charge Nurse regarding:

- Number of expected pediatric patients and their conditions
- Hazardous materials or decontamination issues
- Equipment, staff, or medication shortages/issues
- Current total number of Emergency Department patients.

___ Determine number of available pediatric beds (in-patient) and report to Operations Chief for planning purposes.

___ Determine on-site pediatric qualified staff members (MD, RN, RT, others)

___ Determine additional staff needed based on expected patient volume.

___ Alert Discharge Unit Leader to institute early discharge/or internal/external transfer of patients to open appropriate beds for pediatric patients as needed

___ Activate Pediatric Emergency Team as per plan:

- Predetermined Physicians (Pediatric/Family Practice/Staff/Community)
- Predetermined Nurses (with pediatric experience and/or PALS/ENPC certification)
- Predetermined ancillary technicians/others with pediatric experience

___ Determine if Pediatric Safe Area should be activated:

- Assign Pediatric Safe Area Coordinator and determine staffing

___ Communicate with Operations Chief to assure coordination with non-pediatric ancillary/support personnel

___ Assure preparation of required pediatric patient care areas:

- Clear area and designate each specific area per plan and based on expected casualties
- Assure support personnel are assigned to each area
- Assure delivery of medical and non-medical pediatric equipment
- Assure set-up of pediatric equipment by clinical staff

- Coordinate with Casualty Care Supervisor and other pediatric inpatient placement and assist with inpatient transfers and transportation as needed

Intermediate (2-12 hours)

___ Assess on-going staff and materials needs based on patient status report from:

- Pediatric healthcare personnel (emergency department, in-patient, OR)
- Non-pediatric ancillary /support personnel
- Pediatric Safe Area Coordinator and supplemental staff

___ Assist Logistics and Planning Section Chiefs in detailing/obtaining additional resources:

- Recommend substitutions and adaptations as required.
- Provide policy guidance when pediatric resources must be triaged due to patient volumes or resource shortfalls.

___ Assess additional medical and non-medical pediatric equipment/supply needs

- Communicate with Logistics in coordination with Medical Care Branch Director

___ Assure delivery of needed pediatric supplies

___ Obtain status of pediatric casualties (discharges, admissions, transfers, and Pediatric Safe Area) and report to Operations Chief

___ Assure information flow from Pediatric Safe Area to Hospital Support Center and via Liaison Officer to community Family Assistance Center

___ Ensure pediatric identification and tracking systems are implemented, to include identified, unidentified and unaccompanied children/victims

___ Obtain Pediatric Registration forms from all pediatric patient areas for unidentified and/or unaccompanied minors

____ Report any unidentified or unaccompanied pediatric patients to Operations Section and Hospital Support Center

____ Determine timing and process for demobilizing the Pediatric Safe Area and where remaining children will be sent until re-unified with caregiver

Extended (>12 hours)

____ Assure rest, nutrition, and psychological support are available for staff

____ Coordinate with Mental Health Branch Director for support and, if needed, evaluations of mental health of volunteers and children.

____ Track issues (successes and opportunities) for after-action analysis

____ Upon shift change—brief your relief—including situation update, actions taken, issues and problems to be addressed, key contacts, and anticipated actions for the subsequent operational period.

Demobilization/Recovery

____ Ensure return/retrieval of equipment and supplies and return all assigned HICS equipment

____ Upon deactivation of your position, ensure all documentation and operational logs (ICS 214) are submitted to the Operations Section Chief or Incident Commander as appropriate.

____ Brief the Operations Section Chief or Incident Commander as appropriate on problems, outstanding issues, and follow-up requirements.

_____ Submit comments to Operations Section Chief or Incident Commander, as appropriate for discussion and possible inclusion in the after-action report. Topics include:

- Review of pertinent positions descriptions
- Operation checklist
- Recommendation for procedure changes
- Section accomplishments and issue

APPENDIX C: Pediatric Safe Area Unit Leader Job Action Sheet

Table C.1: Brief Job Description

Position Description:	The Pediatric Safe Area Unit Leader will ensure the pediatric safe area (PSA) is properly staffed and stocked during an emergency and will ensure the safety of the children requiring the PSA until an appropriate disposition can be made.
Reports to:	To the Pediatric Services Supervisor (Operations).
Minimum Required Qualifications:	<ul style="list-style-type: none"> • Pediatric specialist. • Completion of internal HICS training. • Knowledge of the Pediatric Surge Plan and internal hospital surge plans.

*****Read This Entire Position Checklist Before Acting*****

Immediate (0-2 hours)

___ Read this entire Job Action Sheet and review organizational chart.

___ Follow facility ICS process.

___ Obtain briefing from the Incident Commander or Operations Section Chief or another assigned individual.

___ Document any decisions and actions made during the response that will be vital in compiling an after report/improvement plan. (ICS 214)

___ Determine if the pre-designated pediatric safe area is available

___ If not immediately available, take appropriate measures to make the area available as soon as possible or determine if a back-up area will be used

___ Gather information about how many children may present to the PSA and likely timeframe for family members to arrive to claim them

___ Assure enough staff is available for PSA (minimum staff: patients - <5yrs 1:7, >5yrs 1:15)

___ Assure adequate security staff is available for PSA

___ Establish adequate communication between PSA and the Hospital Support Center

___ Establish registry (sign in/out log) for PSA

___ Make sure that all items in PSA checklist have been met; if there are any deficiencies, address them as soon as possible and report them to the Pediatric Services Supervisor

Intermediate (2-12 hours)

___ Determine the need for ongoing staff or other support (food, bedding, entertainment, etc. for PSA)

___ Maintain registry of children in PSA as they arrive or are released to appropriate adult, complete unidentified and/or unaccompanied children registration forms

___ Determine expected duration of need for PSA and plans for demobilization – where will remaining children be sent?

___ Communicate with Pediatric Services Supervisor for planning/resource needs

___ Determine if there are any medical or non-medical needs of children in PSA

- ___ Provide informational updates for the children in the PSA
- ___ Sleeping space and supervision if needed
- ___ Snack and meal support as needed
- ___ Report frequently to Pediatric Services Supervisor concerning status of PSA

Extended (>12 hours)

- ___ Make sure that PSA staff have breaks, water, and food during their working periods
- ___ Coordinate with Mental Health Branch Director for support and, if needed, evaluations of mental health of volunteers and children
- ___ Document all action/decisions
- ___ Identify issues for after-action analysis

Demobilization/Recovery

- ___ Ensure all children in PSA have been released to an appropriate adult
- ___ Return equipment and supplies
- ___ Return space to original condition
- ___ Give PSA registry to Pediatric Services Supervisor
- ___ Brief Pediatric Services Supervisor on current conditions, issues, and follow-up requirements
- ___ Upon deactivation of your position, ensure all documentation and operational logs (ICS 214) are submitted to the appropriate HICS position

____ Submit comments to Pediatric Services Supervisor for discussion and possible inclusion in the after-action report. Topics include:

- Review of pertinent positions descriptions
- Operation checklist
- Recommendation for procedure changes o Section accomplishments and issue

APPENDIX D: Legal Authorities and References

Definitions		
Code	Usage	Description
IC 16-18-2-266.4	<i>Definition of Parent, Legal Guardian, Custodian</i>	<ul style="list-style-type: none"> • Parent, Legal Guardian, Custodian, or a minor including: <ul style="list-style-type: none"> ○ Parents with legal custody of minors. ○ Biological father of child if the father is married to the mother of the child and the mother has custody of the child, regardless of father’s custody status. ○ Legal guardian of the minor. ○ Legal custodian of the minor. • Parent, Legal Guardian, Custodian of a minor do not include prisons.
Emergency Declaration – Suspension of Laws		
Code	Usage	Description
IC 10-14-3-12	<i>Disaster Declaration; Governor’s Powers under a Disaster Declaration</i>	<ul style="list-style-type: none"> • Disaster declaration procedure. • Under a disaster declaration the governor can: <ul style="list-style-type: none"> ○ Suspend provisions of regulatory statutes. ○ Use state and local resources. ○ Use state agencies and personnel for emergency services. ○ Commandeer or use private property. ○ Assist in evacuations. ○ Suspend or limit the sale of alcohol. ○ Make provisions for temporary emergency housing. ○ Allow out of state health practitioners to practice in Indiana. ○ Give authority to allocate drugs, food, other resources, and services.
IC 10-14-3-11 IC 10-14-3-12	<i>Governor suspending laws</i>	<ul style="list-style-type: none"> • The governor may make, amend, or restrict orders, rules, and regulations during an emergency. • The governor may suspend provisions of regulatory statutes during a disaster declaration.
IC 10-14-3-22	<i>State agencies suspending laws</i>	<ul style="list-style-type: none"> • Indiana state agencies may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes.
IC 10-14-3-22	<i>Local governments suspending laws</i>	<ul style="list-style-type: none"> • Local governments may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes.

<p>IC 10-14-3-33.5</p>	<p><i>Regulation of Firearms during Emergencies</i></p>	<ul style="list-style-type: none"> • State and local governments cannot prohibit or restrict lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. • Exceptions include: <ul style="list-style-type: none"> ○ School property. ○ Property use for school functions. ○ School buses. ○ Post-secondary education institutions. ○ Emergency shelter care child caring institutions. ○ Domestic violence shelters.
Consent to Medical Care		
Code	Usage	Descriptions
<p>IC 34-18-12-9</p>	<p><i>Emergency Exception to Consent Requirement</i></p>	<ul style="list-style-type: none"> • Consent to health care is not required in an emergency.
<p>IC 16-36-1-3 IC 16-36-1-3.5</p>	<p><i>Age of Consent</i></p>	<ul style="list-style-type: none"> • Age of consent is 18 years old. • Exception to age of consent: <ul style="list-style-type: none"> ○ Emancipated minor. ○ 14- to 17-year-old who 1) is not dependent on parents, 2) not living with parents, and 3) managing his/her own affairs. ○ Marriage. ○ Military service. ○ At least 16 and pregnant. ○ Exposure to venereal diseases.
<p>IC 16-36-1-5 IC 16-36-1-17</p>	<p><i>Individuals who can Consent for Minors</i></p>	<ul style="list-style-type: none"> • The following individuals can consent to healthcare treatment for minors: <ul style="list-style-type: none"> ○ Judicially Appointed Guardians. ○ Parent or individual acting as a parent. ○ Adult sibling. ○ Grandparent. ○ Health care provider shall make a reasonable inquiry as to the availability of individuals who are able to provide health care consent.
<p>IC 16-41-6-2</p>	<p><i>Compulsory Testing for Communicable Disease</i></p>	<ul style="list-style-type: none"> • With a court order and convincing evidence of a serious and present health threat to others, the State Health Commissioner or local health officer may compel examination of an individual (including minors).
<p>IC 16-41-9-1.7</p>	<p><i>Immunizations</i></p>	<ul style="list-style-type: none"> • A minor may not be required to receive an immunization without the consent of the minor’s parent, guardian, or custodian.

		<ul style="list-style-type: none"> A minor can be put into isolation or quarantine if his/her parent, guardian, or custodian does not consent to immunization.
IC 10-14-3-23 IC 10-31-1-3 IC 16-35-1-10 IC 16-41-1-1	<i>Religious exception to compulsory medical treatment</i>	<ul style="list-style-type: none"> The government cannot compel a minor to submit to physical examination, medical treatment, or immunization if his/her guardian 1) decides to rely on spiritual means or prayer to prevent or cure disease or suffering, or 2) rejects to the medical examination or treatment on religious grounds.
Isolation and Quarantine		
Code	Usage	Description
IC 16-41-9-1.5 IC 16-41-9-1.6	<i>Isolation and Quarantine</i>	<ul style="list-style-type: none"> If a minor is in quarantine in a location other than the minor's home, a parent or guardian can remain with the minor in quarantine. The parent or guardian remaining with the minor in quarantine may be required to submit to vaccination or treatment for the disease which caused the quarantine. If an individual in quarantine is the sole parent or guardian of a minor who is not in quarantine, the minor will be placed in the residence of a relative, friend, or neighbor during the quarantine period.
IC 16-41-9-3	<i>Exclusion of Infected Student from School</i>	<ul style="list-style-type: none"> A local health officer can exclude a student, with a dangerous communicable disease that is transmissible through school contacts and possesses a substantial threat to the health and safety of the school community, from attending school. A certificate of health to readmit the student to school will be provided by the local health officer when the student is deemed to no longer have the dangerous communicable disease.
Bad Weather		
Code	Usage	Description
IC 16-19-3-6.5	<i>Safety Precautions for Children in Bad Weather</i>	<ul style="list-style-type: none"> The state must adopt guidelines for protecting children during bad weather conditions including blizzards, tornadoes, rainstorms, extreme heat, etc. Guidelines must include locations where children may be exposed to bad weather including schools, childcare centers, preschools, sporting events, and public parks.
Fatality		
Code	Usage	Description

IC 16-49	<i>Child Fatality Reviews</i>	<ul style="list-style-type: none">• Local and state teams may review sudden, unexpected, and unexplained deaths of children.• Local and state review teams shall identify factors surrounding the child’s death and determine if similar deaths can be prevented.
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INDIANA DISTRICT 2 HEALTHCARE COALITION

INFECTIOUS DISEASE PLAN



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

January 2026

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I. INTRODUCTION

A. Purpose

The purpose of this infectious disease outbreak plan is to outline the essential steps primary care facilities should take to care for infected patients and provide continuity of services to non-infected patients. It is intended to provide a broad view of infectious disease outbreak planning with the understanding that disease-specific information and guidance will provide more detail during the response.

B. Scope

This plan supports all applicable facilities within Indiana District 2 which includes Elkhart, Fulton, Kosciusko, Marshall, Starke, Pulaski, and St. Joseph counties. The plan is based on the Indiana District 2 Healthcare Coalition's all-hazards response plan and provides support and framework to each individual facilities plan. The scope of this plan is limited to infectious disease outbreaks that present public health emergencies.

C. Situations and Assumptions

- Infectious disease outbreaks that tax the public health and healthcare systems will occur.
- Vaccine, treatment, and/or reliable tests may or may not be available.
- Resources such as medical supplies and Personal Protective Equipment (PPE) may be limited.
- Guidance on management of infectious disease may change frequently and/or be inconsistent.
- Large-scale emergencies may disrupt schools and transportation making it challenging for staff to report to work.
- Disease outbreak may require a significant increase in data-reporting to public health authorities.
- Staff may have concerns about reporting to work.
- Risk communication may be challenging, particularly if messaging changes.
- Managing mental health concerns will be essential.
- Hospitals and public health authorities may push patients towards the primary care setting.
- Infectious disease outbreaks that tax our local birds and food sources (avian influenza)

D. Administrative Support

The Infectious Disease Plan will be reviewed and updated annually by the Planning Coordinator with updates to be approved by the Executive Committee, which consists of the core 4 members (Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representative), and membership of the coalition. Additionally, when exercises or real events warrant changes to the plan, the Planning Coordinator will be assigned an additional review at any time during the year. In addition, the following table shall be used to track changes in the document:

Update	Location in Plan	Name
3/2021	Draft Plan Created	
6/2021	Approved by HCC	Jennifer Tobey
6/2022	Reviewed, Approved	Jennifer Tobey
6/2023	Reviewed, Approved	Jennifer Tobey
6/2024	Updated notification matrix	Jennifer Tobey
5/2025	Review/Update/added Avian Influenza	Jennifer Tobey
1/2026	General review	Jennifer Tobey

E. Standard Precautions:

are designed to reduce transmission from both recognized and unrecognized sources of infection in healthcare facilities, and are recommended for all patients receiving care, regardless of the diagnosis or presumed infection status. For certain diseases or syndromes (e.g., smallpox, pneumonic plague, viral hemorrhagic fevers, influenza or other highly infectious respiratory illnesses, avian influenza), additional Transmission Based Precautions may be needed to reduce the likelihood for transmission.

➤ **Contact Precautions:**

1. Confer with infection prevention to determine what communicable disease is being considered.
2. If contact transmission is suspected or confirmed proceed to next step.
3. Admit patients to any unit as determined by bed availability and level of care needed.
4. Notify Distribution/Logistics Section to ensure adequate gowns and gloves for PPE use.
5. Follow Contact Precautions recommendations.

➤ **Droplet Precautions:**

1. Confer with infection prevention to determine what communicable disease is being considered.
2. If droplet transmission is suspected or confirmed proceed to next step.
3. Admit patients to units as recommended by infection prevention and incident command.
4. Notify Distribution/Logistics Section to ensure adequate surgical masks for PPE use.
5. Follow Droplet Precautions recommendations.

➤ **Airborne Precautions:**

1. Confer with infection prevention to determine what communicable disease is being considered.
2. If airborne transmission is suspected or confirmed proceed to next step.
3. Confer with Facilities/Infrastructure Branch to determine airflow and unit(s) capable of being isolated from other air handling unit(s) and ability to maintain negative air pressure.
4. Notify Distribution/Logistics Section to determine adequate PAPR's for use as PPE. Follow Airborne Precautions recommendations.

II. INSTRUCTION FOR USE

This plan is to be used in conjunction with a facility's all-hazard response plan and notification protocols. Response in an infectious disease outbreak will be coordinated with District 2 Healthcare Coalition (HCC), local emergency responders, Indiana Department of Homeland Security (IDSH) and Indiana Department of Health (IDOH). Response actions may need to be modified in accordance with disease-specific guidance and response needs.

A. Incident Management Actions (District)

*Reference D2 Response Plan-District 2 will support local agencies and ensure information sharing.

B. Command and Control (Local)

-Activation and deactivation

- The decision to activate Incident Command System (ICS) and open the Emergency Operations Center (EOC) will be made in accordance with local policies.
- Deactivation will occur upon completion of recovery operations under the authority of the Incident Commander.

-Incident Command System

- The incident will be managed under the organization incident command procedures.

C. Communications (District/HCC)

-During Normal Operations

- Facilities will remain in contact with HCC Executive Board or D2 Readiness and Response Coordinator (RRC) as needed and/or requested to provide situational awareness.
- Essential communication includes but is not limited to: activation, deactivation, suspension/resumption of services, critical resource shortages, and hazardous situations.
- The facility will maintain communications with staff regarding potential closure and/or other changes of services.

- HCC will assist with communication with necessary authorities, for example: BOAH, DNR.

-During Off-Hours or Facility Closure

*Reference Appendix A: HCC Notification Matrix

- Communication with HCC Executive Board or RRC and staff should be maintained, and updates provided.
- HCC will assist with communication with necessary authorities, for example: BOAH, DNR.

-The CDC Health Alert Network (HAN) and /OR the Indiana Health Alert Network (IHAN)

*Highly recommended that every facility has at least one individual signed up to receive alerts and notifications.

- HCC Executive Board and facility leadership should monitor the Health Alert Network.
- The HAN provides up-to-date information on urgent and emergent public health situations and maintains a document library of ongoing public health information and provides interactive facilities for providers to communicate with public health officials and one another.

D. Infection Control Support (Local)

* Actions based on Federal and State Health recommendations.

-Staff

- Monitor symptomatic employees and send them home if illness is suspected.
- Develop a policy for ensuring that sick employees or unvaccinated employees caring for sick family members remain home.
- Explore tele-work strategies to ensure that non-essential employees are well limiting their exposure to infectious patients.
- Implement an employee vaccination program.

-Patient Care

- Screen all patients, visitors, and employees for relevant symptoms at all points of entry and refer those people exhibiting symptoms to triage stations.
- Consider postponing visits and non-essential visits for uninfected patients.
- Set up stations that improve patient flow by separating triage stations based on symptoms with stations dedicated to patients with disease specific symptoms.
- Place surgical masks on patients with symptoms when transported throughout facility.
- Use higher level of protection if disease protocols indicate to do so.
- Develop protocol for communicating the presence of symptomatic patients to clinicians.

- Arrange seating in waiting areas so that symptomatic people are cohorted and social distancing protocols are followed in other areas.

-Communications

- Create and post signage in multiple languages for community.
- Develop a policy to communicate when and how to use medical resources.

-EMResource

- Used to document healthcare infrastructure capabilities.
- Used to identify resource availability and limitations.
- Provides real time visibility to healthcare status and patient throughput information.

-Visitor/Access Control

- Develop a process for access control to the facility and visitors screening protocols.
- Review visitation policies and protocols.

-Hygiene

- Implement a respiratory hygiene and cough etiquette policy.
- Implement a hand hygiene policy.
- Make tissues, masks, and alcohol-based sanitizers available for patients and visitors and provide appropriate receptacles for disposal of tissues and masks.

-Sanitation

- Establish protocol for cleaning frequently touched surfaces such as door handles, desks, phones, and elevator buttons.

E. Transportation (Facility)

- Assist with establishing Memoranda of Agreement (MOA) with medical transport companies to assist with transporting patients to other medical facilities.

F. Resource Management

➤ HCC

- Continually review updates to personal protective equipment recommendations made by CDC and Occupational Safety and Health Administration (OSHA).
- Ensure the maximum levels of disease-specific PPE are maintained throughout the District facilities.
- Offer training on donning, doffing and use of PPE.
- Make available PPE like surgical masks at all facility points of entrance and triage stations.
- Assist with communication and reporting to authorities, for example BOAH and DNR.

- ****See D2HCC Resource Management Plan****

➤ Local Facilities

- Provide policy support for receiving, documenting, and tracking resources offered by governmental channels.
- Ensure MOA with critical suppliers including those companies that deliver medical supplies, food and water.

G. Recovery (District/HCC)

- Track as facilities deactivate and return to normal operations.
- Re-stock supplies of PPE for facilities that need assistance and as a district.
- Conduct an after-action conference and develop an after-action report.
- Utilize the after-action report to create an involvement plan.

H. Exposure Classifications

*Facilities may use the following scale to assess exposure risks. Facilities should also reference health exposure requirements by OSHA or a site-specific hazard assessment.

Occupational Risk Pyramid



- **Very High Exposure Risk:** This category includes jobs with a high potential for exposure to known or suspected sources of infectious diseases specific to medical, postmortem, or laboratory procedures.
- **High Exposure Risk:** This category includes jobs with a high potential for exposure to known or suspected infectious disease workers which may include healthcare delivery and support staff, medical transport workers, and mortuary preparation employees.

- **Medium Exposure Risk:** This category of jobs includes those that require frequent and/or close contact with other people who may be infected with a virus.
- **Lower (Caution) Exposure Risk:** This category covers jobs that do not require contact with people known to be, or suspected of being, infected with, a virus.

I. Descriptions of Infectious Diseases

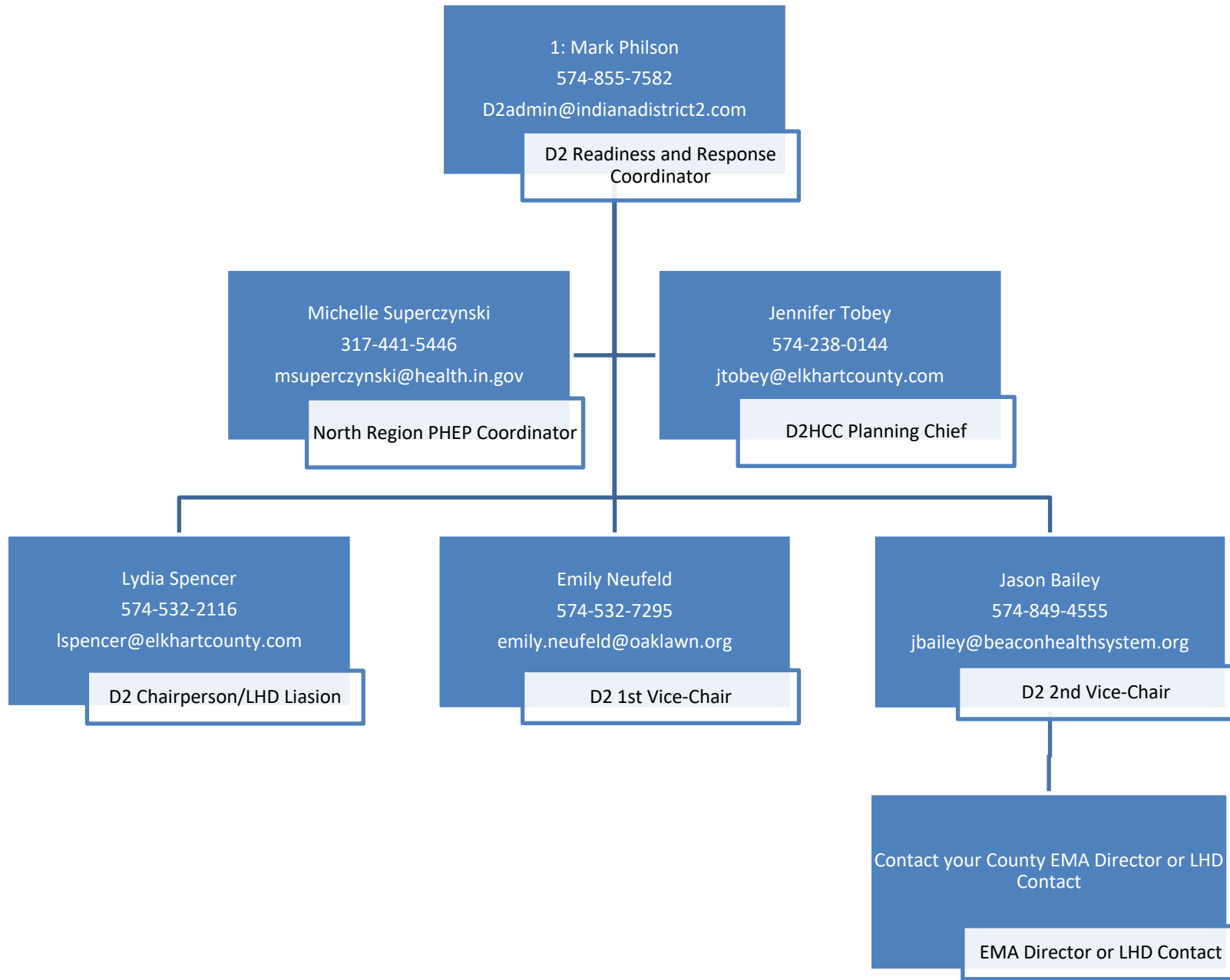
*Emerging infectious diseases are those whose incidence in humans has increased in the past 2 decades or threaten to increase in the near future. These diseases, which respect no national boundaries, can challenge efforts to protect workers as prevention and control recommendations may not be immediately available. The occupational safety and health community can prepare for these unpredictable disease outbreaks and prevent disease transmission with these resources for protecting workers, particularly healthcare workers, nurses, doctors, and first responders. Examples may include but are not limited to the following:

- **COVID-19:** The novel coronavirus outbreak originated in the Wuhan province of China. Symptoms may appear 2-14 days after exposure. The novel coronavirus is believed to spread from close person-to-person contact, primarily through respiratory droplets produced when an infected person coughs or sneezes.
- **Pandemic Flu-Influenza:** Influenza (FLU) viruses can cause a severe disease, even death. Flu viruses are grouped into three types:
 - Type A:** can affect both humans and animals and are associated with more severe disease.
 - Type B:** can infect only humans and cause seasonal outbreaks and less severe disease.
 - Type C:** very common, usually causes mild respiratory symptoms.
- **MERS/SARS:** Middle East Respiratory Syndrome and Severe Acute Respiratory Syndrome.
- **MERS:** also known as the “camel flu.” A new respiratory virus for humans. Symptoms include fever, cough, diarrhea and shortness of breath. Transmission is believed to be through respiratory droplets with an incubation time of 5-7 days.
- **SARS:** A severe respiratory disease that started in Southern China. Initial symptoms are flu-like including muscle pain, high fever, sore throat, cough and possible diarrhea. These symptoms may lead to shortness of breath and/or pneumonia. The incubation period is 4-6 days.
- **Anthrax:** A serious infectious disease that can cause death. Anthrax gets into the body through skin, lungs or gastrointestinal tract. All types of Anthrax are bacterial and can spread throughout the body quickly if not treated with antibiotics.
- **Ebola:** A rare viral hemorrhagic fever in humans and non-human primates. Symptoms include fever, sore throat, muscular pain, and headaches and begin between 2 days and 3 weeks after contracting virus. An infected person has a high risk of death killing at least 25% of those infected.

-
- **Avian Influenza:** A virus that usually affects only birds. It circulates among the wild bird population and, like other flu viruses, can change or mutate. Avian influenza can affect a wide variety of birds, including migratory waterfowl and poultry. Each year, birds experience the flu season just like humans and, as with people, some forms of the flu are worse than others.

*Reference HCC Mass Fatality Plan

Appendix A



INDIANA DISTRICT 2 HEALTHCARE COALITION

BURN SURGE ANNEX



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

January 2026

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I. INTRODUCTION

The 2024-2029 Hospital Preparedness Program (HPP) Funding Opportunity Announcement (FOA) requires Healthcare Coalitions (HCCs) to develop a complementary coalition-level Pediatric Annex to its base medical surge/trauma mass casualty response plan to improve capacity and capabilities to manage many casualties that are children. According to the 2017-2020 Health Care Preparedness and Response Capabilities, HCCs “should promote...members’ planning for pediatric medical emergencies and foster relationships and initiatives with emergency departments that can stabilize and or manage pediatric medical emergencies” (Capability 4, Objective 2, Activity 6)

This burn-focused operational annex is meant to be an annex to a coalition’s HCC Response Plan. It is intended to be a high-level response plan, identifying the experts and specialized resources that exist within the HCC, the mechanisms/ processes that will be used to determine which patients go to which facilities, and an understanding of how many children each facility will need to plan to receive.

A. Purpose

The purpose of this annex is to provide support and guidance in preparing the District 2 Healthcare Coalition (HCC) facilities for a disaster involving many burn patients. This functional annex will be used to expand existing facility surge plans and assist in coordination of care for burn patients and their specific needs, allowing for the best possible outcome in a disastrous event.

B. Scope

While “burn” mass casualty incidents are uncommon events, managing burn patients requires a significant level of coordination between responders on the scene and hospitals that receive the patients. Burn patients present complex challenges for hospitals, and in a mass burn surge, there are additional factors to consider including logistical limitations due to the geographical distance between American Burn Association (ABA) Verified Burn Centers (VBCs), limited number of burn beds, and limited number of supplies and tissue. Because of these challenges, alternative healthcare facilities must be identified.

C. Overview/Background of HCC and Situation

Location

Located in the Great Lakes region of the United States, Indiana is the 17th most populous state and 38th in land area. It is comprised of 92 counties. The Indiana District 2 Healthcare Coalition consists of 7 counties: Elkhart, Kosciusko, Marshall, Fulton, Starke, Pulaski, and St Joseph.

Members

The District 2 Healthcare Coalition consists of a variety of healthcare organizations. The District 2 Healthcare Coalition Core members include Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representatives. 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, Indiana 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

D. Planning Assumptions

The following assumptions have been made for planning purposes:

- A burn surge is an event in which the number of burn victims exceeds the capacity of the local burn center to provide optimal burn care.
- Existing burn beds in the state of Indiana are limited and have a restricted ability to surge at any given point.
- When the capacities of burn centers are exceeded, it is expected that non-burn centers may need to temporarily (for 12-72 hours or longer) assess, treat, and provide supportive care to some of the burn surge event patients.
- Short-term supportive burn care will be implemented until the patient can be transferred to a VBC for definitive care.
- All burn patients are not equal and as such, the scope and intensity of care and resources required will vary.
- Patients of a burn incident may sustain co-existent traumatic injuries (inhalation injury, blunt, penetrating, etc.).
- Federal resources may not be available for at least the first 72 hours and therefore plans must be in place to manage burn patients within the region.
- Healthcare infrastructure within the state remains intact.
- Support from non-burn center hospitals will be needed for at least the first 72 hrs.
- Burn centers in the state will operate at 150% capacity per ABA recommendations.

E. Administrative Support

The Burn Surge Plan will be reviewed and updated annually by the Policy Committee and or Planning Chief with updates to be approved by the Executive Committee, which consists of the core 4 members (Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representative), and membership of the coalition. Additionally, when exercises or real events warrant changes to the plan, the Policies Committee and or Planning Chief will be assigned an additional review at any time during the year. In addition, the following table shall be used to track changes in the document:

Update	Location in Plan	Name
3/2022	Draft Plan Created	Jennifer Tobey
6/2022	Approved plan	Jennifer Tobey
6/2023	Plan reviewed/updated, approved	Jennifer Tobey
6/2024	Grammar updated	Jennifer Tobey
5/2025	Review/Updated	Jennifer Tobey
1/2026	Review/Updated	Jennifer Tobey

II. CONCEPT OF OPERATIONS

A. Definition of a Burn Surge Event (BSE)

A burn surge incident is an event that results in burn patients as defined by the ABA guidelines that exceed the resources of the impacted area. Capacity includes the availability of:

- Burn beds
- Burn surgeons
- Burn nurses
- Other support staff
- Operating rooms
- Equipment
- Supplies and related resources

A burn surge plan should be scalable as the response to a burn surge is based on the number of patients and resources available within the local and regional jurisdiction. Graduated response levels should be developed to guide First Responders and hospitals in determining how best to manage the event, as well as determining a trigger to activate additional resources from other regions within the state.

B. Activation

This annex can be partially or fully activated in public health and medical emergency events where burn resources are strained or exhausted in the District. This may include issues such as any overwhelming influx or surge of burn patients, damage or threats to the healthcare facility, inadequate burn patient healthcare facility resources (beds, supplies, equipment, etc.), or staffing limitations for qualified staff to care for burn patients.

C. Notifications

Upon activation of the Burn Surge Annex, the designated D2 HCC Incident Command will then follow the attached notification guide to activate. (See Appendix 1)

Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information from their facility. Communication during an incident is vital and information sharing needs to occur with not only the healthcare facilities but also with agencies and non-healthcare facilities that are affected by the incident. Information will be shared using redundant communication including but not limited to telephone, text messaging, radio systems, WebEOC, email, Preparis, SERV-IN, and or EMResource.

D. Roles and Responsibilities

D2 HCC/MESH/Local ESF8

Role – Regional Coordination of Health Response

Responsibility - Support information sharing and coordination of activities between coalition members, local and state health departments as well as other Indiana District Healthcare Coalitions. Help manage resources between facilities in the district and across the state. May assist with patient transfer coordination.

Indiana Department of Health (IDOH)

Role – Lead State agency for health-related issues

Responsibility - Support HCC information exchange and situational awareness needs. Facilitate health care resource requests to state/inter-state/federal partners. Request State Disaster or Public Health Emergency Declarations and the governor's emergency orders as required to support response. Provide health-related guidance and recommendations for clinicians, local and tribal public health, and community members.

Indiana Department of Homeland Security (IDHS)

Role – Lead State agency for Incident Coordination

Responsibility – Serve as point of contact for resource requests. Request state declaration of emergency, if needed.

EMS Agency Responding

Role – Coordination of EMS, Emergency Response and Patient Transport

Responsibility – Support information sharing of activities between EMS, hospital, emergency management, and local, regional, and state emergency operations centers. Assist in coordination of EMS resources and emergency management in collaboration with the State, Regional, or Local Emergency Operations Centers. If needed, activate an EMS Multi-Agency Coordination Center (MACC) to assist with the influx of victims. May activate and perform regional procedures for EMS disaster response. Following normal surge protocols, coordinate patient destination hospitals to the degree possible to avoid overloading a single facility. Interface with local hospitals and regional health care coalition to share information/status.

Verified Burn Center

Role – Lead Treatment

Definition & Responsibility – Hospitals that are Verified Burn Centers are accredited by the American Burn Association and the American College of Surgeons. During a burn surge event, the most critically injured will be transported to a burn center by ABA protocol. The VBC will be the lead treatment facility and provide long-term follow-up for burn patients.

Trauma Center

Role – Support, Evaluate & Stabilize Patients

Definition & Responsibility – Hospitals that are designated Trauma Centers and accredited by the American College of Surgeons as either Level 1, Level 2, or Level 3. First responders shall determine which Level of Trauma Center burn surge event patient(s) will be transported to per appropriate triage and transport protocols. Each Trauma center should have enough ABLIS-trained or ATLS-trained physicians to be available during a burn surge event. Trauma centers will function as the initial stabilization/evaluation/transport staging center.

Potential Burn Surge Facility (PBSF)

Role – Support & Stabilize Patients

Definition & Responsibility – Hospitals that are non-burn centers and non-trauma centers are selected as *potential* facilities to provide interim care to burn patients based on the following capabilities: (1) the hospital has an emergency department; (2) the hospital has intensive care services with greater than 30 beds; and (3) the hospital has 24/7 on-call general surgeon coverage. Geographic coverage for the state was also considered when identifying PBSFs. Ideally, PBSFs will receive the least injured burn patients and shall provide life-sustaining and basic burning care until transfer to a higher level of care can be arranged.

Additional Support Agencies

- Acute Care Hospitals
- Critical Care Hospitals
- Ambulatory Surgery Centers
- Behavioral Health Agencies

E. Command, Control, and Coordination

In Indiana, as it is across the country, emergency incidents are responded to and handled at the lowest jurisdictional level, meaning the city or township, then escalated to the county, and finally escalated to the State.

The State of Indiana is divided into ten Public Health Districts, each with varying emergency response resources. More heavily populated areas have full-time fire departments, police departments, emergency medical services, and abundant hospital and healthcare assets, while other counties are served by part-time or volunteer responders, as well as little to no healthcare resources. The coordination among counties and Districts is critical to the successful response to a burn surge event.

The Healthcare Coalition exists within each District that interfaces with other community response partners to actively assist in information sharing and resource coordination, working closely with the local Emergency Support Function 8 coordinators.

If the incident needs are greater than local resources, the Indiana Department of Homeland Security (EOC) Emergency Operations Center is notified, and the Emergency Support Function #8 (ESF-8) State Coordinator, a representative from the Indiana Department of Health IDOH), shall serve as the coordinator for public health and medical incident response and resource requests.

F. Staged Burn Surge Event Response

For all burn surge incidents, local jurisdiction triage and transport protocols should be followed. Based on the size and scope of the event, patient transfer priorities should be based on ABA transfer criteria, availability of resources, and or expert consultation from VBCs. The appropriate coordinating entity, as determined or appropriate, may direct transport to VBCs, trauma centers, or BSFs.

Local Burn Surge Events

For purposes of this document, Local Burn Surge events are defined as burn surge events in which local resources are overwhelmed with burn patients, but the response remains manageable locally. During a local burn surge event, local hospitals will coordinate patient transfers to VBCs per standard processes and procedures (i.e., direct contact/communication).

District Burn Surge Events

District burn surge events are defined as a burn surge event in which local and District resources are overwhelmed with burn patients. During a District Burn Surge Event, a regional coordinator may be required and established, in consultation with clinical experts from VBCs, to coordinate patient transfers to VBCs, Trauma Centers, or BSFs.

The coordinating entity will notify all statewide VBCs, Trauma Centers, and BSFs for situational awareness/ alert status depending on the size and scope of the incident. Potential receiving hospitals will be notified of the event and will activate, as necessary, their external emergency operations plans or disaster plans, to prepare for the influx of patients from the burn surge event. This type of response should additionally be coordinated with local ESF-8 representatives, respective Healthcare Coalitions, and the Indiana State Department of Health as appropriate.

State Burn Surge Event

State burn surge events are defined as a burn surge event in which local, District, and State burn resources are overwhelmed with patients. During a state burn surge event, the local jurisdiction(s) where an incident has occurred, should notify the State (through potentially multiple channels) of requests of support. In the event State support is needed, it may be anticipated in an increase the activation level of the IDHS EOC to include staffing of the state ESF-8 representative. The IDOH Department Operations Center may additionally be activated

and staffed to assist the regional coordinator (if applicable) or federal regional coordinator (if appropriate) in coordinating patient transfers to VBCs, trauma centers, or BSFs, in consultation with clinical experts from VBCs, and make additional multi-state or federal resource requests as needed.

Federal resources requests may include Disaster Medical Assistance Teams (DMAT), National Disaster Medical System (NDMS) for patient transportation outside the state, Federal Coordinating Center (FCC) through the Veterans Affairs, burn blast kits through the CDC Strategic National Stockpile (SNS), or other requests.

Burn Surge Event	Definition	Response Plan
Local	Burn surge event in which local resources are overwhelmed with burn patients, but manageable locally	<ul style="list-style-type: none"> • Individual hospitals manage their disaster plans. • Local jurisdictions notify the surrounding area for assistance and notification to surrounding hospitals via mutual aid agreements. • Transfers to appropriate VBC managed by individual hospitals. • Assistance from County EOC/ESF-8 coordinator as needed.
District	Burn surge event in which district resources are overwhelmed with burn patients.	<ul style="list-style-type: none"> • County EOC/ESF-8 representatives assist hospitals. • Healthcare Coalitions assist with the coordination of transport with affected hospitals. • All VBCs, Trauma Centers, and BSF Notified. • State EOC/ESF-8 support may be necessary.
State	Burn surge event in which State burn resources are overwhelmed with patients.	<ul style="list-style-type: none"> • State EOC/ESF-8 supports assisting hospitals. • State EOC/ESF-8 assists with coordination of transport within Region V and surrounding VBCs. • State-level activation of the EOC along with supportive agencies.

G. Intra-facility Guidance for Triage and Transfer to Verified Burn Centers (VBC)

The following guidance is intended to facilitate appropriate coordination and transport of patients most likely to derive the greatest benefit from transport to a VBC. To assist Trauma Centers and PBSFs in caring for burn surge event patient(s), the least affected VBC ideally should provide clinical guidance to the appropriate coordinating, based on the Stage Response described above. Telemedicine capability may be utilized to provide clinical consultation with burn center physicians to Trauma Centers or BSFs where available. It should be noted, however, that not all facilities have this capability, and that physician-to-physician contact is essential to ensure that the patient’s needs are met throughout every aspect of the transfer. The referring physician should provide demographic and historical data, the results of his/her primary and secondary assessment. The VBC and the referring

physician, working in collaboration, should decide as to the means of transportation and the required stabilization measures. Personnel trained in burn resuscitation should conduct the actual transport. In most cases (subject to state law), the referring physician maintains responsibility for the patient until the transfer is completed.

Under normal daily procedures, there are established recommendations for transfer or follow-up care at a Verified Burn Center (VBC). The following are general guidelines for normal burn care referrals.

- The partial thickness burns greater than 10% of the total body surface area.
- Burns that involve the face, hands, feet, genitalia, perineum, and major joints.
- Third-degree burns in any age group.
- Electrical burns, including lightning injury.
- Chemical burns.
- Inhalation injury.
- Burn injury in patients with preexisting medical disorders could complicate management, prolong recovery, or affect mortality.
- Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses a greater immediate risk, the patient's condition may be stabilized initially in the trauma center before transferring to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
- Burned children in hospitals without qualified personnel or equipment for the care of children.
- Burn injury patients will require special social, emotional, or rehabilitative intervention.

During a burn surge event, referral criteria to a VBC may be altered to manage patient surge. The following are general guidelines for burn surge event referrals, as adopted from the State of Michigan Multi-Casualty Burn Incident Plan, Version 19 (2023).

- Partial thickness burns greater than 40% of the total body surface area (TBSA).
- Circumferential full-thickness burns involving an extremity.
- Full thickness burns greater than 5% TBSA.
- High voltage (>1000 volt) electrical burns.
- Burn injury in patients with preexisting medical disorders could complicate management, prolong recovery, or affect mortality.

A transfer agreement between the referring hospital and the burn center is desirable and should include a commitment by the burn center to provide the transferring hospital with appropriate follow-up. Quality indicators will provide continuing education on initial stabilization and treatment of burn patients.

H. Basic Treatment Recommendations for all Receiving Hospitals

VBC clinical consultation will address the management of patient injuries based on the mechanism of injury, the condition of the patient(s), and strategies to meet treatment challenges experienced by Trauma Centers and or BSFs. However, within the first six hours of a burn surge event, the primary concerns are Airway, Breathing, Circulation (ABCs), wound assessment, resuscitation, airway insufficiency, and shock. Within the following six to twenty-four hours of a burn surge event, concerns include compartment syndrome and respiratory/renal insufficiency. To that end, the airway and wounds are monitored, and fluids are given. From days two through six, primary concerns include supportive care and preventing wound infections.

Refer to Appendix 2 for Treatment Considerations for Potential Burn Surge Facilities during a Burn Surge Event.

Refer to Appendix 3 for Ongoing Patient Management Recommendations.

I. ADDITIONAL CONSIDERATIONS

A. Supplies and Resources

Minimal recommended supplies for Trauma Centers and BSF facilities to keep on hand in the event of a burn surge event include (1) silver-based long-acting dressing (Burn/3) (three 16" x 16" sheets per patient); and (2) Silver Sulfadiazine (Silvadene) Dressing (one jar per patient). Hospitals that require additional supplies when caring for a burn patient shall make all attempts to procure those supplies through normal/emergency procurement procedures.

If the procurement efforts at the hospital are unsuccessful, the hospital shall place a resource request through their local ESF-8 representative. If the resource request is unable to be filled locally, the ESF-8 representative will then submit a 213RR to the District Healthcare Coalition. Additionally, the State ESF-8 coordinator may make requests for additional supplies via the state EOC to surrounding States and VBCs when appropriate. VBCs may provide prioritization and allocation recommendations to Trauma Centers or BSFs to assist with resource management.

B. Burn Surge Event Training Recommendations

To support the role of Trauma Centers and PBSFs in providing extended care for burn surge event patients, it is recommended that both types of facilities provide or seek additional training opportunities for clinical staff. To conclude, the following training is recommended for all Trauma Centers and PBSFs:

- Completion of the ABA's in-class or online Advanced Burn Life Support course (minimum staffing of fifteen nurses and five physicians).
- Completion of supplemental online courses available such as burncentertraining.com, and www.ameriburn.org.
- Rotation of PBSF clinical staff through VBCs, Trauma Centers, and other BSFs to enhance clinical experience dealing with severe burns.

C. Mass Fatality Management and Family Reunification

Local ESF-8 representatives shall handle the management of the deceased in conjunction with the local coroner's office. If a burn surge event exceeds the local resources in handling a mass fatality event or exists in multiple jurisdictions, the local jurisdiction should make a request through the IDHS EOC for additional resources for fatality management.

Healthcare organizations, law enforcement agencies, and public health departments will work locally to gather patient demographics to assist with reunification with family members. Should the IDHS EOC be activated in response to a burn surge event, it is recommended that the State provide a single point of contact for local jurisdictions and hospitals to report the name and or description of the deceased. Should this event be related to a commercial transportation accident, the State and Local jurisdiction should coordinate these efforts with the National Transportation Safety Board (NTSB) as the NTSB will provide resources for fatality management

(Health and Human Services DMORT) and family assistance centers.

D. Behavioral Health Considerations

The use of the Elkhart County and St Joseph County Crisis Intervention Team (CIT) is recommended to provide additional trained mental health support to a hospital and/or community that has experienced a disaster event. Mental health support is especially important when the event involves children. Detail the staffing, mission, activation, and operations of such teams or personnel in advance of an incident. While awaiting such teams, the hospital should have a plan to bring in facility staff, volunteers, or other community-based volunteers if there are several unaccompanied pediatric patients requiring escort or support.

E. Deactivation & Recovery

The decision to deactivate this plan will be made by the D2 Executive Board Members. Responding resources will be demobilized as soon as they are no longer needed for the emergency response and the process of returning them to their day-to-day function will be expedited.

Recovery components should include follow-up care for burn patients and providing behavioral health services to everyone involved.

As soon as possible, following the stabilization of the incident, a multi-agency debriefing will be held along with an After-Action Review. Using the information collected along with participating in agency reports, an After-Action Report and Improvement Plan will be developed and made available to member organizations.

F. Definitions

ABA Primary Triage Policy: Burn patients should be triaged to a burn center within 24 hours of an incident. The local emergency operations center manager or EMS transport officer should call the nearest verified burn center regarding available capacity and alternate site burn center information if needed. Appropriate field triage may depend upon the first responders' and hospital emergency room personnel knowledge of burn triage recommendations.

ABA Secondary Triage Policy: Secondary triage should be implemented by the Burn Center Director when the Burn Center's surge capacity is reached. Transfer of burn patients should be to verified burn centers when feasible, then to other burn centers, within the first 48 hours following the incident when possible.

Burn Surge Event: Any incident generating burn patients that severely challenges or exceeds the current capabilities of the adult and/or pediatric burn centers in Indiana.

Burn Surge Event Levels: Used to convey the scope and seriousness of an incident involving burn patients and used by the healthcare system in the state of Indiana to determine the expanse of response needed.

Disaster Mortuary Operations Team (DMORT): A state and federal asset comprised of equipment and staff who specialize in mortuary operations, including victim identification.

Emergency Operations Center: A center that is dedicated to coordinating multiple resources during an emergency.

Emergency Support Function: Emergency support resources for incident response are separated by function. Includes public, private, non-profit, and volunteer organizations.

Emergency Support Function #8: Public health and medical resources.

Public Health District: A breakdown of geographical areas designated by the Indiana State Department of Health.

Multi-Agency Coordination: Multiagency coordination is a process that allows all levels of government and disciplines to work together more efficiently and effectively. Multiagency coordination occurs across the different disciplines involved in incident management, across jurisdictional lines, or levels of government.

National Disaster Medical System (NDMS): A federally coordinated system that augments the nation's medical response capability.

Secondary Triage: Secondary triage is the transfer of burn patients from one burn center to another burn center upon reaching surge capacity. A secondary triage policy should be put in place at every burn center, with formal written transfer agreements.

Surge Capacity: Surge capacity is the capacity to handle up to 50% more than the normal number of burn patients when there is a disaster. Normal capacity will be different for each burn center, maybe seasonal, and will vary from week to week or possibly even day to day.

APPENDIX 1

BURN SURGE EVENT RESPONSE AND NOTIFICATION STEPS

- Burn Surge event Occurs
- Local First Responders Notified & Dispatched
- First Responders Triage & Transport Patients Based on Local Protocols
- Local Resources Overwhelmed with Burn Patients (Local Response)
- Local Hospitals Coordinate Patient Transfers to VBCs Per SOPs
- District Resources Overwhelmed with Burn Patients (District Response)
- Hospital Coalitions Notify Statewide VBCs, Trauma Centers, and PBSFs
- Hospital Coalitions to Consult with VBCs to Coordinate Patient Transfers
- State Resources Overwhelmed with Burn Patients (State Response)
- State ESF-8 Representative to Consult with VBCs to Coordinate Patient Transfers

APPENDIX 2

TREATMENT CONSIDERATIONS FOR PBSFS DURING A BURN SURGE EVENT

1. Provide initial first aid
 - a. Stop the burning process
 - b. Use universal precautions
 - c. Remove clothing or jewelry
 - d. Cool any burns that are warm to touch with tepid water and then pat dry
 - e. Rinse liberally with water if chemicals are suspected according to protocols, then dry
 - f. Cover with a clean DRY sheet or bedding to prevent hypothermia

2. Perform primary survey
 - a. Airway maintenance with cervical spine protection
 - i. Chin lift/jaw thrust with cervical spine precautions as needed
 - ii. Assess for signs of airway injury such as hypoxia, facial burns, carbonaceous sputum, stridor, and nasal singe
 - iii. Assess the history of a closed-space fire
 - iv. Insert an oral pharyngeal airway or endotracheal tube (ETT) in the unconscious patient (Intubate early)
 - b. Breathing and ventilation
 - i. Assess for appropriate rate and depth of respirations with adequate air exchange
 - ii. 100% (15L) FIO₂ non-rebreather face mask or endotracheal intubation until ABG result: (a) ABG with CO level is required for suspected inhalation injury; (b) CO levels are decreased by ½ every 40 minutes while on 100 % FIO₂, CO level goal is <10%
 - iii. Mechanical ventilation as needed.
 - iv. If extensive facial burns or greater than 40% TBSA, intubation for airway protection prior to expected facial swelling is indicated.
 - v. Monitor pulse oximetry while checking CO level (as needed)
 - vi. Head of bed (HOB) elevated

3. Circulation with hemorrhage control
 - a. Vital Signs
 - i. Heart rate
 - ii. Blood pressure
 - iii. Capillary refill
 - iv. Temperature
 - v. Skin color of unburned skin
 - b. Cardiac monitoring as needed
 - i. May be needed if there is an electrical injury, concurrent trauma, or cardiac issues
 - c. Oral resuscitation can be used in the following patients

- i. Patient is not intubated
 - ii. Injury is not an electrical injury
 - iii. No other injuries
 - d. Heplock IV (as needed) if taking adequate PO fluids
 - e. If the patient is intubated
 - i. Start maintenance fluids – large bore peripheral IV in non-burned, upper extremities
 - ii. Place a soft feeding tube (preferably post-pyloric)
 - f. Pediatric patients with burns > 10% TBSA require resuscitative fluids and maintenance fluids
 - g. Pediatric patients less than 30 kg require D2 LR at maintenance rate if not taking adequate PO or are intubated: pediatric calculation for maintenance fluid formula:
 - i. For the first 10 kg of body weight: 4 mL per kg per hour
 - ii. For the second 10 kg of body weight: 2 mL per kg per hour
 - iii. For the remaining kg of body weight up to 30kg: 1ml per kg per hour
 - h. Labs on admission and then as dictated by medical condition
 - i. Arterial blood gas
 - ii. Carboxyhemoglobin (COHb) level, always add this to a blood gas
 - iii. Electrolyte panel
 - iv. CBC
 - v. Cardiac panel for electrical injuries.
 - vi. EKG for electrical injury or cardiac history
 - vii. CXR if intubated, inhalation injury suspected, or underlying pulmonary condition
 - viii. Tetanus prophylaxis unless given in the last 5 years
4. Disability
- a. Neurologic checks every 4-8 hours and PRN
 - i. The goal is to be an alert and oriented patient.
 - b. If neurological status alters, consider the following:
 - i. Associated injury
 - ii. CO poisoning
 - iii. Substance abuse
 - iv. Hypoxia
 - v. Pre-existing medical condition
 - c. Determine the level of consciousness. Consider using the “AVPU” method:
 - i. A - Alert
 - ii. V - Responds to verbal stimuli
 - iii. P - Responds to painful stimuli
 - iv. U - Unresponsive
5. Exposure
- a. Remove all clothing and jewelry

- b. Initially place a clean, dry sheet over the wounds until thorough cleaning is done
- c. Keep patient normal thermic, especially during wound care; this may be accomplished by:
 - i. Keeping patient covered
 - ii. Covering the patient's head
 - iii. Warming the room
 - iv. Warming IV fluids

ONGOING PATIENT MANAGEMENT RECOMMENDATIONS

1. History
 - a. Obtain circumstances of injury
 - b. Obtain medical history
 - i. A – Allergies
 - ii. M – Medications
 - iii. P – Previous illness, past medical history
 - iv. L – Last meal or fluid intake
 - v. E – Events/environment related to the injury

2. Complete physical examination
 - a. Head-to-toe exam
 - b. If eye involvement or facial burns, consult an Ophthalmologist

3. Determine the extent/size of the burn by calculating the TBSA burn:
 - a. Rule of Nines
 - b. Lund-Browder chart
 - c. Rule of the Palm

4. Determine the depth of the burn
 - a. DO NOT include superficial (1st degree) burns when calculating TBSA.
 - b. Superficial partial thickness (2nd degree)
 - c. Involves the epidermis and a thin layer of dermis
 - i. Red, blistered, moist, blanches
 - d. Deep partial thickness (2nd degree)
 - i. Involves the entire epidermis and variable portion of the dermis
 - ii. Red, blistered, and edematous
 - e. Full thickness (3rd degree)
 - i. Involves the destruction of the entire epidermis and dermis
 - ii. White, brown, dry, leather with possible coagulated vessels

5. Assess the need for escharotomies
 - a. Monitor the following signs and symptoms in full thickness, circumferential burn injuries which may indicate a circulation deficit requiring decompression by incision of burn wound:
 - i. Cyanosis of distal unburned skin on a limb
 - ii. Unrelenting deep tissue pain
 - iii. Progressive paresthesia
 - iv. Progressive decrease or absence of pulses
 - v. Inability to ventilate in patients with deep circumferential burns of the chest

6. Comfort

- a. Frequent pain/sedation assessment
 - i. Every hour
 - ii. Before and after pain/sedation medications given
- b. Use age-appropriate pain scales for pediatric patients

- c. Give whatever pain medication is required
 - i. Narcotic/Analgesic PO/IV
 - ii. Oxycodone PO
 - iii. Ativan/Versed PO/IV

7. Wound care

- a. Assess and monitor the wound for:
 - i. Change in wound appearance
 - ii. Change in size of the wound
 - iii. Signs or symptoms of infection
- b. Wound care should include
 - i. Washing the wounds with soap and warm tap water using a washcloth
 - ii. Remove water by patting it dry
- c. Wound care should be performed every day if using the following:
 - i. Silver sulfadiazine cream
 - ii. Bacitracin
- d. Burned scalps and faces
 - i. Should be shaved daily
- e. All blisters should be debrided, except for the following:
 - i. Intact blisters on hands and feet. The exception would be if the blister is impeding the range of motion to the joints.
- f. Ears are poorly vascularized and at risk of chondritis
 - i. Topical sulfamylon cream should be used; if unavailable, use Silvadene
 - ii. Make sure to plug the ear canal due to the toxicity of sulfa into the auditory canal.
 - iii. Avoid external pressure including pillows and constrictive dressings
- g. For extensive and severe burns to the face:
 - i. Apply a thin layer of SSD cream, approximately a thickness of nickels or enough to cover the wound, so that it doesn't dry out prior to the next dressing change. The purpose of the gauze dressing is to keep the cream from rubbing off before the next dressing change.
 - ii. Avoid creams near the eyes.
- h. For moderate facial burns:
 - i. Bacitracin or another antibiotic ointment without dressing can be used if fingers and toes are burned:
 - ii. Dress and wrap separately to promote range of motion and prevent webbing of the digits.
- i. Genitalia and perineal burns require:

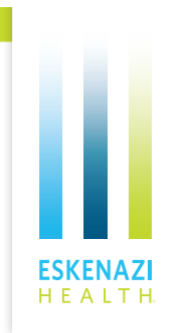
- i. A greasy gauze and/or lubricant between the labia and the foreskin to prevent adhesions
 - ii. A foley is never indicated to maintain patency.
 - iii. May be used to monitor urine output, if needed.
 - j. Elevate burned extremities above the level of the heart
 - k. If applying for an Acticoat dressing:
 - i. Apply a single layer of the dressing moistened with water over burn wounds so that all areas are covered.
 - ii. Water should be used to keep the Acticoat and overlying gauze moist to maintain the dressing's antimicrobial activity. (DO NOT use saline because it deactivates the silver's antimicrobial ability.)
 - iii. It should be held in place with a water-moistened gauze dressing.
 - iv. Dressing does not need to be changed for 7 days (the overlying gauze can be changed as necessary and if signs of infection appear, remove the dressing to assess the wound).
 - v. Record the date of the application
- 8. Ongoing Resuscitation (as needed)
 - a. Monitor urine output
 - i. Adjust fluids to keep urine output between the following: Adults- 30-50 ml/hr.; Pediatrics- 2 ml/kg/hr.
 - b. Additional fluid needs can occur with:
 - i. Very deep burns
 - ii. Inhalation injury
 - iii. Associated injuries
 - iv. Electrical injury
 - v. Delayed resuscitation
 - vi. Prior dehydration
 - vii. Alcohol or drug dependence
 - viii. Small children
 - c. Children, the elderly, and patients with preexisting cardiac disease are particularly sensitive to fluid management
 - d. If Myoglobin in the urine (burgundy color):
 - i. Maintain urine output of 100 ml/hour for adults and 4ml/kg/hr. for pediatrics by increasing fluid rate.
 - ii. Place a foley
 - iii. Increase fluid rate (LR)
 - iv. Diuretics are never indicated with myoglobinuria
 - v. Mannitol may be used only as a last resort to maintain urine output.
 - vi. Intravenous sodium bicarbonate may be administered to maintain alkaline urine with a pH > 6
 - e. For circumferential burns to extremities:

- i. Perform pulse checks every 1 hour to determine the need for emergent escharotomy
 - ii. Monitor by palpation or Doppler exam for decreased sensation, severe deep tissue pain, diminished distal pulses, or slowed capillary refill.
 - iii. After 24-48 hours, decrease the frequency of pulse checks to every 2 hours if stable
 - f. Elevate extremities above the level of the heart
- 9. Nutrition
 - a. Obtain dry Weight on admission
 - b. Dietary consultation, as needed
 - c. Regular high-calorie, high-protein diet if able to take PO
 - d. If intubated, begin tube feeding at full strength increasing to goal rate. a. soft feeding tubes are preferred over hard Salem sump nasogastric tubes
 - e. Ensure stool softeners are ordered to prevent constipation due to pain medications
- 10. Mobility
 - a. Physical Therapy/Occupational Therapy consult, as needed.
 - i. In a disaster, therapists may splint patients into functional positions as needed
 - b. HOB always elevated
 - c. Ear burns
 - i. No external pressure should be applied
 - ii. No pillows or blankets under the head
 - d. Neck burns
 - i. Maintain the head in a neutral position
 - ii. No pillows or blankets under the head flexing the neck forward
 - e. Axilla burns
 - i. Keep arms extended to decrease contractures
 - f. Elevate burned extremities above the level of the heart to decrease swelling
 - g. If legs are burned, apply ace wraps when OOB (Out of Bed)
 - i. Encourage active range of motion hourly, when awake
 - h. Encourage Activities of daily living
 - i. The patient should have enough pain control to perform these activities.
- 11. Infection Control
 - a. Utilize universal precautions
 - b. If wounds are exposed:
 - i. Apply gown, mask, and gloves to protect patient
 - c. No systemic antibiotics are required for burn injuries
- 12. Psychosocial
 - a. Explain any procedures

- b. Involve patient and family
- c. Consider Social Worker consultation
- d. Offer Spiritual Care

APPENDIX 3

ONGOING PATIENT MANAGEMENT RECOMMENDATIONS



Richard M. Fairbanks Burn Center at Eskenazi Health

BURN STABILIZATION PROTOCOL

1.800.4.TRAUMA

For patient transfers or to talk with a burn or trauma surgeon 24 hours a day

American Burn Association Burn Center Referral Criteria

Burn injuries that should be referred to a burn center include:

- Partial thickness burns greater than 10 percent of total body surface area (TBSA)
- Burns that involve the face, hands, feet, genitalia, perineum or major joints
- Third-degree burns in any age group
- Electrical burns, including lightning injuries
- Chemical burns
- Inhalation injuries
- Burn injuries in patients with pre-existing medical disorders that could complicate management, prolong recovery or affect mortality
- Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality (In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.)
- Burned children in hospitals without qualified personnel or equipment for the care of children
- Burn injury patients who will require special social, emotional or rehabilitative intervention

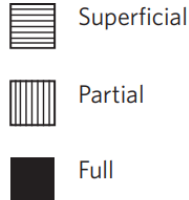
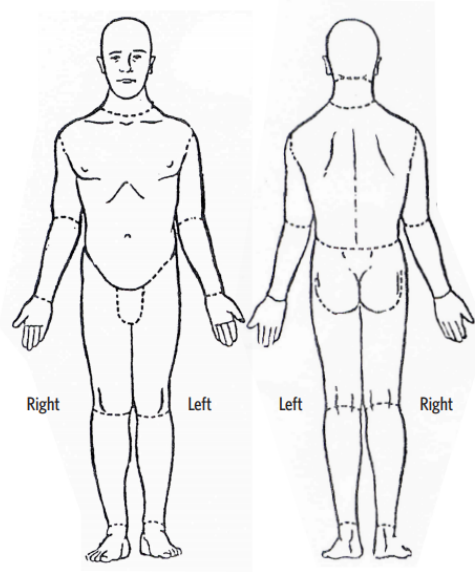


Treatment Protocol

1. Remove any sources of heat.
 - Cool any burns that are warm to the touch with tepid water and then dry patient.
 - Cover patient with a clean, dry sheet or blanket to prevent hypothermia.
2. Assess airway/breathing.
 - Carbon monoxide may present as restlessness, headache, nausea, poor coordination, memory impairment, disorientation or coma. Administer highest level of O₂ possible via non-rebreathing face mask.
 - **Useful labs:** Blood gases, carboxyhemoglobin level
 - Intubation is generally only necessary for unconscious patients, hypoxic patients with severe smoke inhalation or patients with flame or flash burns involving the face and neck. Indications include pharyngeal burns, air hunger and carbonaceous sputum with hoarseness.
 - If breathing seems to be compromised by tight circumferential trunk burns, consult with burn center surgeons immediately.
3. Estimate the percent of the total body surface area (TBSA) burned.
 - Use the Rule of Nines initially. See the back of this folder for a chart to aid in accurate assessment.
 - **Reminder:** Remove as much soot as possible for a more accurate assessment. First-degree burns are not included in estimation.
4. Obtain IV access.
 - Burns of less than 15 percent TBSA can be resuscitated orally, unless the patient has an electrical injury or associated trauma.
 - For burns of 15-40 percent TBSA, secure one large bore IV line in upper extremity. Add a second line if the transport will be longer than 45 minutes.
 - Burns of more than 40 percent TBSA require two large bore IV lines in unburned skin in upper extremities if possible.
 - **Reminder:** IVs may be placed through a burn if necessary (suture to secure). Avoid saphenous vein if at all possible. Avoid cut-downs through unburned skin if possible.
5. Initiate fluid resuscitation.
 - **Adults:** 4 ml ringers lactate x (kg of body weight) x (% TBSA burn) = ml in first 24 hours, with half of this total given in the first eight hours post-injury.
 - **Children younger than age 14:** 3 ml ringers lactate x (kg of body weight) x (% TBSA burn) = ml in first 24 hours, with half of this total given in the first eight hours post-injury.
 - **Electrical:** 4 ml ringers lactate x (kg of body weight) x (% TBSA burn) = ml in first 24 hours, with half of this total given in the first eight hours post-injury.
 - Children weighing less than 40 kg should be given daily maintenance fluids in addition to fluid resuscitation, including dextrose.
 - **Example** – Patient weighing 70 kg with a burn of 50 percent TBSA: 4 ml x 70 kg x 50% = 14,000 ml needed in the first 24 hours, with 7,000 ml needed in the first eight hours. IVs are initially started at 875 ml/hour. Round to the nearest ml.
 - **Reminder:**
 - Do not give dextrose solutions – they may cause an osmotic diuresis and confuse adequacy of resuscitation assessment.
6. Assess urine output: Urine output target = 0.3 – 0.5 ml/kg/hour
 - **Reminder:** Lasix and other diuretics are never given to improve urine output. Fluid rates are adjusted to increase urine output.
 - Observe urine for burgundy color, which is often seen with massive injuries or electrical burns. There is a high incidence of renal failure associated with these injuries, requiring prompt and aggressive intervention. Increase IV fluids to ensure an increased urine output of 1ml/kg/hr.
 - **Reminder:** If unable to stimulate high urine flow or clear pigments with increased fluid administration, consult a burn center.
7. Insert nasogastric tube.
 - Insert nasogastric tube on intubated patients, burns >20% TBSA and unresponsive patients.
 - Initiate antacid therapy if patient will not be transported within 12 hours.
 - Keep NPO for stabilization and transport.

8. Prepare for escharotomy.
 - Assess for circumferential full-thickness burns of extremities or trunk. Elevate burned extremities on pillows above the level of the heart. If transfer will be delayed beyond 12 hours, check distal pulses hourly and call a burn center if pulses disappear.
 - Call the burn center prior to performing an escharotomy.
9. Administer medication.
 - Give tetanus immunization.
 - After fluid resuscitation has been started, pain medication may be given in appropriately titrated doses. Blood pressure, pulse, respiratory rate and state of consciousness should be assessed after each increment of IV morphine.
 - **Guideline:** In an adult patient, give doses of 3 - 5 mg IV morphine repeated in 5- to 10-minute intervals until pain appears to be under control.
 - **Reminder:** Even small degrees of hypovolemia may grossly exaggerate effects of all medications. If blood pressure or respiratory rate falls or pulse rises by more than 20 percent of baseline, do not give additional morphine without consulting a burn center.
 - Consult a burn center before giving any antibiotics.
10. Give wound care.
 - If transfer of patient will be completed within 12 hours, debridement and application of topical antimicrobials is unnecessary. Transport patient wrapped in a dry sheet and blanket.
 - If it will be longer than 12 hours before transfer is completed, debride all loose tissue and gently cleanse the wounds of all debris with mild soap and water. This should be done with opiate analgesia but not general anesthesia. Consult burn center for topical therapy.
 - **Reminders:**
 - Warm the treatment area as much as possible.
 - Work efficiently.
 - Monitor patient temperature.
 - Place dressings as quickly as possible.
 - Remember these general items when transferring a burn patient:
 - A history, including details of the accident and pre-existing disease or allergies, should be recorded and sent with the patient.
 - Copies of all medical records, including all fluids and medications given, urine outputs, and vital signs, must accompany the patient.
 - Transport assistance is available upon request by calling 1.800.4.TRAUMA.
 - Record the following:
 1. Mechanism of injury; 2. Past medical history; 3. Tetanus immunization status; 4. Medications; 5. Allergies; 6. Head-to-toe survey; 7. Time of last meal
11. Make special considerations for chemical burns and consult with a burn center.
 - Brush powdered chemicals off wound if necessary. Then, flush chemical burns for a minimum of 20 - 30 minutes with running water.
 - **Reminder:** Never neutralize an acid with a base or vice versa.
 - Irrigate burned eyes with a gentle stream of saline, flushing both the injured eye and the conjunctiva. Follow with an ophthalmology consult if transport is not imminent.
 - **Reminder:** Always irrigate eyes with the inside canthus out to avoid washing chemicals down the tear ducts.
 - Determine what chemical and what concentration of the chemical caused the injury.
12. Make special considerations for electrical burns and consult with a burn center.
 - Attach cardiac monitor. Treat life-threatening dysrhythmias as needed.
 - Assess for associated trauma. Assess central and peripheral neurologic function.
 - Administer ringers lactate. Titrate fluids to maintain adequate urine output or to flush pigments through the urinary tract (see instructions for urine output in No. 6).
 - **Useful lab:** ABG with acid/base balance
 - Elevate burned extremities above the level of the heart with pillows. Monitor distal pulses (escharotomy or fasciotomy may ultimately be required).
 - If transfer will be delayed beyond 12 hours, check distal pulses hourly. Consider arranging for a general surgeon to perform an escharotomy or fasciotomy if pulses disappear. Consult a burn center prior to performing an escharotomy or fasciotomy.

Richard M. Fairbanks Burn Center at Eskenazi Health
 720 Eskenazi Ave., Indianapolis, IN 46202
 Phone: 317.880.6900, Toll Free: 1.866.380.2876
 Fax: 317.880.0416



Classify the burn as one of the following based on indicated characteristics:

Superficial	Partial Thickness	Full Thickness
Red	Moist	Dry, Leathery
Dry	Blisters	Insensate
Painful	Painful	Color Variable

Depth of burn will evolve over the next 12 - 18 hours.
 Superficial burns are not included in estimation of TBSA.

AREA	0 - <12 Months	1 - 4 Years	5 - 9 Years	10 - 15 Years	Adult	Partial %	Full Thickness %	% Total
Head	19	17	13	10	7			
Neck	2	2	2	2	2			
Ant. Trunk	13	13	13	13	13			
Post. Trunk	13	13	13	13	13			
Right Buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2			
Left Buttock	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2			
Genitalia	1	1	1	1	1			
Right Upper Arm	4	4	4	4	4			
Left Upper Arm	4	4	4	4	4			
Right Lower Arm	3	3	3	3	3			
Left Lower Arm	3	3	3	3	3			
Right Hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2			
Left Hand	2 1/2	2 1/2	2 1/2	2 1/2	2 1/2			
Right Thigh	5 1/2	6 1/2	8	9	9 1/2			
Left Thigh	5 1/2	6 1/2	8	9	9 1/2			
Right Leg	5	5	5 1/2	6	7			
Left Leg	5	5	5 1/2	6	7			
Right Foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2			
Left Foot	3 1/2	3 1/2	3 1/2	3 1/2	3 1/2			
TOTAL								

APPENDIX 4

DECISION TOOLS FOR TRANSFER

The following triage table is intended for use in burn surge events where responders are overwhelmed, and transfer possibilities are insufficient to meet needs.

ABLS Provider Manual Triage Decision Table of Benefit-to-Resource Ratio on Patient Age and Total Burn Size (2010)

Age/ years	Burn Size (%TBSA)									
	0 – 10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91+%
0-1.99	High	High	Medium	Medium	Medium	Medium	Low	Low	Low	Expectant
2-4.99	Outpatient	High	High	Medium	Medium	Medium	Medium	Low	Low	Low
5-19.9	Outpatient	High	High	High	Medium	Medium	Medium	Medium	Medium	Low
20-29.9	Outpatient	High	High	High	Medium	Medium	Medium	Medium	Low	Low
30-39.9	Outpatient	High	High	Medium	Medium	Medium	Medium	Medium	Low	Low
40-49.9	Outpatient	High	High	Medium	Medium	Medium	Medium	Low	Low	Low
50-59.9	Outpatient	High	High	Medium	Medium	Medium	Low	Low	Expectant	Expectant
60-69.9	High	High	Medium	Medium	Medium	Low	Low	Low	Expectant	Expectant
70+	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant

Definitions:

Outpatient: Survival and good outcome expected without requiring initial admission

High Benefit/Resource: Survival and good outcome expected (survival greater than/equal to 90%) with limited/short-term initial admission and resource allocation (LOS less than or equal to 14 days, 1-2 surgical procedures).

Medium Benefit/Resource: Survival and good outcome likely (survival greater than 50%) with aggressive care and comprehensive resource allocation, including initial admission (greater than/equal to 14 days), resuscitation, and multiple surgeries.

Low Benefit/Resource: Survival and good outcome less than 50% even with long-term, aggressive treatment and resource allocation.

Expectant: Predicted survival of 10% or less with unlimited, aggressive treatment.

This graph is adapted with scores to adjust for inhalation injuries associated with a dermal burn.

ABA Chart Modified for Michigan Burn Plan to Include Inhalation Injury (2009)

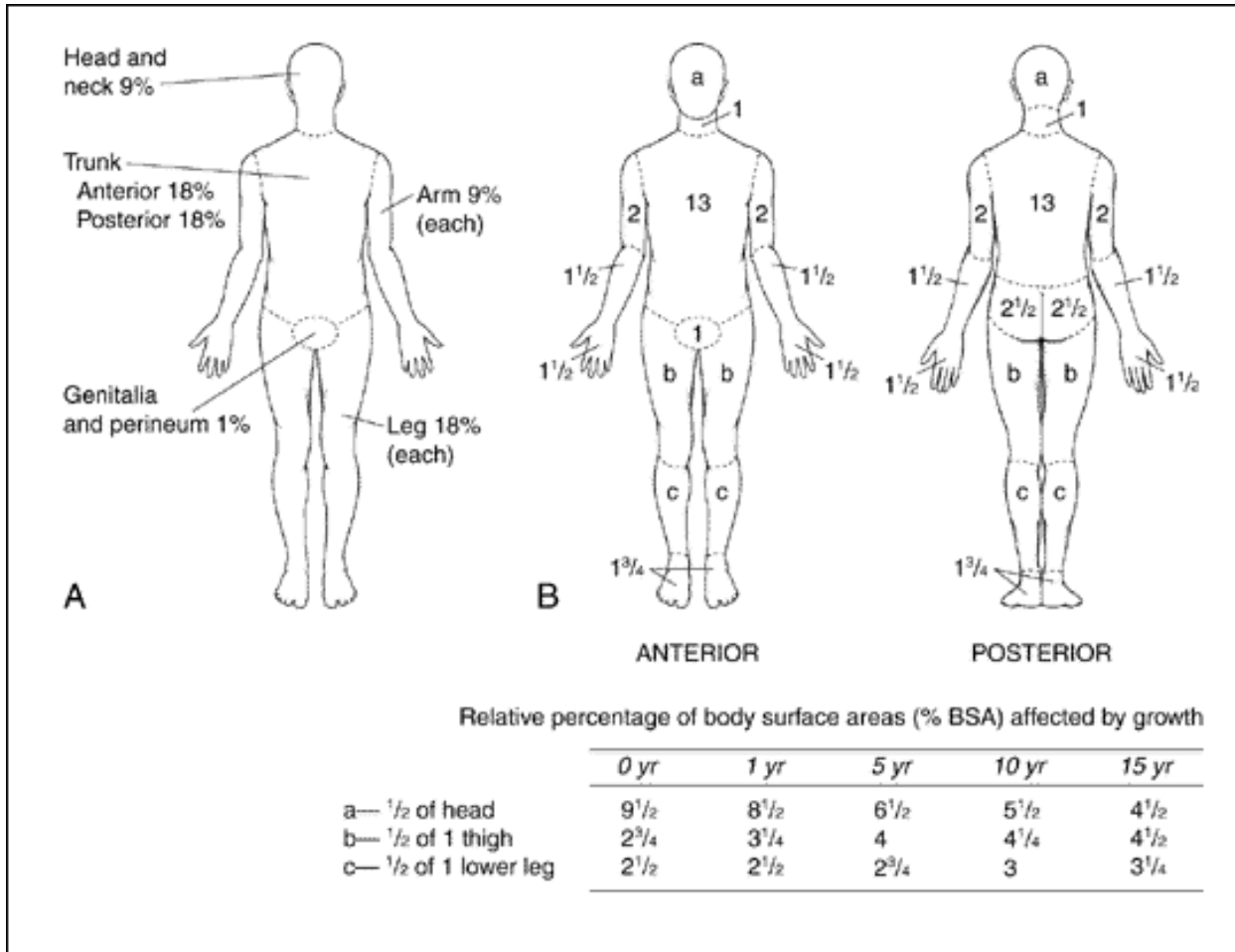
AGE	% Total Body Surface Area Burn + 10 for Inhalation Injury									
	0 - 10	11 - 20	21 - 30	31 - 40	41 - 50	51 - 60	61 - 70	71 - 80	81 - 90	91 +
<2	Very High	Very High	Very High	High	Medium	Medium	Medium	Low	Low	Very Low
2 - 5	Outpatient*	Very High	Very High	High	High	High	Medium	Medium	Low	Low
5 - 19.9	Outpatient*	Very High	Very High	High	High	High	Medium	Medium	Low	Low
20 - 29.9	Outpatient*	Very High	Very High	High	High	Medium	Medium	Low	Low	Very Low
30 - 39.9	Outpatient*	Very High	Very High	High	Medium	Medium	Medium	Low	Very Low	Very Low
40 - 49.9	Outpatient*	Very High	Very High	Medium	Medium	Medium	Low	Very Low	Very Low	Expectant
50 - 59.9	Outpatient*	Very High	Very High	Medium	Medium	Low	Very Low	Very Low	Expectant	Expectant
60 - 69.9	Very High	Very High	Medium	Medium	Low	Very Low	Very Low	Expectant	Expectant	Expectant
70+	Very High	Medium	Medium	Low	Very Low	Expectant	Expectant	Expectant	Expectant	Expectant

Medium Benefit/Resource: Survival and good outcome likely (survival greater than 50%) with aggressive care and comprehensive resource allocation, including initial admission (greater than/equal to 14 days), resuscitation, and multiple surgeries.

Low Benefit/Resource: Survival and good outcome less than 50% even with long-term, aggressive treatment and resource allocation.

Expectant: Predicted survival of 10% or less with unlimited, aggressive treatment.

U.S. Department of Health & Human Services, Chemical Hazards Emergency Medical Management Tool for Assisting in Determining Percentage of Body Surface Area Burned



APPENDIX 5 PEDIATRIC BURN PATIENT CARE GUIDANCE

Pediatric Burn Surge Considerations – Indiana District 2 Burn Surge Annex

With children making up about 25% of the population, they are at high risk of involvement in any disaster and require special consideration in planning. Pediatric patients also have unique characteristics that make them more vulnerable in disasters, and this is evident especially in the case of burns. However, with awareness of these characteristics and a good knowledge base of appropriate stabilization, treatment, and transfer recommendations, we can all work together to give children the best chance of survival and recovery in any burn surge event.

In table 1, some of these characteristics and risks are described. Below, we will discuss specific considerations and treatment protocols to assist in the unfortunate event of a burn surge incident involving children. Of course, consultation and transfer to the Pediatric Burn Center is a priority. However, in a mass casualty event, this information can help stabilize and prioritize patients to minimize morbidity and mortality in any such critical event.

Table 1.

Pediatric Characteristic	Special Risk During Disaster
Respiratory	Higher minute volume increases risk from exposure to inhaled agents
Gastrointestinal	Higher risk for dehydration from vomiting and diarrhea after exposure to contamination
Skin	Higher body surface area increases the risk for skin exposures. Skin is thinner and more susceptible to injury from burns, chemicals, and absorbable toxins. Evaporation loss is higher when skin is wet or cold, so hypothermia is more likely
Endocrine	Increased risk of thyroid cancer from radiation exposure
Thermoregulation	Less able to cope with temperature problems, with higher risk for hypothermia
Developmental	Decreased ability to escape environmental dangers or anticipate hazards, fear of EMS or other providers wearing PPE
Psychological	Prolonged stress from critical events can lead to poor health outcomes. Susceptible to separation anxiety

Basic Treatment Considerations:

PEDIATRIC VITAL SIGNS

Table 2.

Age	Heart Rate (beats/min)	Blood Pressure (mm Hg)	Respiratory Rate (breaths/min)
Premature	120-170	55-75/35-45	40-60
0-3 mo.	100-150	65-85/45-55	35-55
3-6 mo.	90-120	70-90/50-65	30-45
6-12 mo.	80-120	80-100/55-65	25-40
1-3 yr.	70-110	90-105/55-70	20-30
3-6 yr.	65-110	95-110/60-75	20-25
6-12 yr.	60-100	100-120/60-75	14-22

Keep patient NPO until full assessment is completed

AIRWAY

Anatomical differences to be aware of:

- The larynx is higher and more anterior in the neck, and the vocal cords are at a more anterior-caudal angle
- The epiglottis is omega-shaped and soft
- The narrowest portion of the airway is the cricoid ring, not the vocal cords
- Burns to the nasal passage of young infants can cause signs of respiratory distress due to obligatory nose breathing

INTUBATION

Emergently intubate:

- Significant burns to mouth and/or nose
- Stridor, wheezing, respiratory distress, hypoxia
- Altered mental status with the inability to protect the airway

Urgent evaluation of airways:

- Carbonaceous sputum
- Any facial burns
- Cough with distress, stridor, or hypoxia
- Prolonged closed-space heat exposures
- Large burns >20%

Early intubation, if airway control is needed, is vital to prevent a future difficult intubation scenario.

Consider:

- Keep Patient NPO
- Administer 100% Oxygen
- Elevate HOB
- Appropriate size Endo-Tracheal Tube (ETT)
- Appropriate securing device
 - Commercial device
 - Tape/Twill tape/Trach ties
- Nasogastric tube (NG)/Orogastric tube (OG) inserted

Medications for rapid sequence intubation (RSI)

Table 3.

Agent	Dosage	Comment
Induction		
Etomidate	0.2-0.4 mg/kg	Rapid onset (30-60sec), peaks in 1 minute
Versed	0.1-0.2 mg/kg	
Fentanyl	1-5 mcg/kg	
Paralytics		
Rocuronium	1 mg/kg	Rapid onset
Succinylcholine	1-2 mg/kg	Only if <24 hrs. since the injury
Vecuronium	0.1 mg/kg	

Use cuffed endotracheal tubes if available

Equipment (up to 20kg)

Table 4.

Weight	3kg	5kg	10kg	15kg	20kg
ETT	3-3.5	3.5-4.0	4-4.5	4.5-5.0	5.0-5.5
Blade	Miller 0-1	Miller 0-1	Miller 0-1	Miller 1-2	Miller 2
Suction	6-8 Fr	8-10 Fr	10 Fr	10 Fr	10 Fr
NG Tube	5-8 Fr	5-8 Fr	8-10 Fr	10-12 Fr	12-14 Fr
Foley	6-8 Fr	6-8 Fr	8-10 Fr	10-12 Fr	10-12 Fr
Chest Tube	10-12 Fr	12-16 Fr	16-20 Fr	20-24 Fr	24-32 Fr
LMA (cuff)	1 (4ml)	1.5 (7ml)	2 (10ml)	2 (10ml)	2-2.5 (14ml)

Equipment (over 20kg)

Table 5.

Weight	20-25kg	30kg	40kg	>50kg
ETT	5.5-6.0 cuff	6.0-6.5 cuff	7.0-7.5 cuff	7.5-8.0 cuff
Blade	Mil/Mac 2	Mil/Mac 2-3	Mil/Mac 3	Mil/Mac 3
Suction	10 Fr	10 Fr	12 Fr	12-14 Fr
NG Tube	12-14 Fr	14-16 Fr	14-16 Fr	16-18 Fr
Foley	12 Fr	12 Fr	12-14 Fr	12-14 Fr
Chest Tube	28-32 Fr	28-32 Fr	32-40 Fr	32-40 Fr
LMA (cuff)	2.5 (17ml)	3 (20ml)	3 (20ml)	4-6 (30-50ml)

VENTILATION

Initial Ventilator Settings – **Adjust as needed and call Riley Burn Center for further recommendations.**

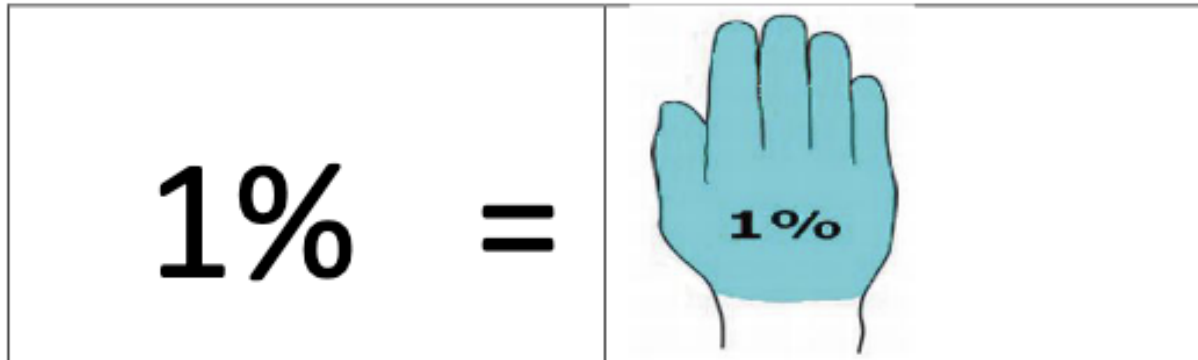
Table 6.

Weight	<10kg	10-40kg	>40kg
Mode	Pressure Control	Pressure Control	Pressure Control
Rate	40	28	16
PIP	15-20 cmH2O	15-20 cmH2O	20 cmH2O
PEEP	5-8 cmH2O	5-8 cmH2O	5-8 cmH2O
FiO2	100%	100%	100%
Inspiratory Time	0.3 sec	0.7 sec	1 sec

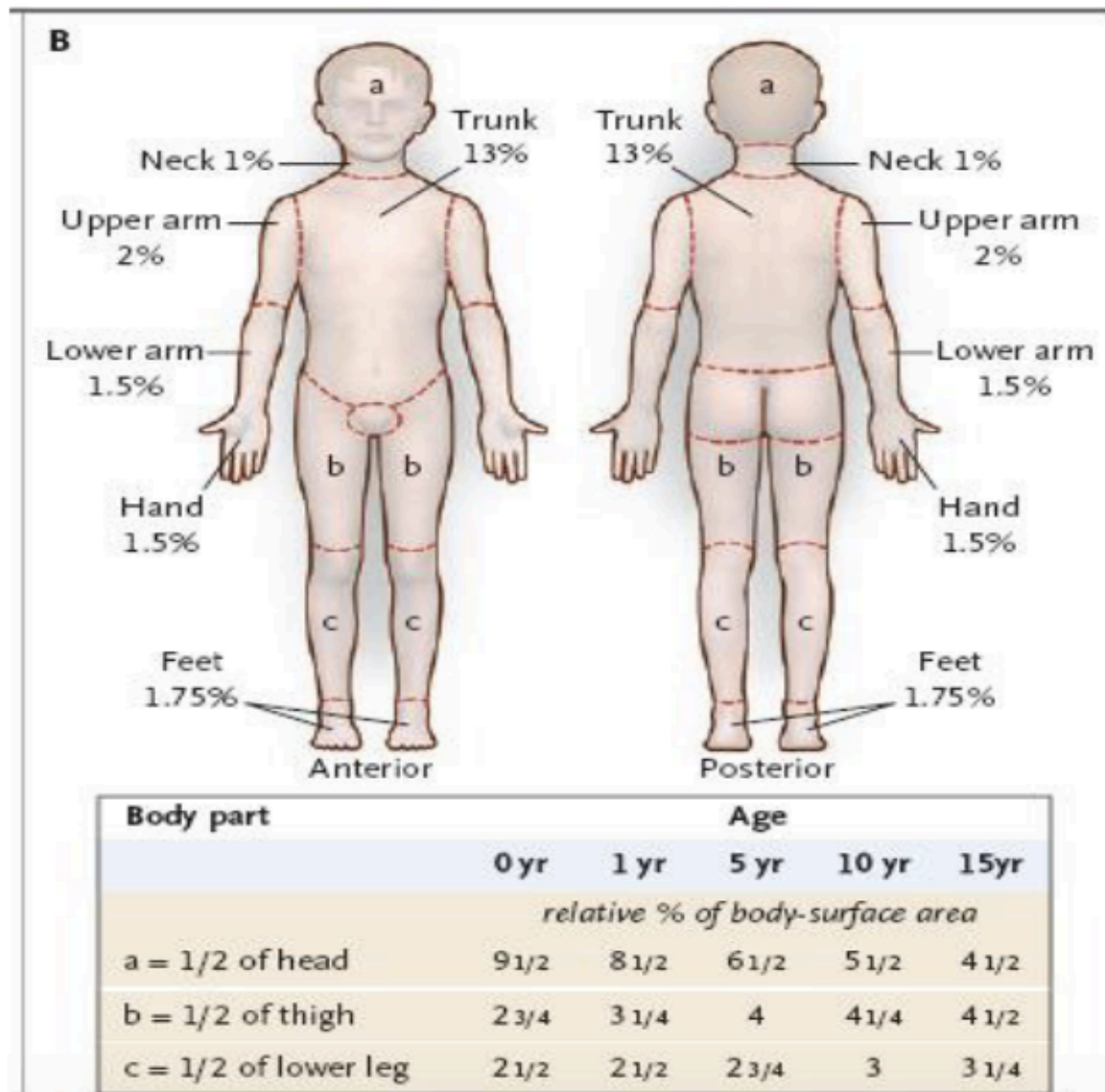
Do not forget pain management and sedation

BURN ASSESSMENT

The Palm Method – The Patient’s palmar surface is equal to 1% of the patient’s body



Lund-Browder Chart –



FLUID RESUSCITATION

If IV access cannot be obtained, intraosseous (IO) access should be used

1. Start resuscitation fluids at the following rates while calculating TBSA and starting the assessment
 - a. 125ml/hr. LR for <5yrs
 - b. 250ml/hr. LR for 6-13 yrs.
 - c. 500ml/hr. LR for >13 yrs.
2. If burns $\geq 15\%$ TBSA, give resuscitation fluids in addition to maintenance fluids (see Exemplar Table)
 - a. To calculate resuscitation fluids: **3ml LR x kg x TBSA (counting only partial and full thickness burns) in the first 24 hours after injury, with $\frac{1}{2}$ given in the first 8 hours and $\frac{1}{2}$ given in the next 16 hrs. For adults, use 2ml LR x kg x TBSA.**
 - b. If < 1 yr. of age, give D2 LR as maintenance fluids, and if ≥ 1 yr of age, use LR as maintenance (in addition to resuscitation fluids)
3. The urine output target is 1-2 ml/kg/hr.

Exemplar Table

Exemplar Burn Resuscitation Fluid Calculations				
Patient Weight	TBSA burn	Calculation	Estimated 24h Resuscitation Total (NOT including maintenance fluids)	Fluid type (dependent on patient weight)
8 kg	20%	3 x 8 x 20	480 ml	D5 LR
8 kg	40%	3 x 8 x 40	960 ml	D5 LR
8 kg	60%	3 x 8 x 60	1,440 ml	D5 LR
8 kg	80%	3 x 8 x 80	1,920 ml	D5 LR
10 kg	20%	3 x 10 x 20	600 ml	LR
10 kg	40%	3 x 10 x 40	1,200 ml	LR
10 kg	60%	3 x 10 x 60	1,800 ml	LR
10 kg	80%	3 x 10 x 80	2,400 ml	LR
20 kg	20%	3 x 20 x 20	1,200 ml	LR
20 kg	40%	3 x 20 x 40	2,400 ml	LR
20 kg	60%	3 x 20 x 60	3,600 ml	LR
20 kg	80%	3 x 20 x 80	4,800 ml	LR
30 kg	20%	3 x 30 x 20	1,800 ml	LR
30 kg	40%	3 x 30 x 40	3,600 ml	LR
30 kg	60%	3 x 30 x 60	5,400 ml	LR
30 kg	80%	3 x 30 x 80	7,200 ml	LR
40 kg	20%	3 x 40 x 20	2,400 ml	LR
40 kg	40%	3 x 40 x 40	4,800 ml	LR
40 kg	60%	3 x 40 x 60	7,200 ml	LR
40 kg	80%	3 x 40 x 80	9,600 ml	LR
50 kg	20%	3 x 50 x 20	3,000 ml	LR
50 kg	40%	3 x 50 x 40	6,000 ml	LR
50 kg	60%	3 x 50 x 60	9,000 ml	LR
50 kg	80%	3 x 50 x 80	12,000 ml	LR

APPENDIX 6

BURN SURGE EVENT RESOURCES AND CONTACT INFORMATION

Tier 1 - Indiana Burn Centers

An American Burn Association (ABA) Verified Burn Center meets strict guidelines set forth by the ABA. Specifically, verification of burn centers is a joint program of the American Burn Association (ABA) and the American College of Surgeons (ACS). It is a rigorous review program designed to verify a burn center's resources that are required for the provision of optimal care to burn patients from the time of injury through rehabilitation. In a burn surge event, the sickest patients ideally are transported to an ABA Verified burn facility. There are two verified burn facilities in Indiana. [American Burn Association](#)

Tier 1 – Region 5 Verified Burn Centers						
Facility	City	Phone	Trauma Level	Burn Beds	Burn Surge	Age
Sidney & Lois Eskenazi Hospital (Richard M Fairbanks Burn Center)	Indianapolis, IN	800-487-2862	Level I Adult	15	23	Adult
IU Riley Children's Hospital	Indianapolis, IN	800-487-2862	Level I Ped	10	15	Peds
University of MI Trauma Burn Center	Ann Arbor, MI	Trauma Burn Clinic: 734-936-5738 Trauma Burn Intensive Care Unit (TBICU): 734-936-9631.	Level I Adult and Ped			Adult and Ped
Children's Hospital of Michigan Burn Center	Detroit, MI	313-831-3220	Level I Ped			Peds
Detroit Receiving Hospital Burn Center	Detroit, MI	313-745-3449	Level I Adult			Adult
Loyola Medicine Children's Hospital	Maywood, IL	888-584-7888	Level I Ped			Peds
Loyola Burn Center	Maywood, IL	708-216-4444	Level I Adult			Adult
University of Chicago/Comer Children's	Chicago, IL	888-824-0200	Level I Adult and Ped	8		Adult and Ped
Akron Children's Hospital Burn Center	Akron, OH	330-543-8224				Adult and Ped
Burn Care Center at MetroHealth	Cleveland, OH	216-778-2876	Level I Adult, Level II Ped			Adult and Ped
Burn Center at Nationwide Children's Hospital	Columbus, OH	614-722-3900	Level I Ped			Peds
The Ohio State Comprehensive Burn Center	Columbus, OH	614-293-2876	Level I Adult			Adult
University of Cincinnati Medical Burn Center	Cincinnati, OH	513-584-1000	Level I Adult			Adult
Ascension Columbia St Mary's Hospital Regional Burn Center	Milwaukee, WI	414-585-6683	Level IV			Adult and Ped
Regions Hospital Burn Center	Saint Paul, MN	800-922-2876	Level I Adult			Adult and Ped

Tier 2 - Indiana Trauma Centers

Indiana’s Trauma System follows guidelines as set forth by the American College of Surgeons. A trauma center is a hospital that is equipped to provide comprehensive care to patients suffering from traumatic injuries. In a burn surge event, once the burn centers reach surge capacity, trauma centers are the next level of care that the patient should be taken to.

[Indiana Department of Health Trauma Centers](#)

[American College of Surgeons Trauma Centers](#)

Tier 2- Indiana Verified Trauma Centers						
Facility Name	Trauma Level	City	District	Phone	Critical Care Beds	Age
Ascension St. Vincent Anderson Regional Hospital	III	Anderson	6	765-646-8373	21	Adult
Ascension St. Vincent Evansville	II	Evansville	10	812-485-4000	39	Adult/Ped
Ascension St. Vincent Indianapolis Hospital	I	Indianapolis	5	317-338-7000	90	Adult/Ped
Community Hospital-Anderson	III	Anderson	6	765-298-4242		Adult
Deaconess Hospital Evansville	II	Evansville	10	812-450-5000	67	Adult
Elkhart General Hospital	III	Elkhart	2	574 294-2621	23	Adult
Eskenazi Hospital	I	Indianapolis	5	800-487-2862		Adult
Franciscan Health Crown Point	III	Crown Point	1	219-738-2100		Adult
Franciscan Health Indianapolis	III	Indianapolis	5	317-528-5000	30	Adult
Franciscan Health-Lafayette East	III	Lafayette	4	800-654-9410	12	Adult
Good Samaritan Hospital	III	Vincennes	10	812-882-5220		Adult
IU Health Bloomington	III	Bloomington	8	812-353-5252	34	Adult
IU Health Methodist Hospital	I	Indianapolis	5	317-962-2000	195	Adult
IU Health-Arnett Hospital	III	Lafayette	4	765-448-8000	14	Adult
IU Health-Ball Memorial	III	Muncie	6	765-747-3111	18	Adult
Lutheran Hospital of Indiana	II	Ft. Wayne	3	260-435-7001	85	Adult/Ped
Memorial Hospital and Health Care Center	III	Jasper	10	812-996-2345		Adult

Memorial Hospital of South Bend	II	South Bend	2	574-647-1000	66	Adult
Parkview Regional Medical Center	II	Ft. Wayne	3	260-266-1000	47	Adult/Ped
Reid Hospital & Health Care	III	Richmond	6	765-983-3000		Adult
Riley Hospital for Children at IU Health	I	Indianapolis	5	317-944-5000		Ped only
Terre Haute Regional	III	Terre Haute	7	812-232-0021		Adult
Union Hospital	III	Terre Haute	7	812-238-7000	36	Adult
Total Critical Care Beds					777	

Tier 3 - Indiana *Potential* Burn Surge Facilities

While Potential Burn Surge Facilities may not provide definitive care, the expectation is that they will take steps to stabilize the patient up to or exceeding 72 hours or until transfer to a higher level of care can be achieved. Facilities meet the criteria span the entire State and may provide surge capability during a burn surge event. The table below is a representative list of possible PBSF based on locations within Public Health Districts.

All PBSFs listed are non-burn centers and non-trauma centers, selected to potentially provide interim care to burn patients based on the following capabilities: (1) the hospital has an emergency department; (2) the hospital has intensive care services with greater than 20 beds; and (3) the hospital has 24/7 on-call general surgeon coverage. Geographic coverage for the state was also considered when identifying BSFs. Ideally, BSFs will receive the least injured burn surge event patients and shall provide life-sustaining and basic burn care until transfer to a higher level of care can be arranged.

Tier 3 - Indiana Potential Burn Surge Facilities					
Facility Name	City	District	Phone	Critical	Notes
Northwest Health Porter	Valparaiso	1	219-983-8300	32	
Community Hospital Munster	Munster	1	219-836-1600	34	
Methodist Hospital	Gary	1	219-886-400	45	
St. Mary Medical Center	Hobart	1	219-942-0551	32	
Franciscan Health	Hammond	1	219-932-2300	20	
Franciscan Health Michigan	Michigan City	1	219-879-8511		

Memorial Hospital of South Bend	South Bend	2	574-647-1000	66	54 adults, 12 PICU
Goshen Health	Goshen	2	574-364-1000	12	Adult only
Elkhart General	Elkhart	2	574-294-2621	23	Adult only
Lutheran Kosciusko	Warsaw	2	574-267-3200	9	Adult only
Parkview Kosciusko	Warsaw	2	574-372-0000	4	Adult only
St. Joseph Regional Medical	Mishawaka	2	574-335-5000	28	Adult only
Community Hospital East	Indianapolis	5	800-777-7775	47	
Community Hospital North	Indianapolis	5	317-621-6262	56	
Community Hospital South	Indianapolis	5	317-887-7000	36	
Franciscan Health	Indianapolis	5	317-528-5000	30	
IU Health University	Indianapolis	5	317-944-5000		
Baptist Health Floyd	New Albany	9	812-944-7701		
Clark Memorial Hospital	Jeffersonville	9	812-282-6631	22	
Memorial Hospital & Health	Jasper	10	812-996-2345	23	
Total Critical Care Beds				519	

* Note: These facilities are only identified based upon the preceding criteria, no hospital has agreed to nor received any type of designation. This list is for potential reference only.

Trauma Center Map

Trauma Centers *in Indiana*

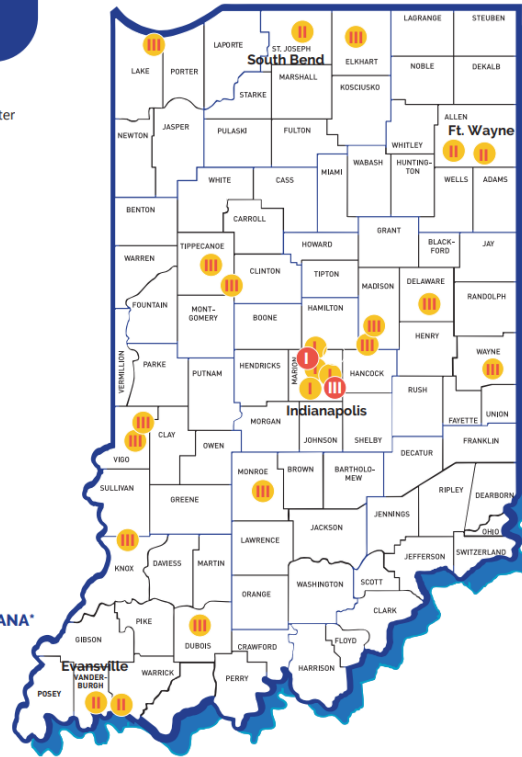
- LEVEL I**
 - Indianapolis**
 - Eskenazi Health
 - IU Health Methodist Hospital
 - Riley Hospital for Children at IU Health
 - Ascension St. Vincent Hospital
- LEVEL II**
 - Evansville**
 - Deaconess Hospital
 - Ascension St. Vincent - Evansville
 - Ft. Wayne**
 - Lutheran Hospital of Indiana
 - Parkview Regional Medical Center
 - South Bend**
 - Memorial Hospital of South Bend
- LEVEL III**
 - Anderson**
 - Ascension St. Vincent Regional Hospital
 - Community Hospital - Anderson
 - Bloomington**
 - IU Health Bloomington
 - Crown Point**
 - Franciscan Health - Crown Point
 - Elkhart**
 - Elkhart General Hospital

- Jasper**
- Memorial Hospital and Health Care Center
- Lafayette**
- Franciscan Health - Lafayette East
- IU Health - Arnett Hospital
- Muncie**
- IU Health - Ball Memorial Hospital
- Richmond**
- Reid Health
- Terre Haute**
- Terre Haute Regional
- Union Hospital - Terre Haute
- Vincennes**
- Good Samaritan Hospital

- PROVISIONAL**
- Indianapolis**
- Peyton Manning Children's Hospital - Ascension St. Vincent
- PROVISIONAL**
- Indianapolis**
- Franciscan Health - Indianapolis

TOTAL TRAUMA CENTERS IN INDIANA*

- I** Level I = 4
- II** Level II = 5
- III** Level III = 13
- I** Provisional = 1
- III** Provisional = 1
- Total = 25**



Division of Trauma & Injury Prevention

* Total includes current and In Process Trauma Centers

Updated: 9-17-2021

APPENDIX 7 FEDERAL RESOURCES

FEDERAL RESOURCES

In a burn surge event, Federal resources will not be available to respond until within 48-72 hours after the initial event. Therefore, all responders and healthcare entities must plan on little to no Federal assistance in the first days of the event. Once the Federal resources have been requested through the appropriate emergency management and homeland security channels, assistance will likely come in the form of activation of the National Disaster Medical System (NDMS).

Based on the incident response needs, activation of the NDMS should be considered. Activation of this resource is done through the state Emergency Operations Center (EOC) through the ESF-8 Coordinator. NDMS manages and coordinates the federal medical response to major emergencies and federally declared disasters, including natural disasters, technological disasters, major transportation accidents, and acts of terrorism, including those that might involve weapons of mass destruction. NDMS is a section within the US Health and Services Agency and works closely with the Department of Defense (DOD) and the Department of Veterans' Affairs (DVA).

NDMS has three functions: (1) medical response to the disaster site; (2) patient movement from the disaster area to unaffected areas of the nation; and (3) definitive medical care in unaffected areas. Under NDMS, the patient regulation and movement mission is the responsibility of the DOD, specifically of the Global Patient Movement Requirements Center (GPMRC) of the U.S. Transportation Command, Scott Air Force Base, Illinois.

NDMS may be activated in three ways: (1) the Governor of an affected state may request a Presidential declaration of disaster or emergency; (2) a state health officer may request NDMS activation by the Department of Homeland Security; and (3) the Assistant Secretary of Defense for Health Affairs may request NDMS activation when military patient levels exceed DOD and DVA capabilities. Once NDMS is activated, Federal Coordinating Center (FCC) coordinators collect available bed data and the number of patients who can be processed through a patient receiving area and transported to local NDMS hospitals within 24 hours. The DOD operates 24 FCCs and the DVA operates 37 FCCs.

ADDITIONAL RESOURCES

Advanced Burn Life Support Course Provider Manual (2018 update)
[2018-abls-providermanual.pdf \(ameriburn.org\)](#)

American Burn Association
[American Burn Association – Improving the lives of those affected by burn injury \(ameriburn.org\)](#)

ASPR Tracie Disaster Behavioral Health
[Disaster Behavioral Health | ASPR TRACIE \(hhs.gov\)](#)

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Peral-Gutierrez de Ceballos, J., et al. 11 March 2004: The Terrorist Bomb Explosions in Madrid, Spain an Analysis of the Logistics, Injures Sustained and Clinical Management of Casualties Treated at the Closest Hospital. (2004). Critical Care online. Retrieved from: <http://ccforum.com/content/9/1/104>.

American Burn Association, 2018, Advanced Burn Life Support Course Provider Manual

HEALTHCARE COALITION RADIATION SURGE PLAN ANNEX

District 2 Healthcare Coalition

January 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)	Name
6/2024	Random	Grammatical corrections	Jennifer Tobey
5/2025	Random	Review/Update	Jennifer Tobey
1/2026	Random	Review/Update	Jennifer Tobey

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OVERVIEW

HCC MEMBER ORGANIZATIONS - CORE MEMBERS IN BOLD

1. **Hospitals (a minimum of two acute care hospitals)**
2. **Emergency Management Agency (EMA)**
3. **Emergency Medical Services (EMS) (including facility and other non-EMS patient transport systems)**
4. **Local Public Health Department(s) (LHD)**
5. Behavioral Health Services and organizations
6. Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
7. Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks
8. State and Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indiana Health Service facilities, military treatment facilities)
9. Home health agencies (including home and community-based services)
10. Infrastructure companies (e.g., utility and communication companies)
11. Jurisdictional partners, including cities, counties, and tribes.
12. Local chapters of professional healthcare organizations (e.g., medical society, professional society, hospital association)
13. Local public safety agencies (e.g., law enforcement and fire services)
14. Medical and device manufacturers and distributors
15. Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
16. 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)
17. Primary care providers, including pediatric and women's health care providers.
18. Schools and universities, including academic medical centers.
19. Skilled nursing, nursing, and long-term care facilities
20. Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
21. Medical examiners/coroners and funeral homes
22. Agency/facility public information specialists
23. Agencies that support an Emergency Support Function (ESF)
24. Other (e.g., childcare services, dental clinics, social work services, faith-based organizations)

PURPOSE

The purpose of this support plan is to supplement existing planning and response guidance with specific information regarding the management of patients during a Radiation Surge Event. The District 2 Healthcare Coalition (D2HCC) Radiation Surge Annex will describe guidance and processes to improve capacity and capabilities to manage many casualties that are affected by a large radiation surge event. According to the 2017-2022 Healthcare Preparedness and Response Capabilities, Healthcare Coalitions (HCC) “are groups of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location that plays a critical role in developing health care delivery system preparedness and response capabilities.”

HCCs serve as multiagency coordination groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities. HCCs coordinate activities among healthcare organizations and other stakeholders in their communities; these entities comprise HCC members that actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained healthcare personnel.

This plan applies to a mass casualty event with many patients affected by a radiation release/event (including a bioterrorism event) and supports the D2HCC Emergency Response Plan (ERP) by addressing specific community needs of those affected by a large radiation surge that may require medical care during a disaster.

SCOPE

This annex is intended to be a high-level response plan describing the following:

- Coalition coordination and support in radiation outbreaks/releases
- Identification of experts and specialized resources that exist within the HCC.
- Tracking of patients throughout an incident
- Identification of strategies to manage surges and scarce resources.
- Coordination support for transferring acutely ill patients as indicated by the incident.
- Coordination support for the decompression of acute care/free-standing facilities to increase specialty bed availability.

This plan is a supplement to, not a replacement for, the response actions and resources described in the coalition, facility, or agency Emergency Operations Plan and provides additional details relevant to an incident that involves significant numbers of victims and is not intended to describe or define processes of individual hospital operations nor supersede hospital plans and processes. Each hospital in the D2HCC is encouraged to develop more detailed plans that support their individual operations and supplement this annex.

For this plan and for the purpose of HCC planning and response, a radiation surge event (RSE) is defined as:

“An incident where an unusual radiological event overwhelms local and/or regional healthcare system capacity to triage, stabilize, and/or transfer patients to a treatment facility and assistance will be requested from the HCC.”

MAINTENANCE

The HCC will conduct an annual review of this annex in coordination with the member agencies and organizations as appropriate. Additional reviews may be conducted after an exercise, a significant incident/event occurs, or regulatory changes indicate a need. The HCC Planning Section Chief (PSC) will track and distribute any changes needed to this plan using the Document Change Record in Table 1 when changes/updates are required outside the official cycle of plan review.

SITUATION OVERVIEW

The HCC serves as the formal entity for healthcare preparedness planning in the Midwest /Region 5. There are 13 acute care hospitals within the district. The following resources exist in the region:

- Memorial Hospital of South Bend: Level II Trauma Center, Level II Newborn ICU, Therapeutic Stroke Center
- St Joseph Regional Medical Center: Level III Newborn ICU, Stroke Center
- Elkhart General Hospital: Level III Trauma Center

Radiation patients could easily overwhelm existing resources in the region. All hospitals are recommended to have surge plans in place for a radiation release/event, with the aim of increasing bed capacity. The entire Northern top of Indiana Region 5 is subject to radiological incidents that may result from a deliberate act or an unintentional release. The most common radiological incidents involve the loss, theft, or mismanagement of relatively small radioactive material sources, or technologically enhanced naturally occurring radioactive material (TENORM), where some exposure of individuals or dispersal into the environment occurs. Generally, greater regulatory control, safeguards, and security accompany larger quantities of radioactive materials, which pose a greater potential threat to human health and the environment. Virtually any facility or industrial practice (including transportation of materials) may be vulnerable to a deliberate act or unintentional act that could release radioactive material.

The definition of ‘radiation emergency event’ is applicable to this annex and can be used as a reference for any radiation (surge) event. Refer to Appendix B for additional radiation terms referenced in this annex.

Radiological Emergency Event: Radiological emergencies are events/circumstances caused by biological and terror agents with the potential for significant illness or death in the population. The Radiation Surge Annex (RSA) and appropriate Emergency Response Plans (ERP) may be used in situations that include nuclear emergencies, dirty bombs, radiological dispersal devices (RDD), radiological exposure devices (RED), nuclear power plant accidents, transportation accidents, terrorism, and occupational accidents.

- Radiological dispersal device (RDD) is any device used to spread radioactive material into the environment with malicious intent using conventional explosives. The harm caused by RDD is principally contamination, and denial of use of the contaminated area, perhaps for many years.
- Radiological exposure device (RED) is any radiological source placed in a way to cause elevated radiological exposure to a person or to people.
- Improvised Nuclear Device (IND) is an illicit nuclear weapon bought, stolen, or otherwise originating from a nuclear state, or a weapon fabricated from illegally obtained fissile nuclear weapons material that produces a nuclear explosion.

PLANNING ASSUMPTIONS

The U.S. Department of Health and Human Services (DHHS) Administration for Strategic Preparedness and Response (ASPR) set the goal that hospitals have the capability of providing radiation exposure care, at a minimum, to at least 50 severely injured adult and pediatric patients per million of a population due to a radiation surge incident.

The MW/R5 does have 3 operational radiation/nuclear facilities:

- Cook Nuclear Plant-Michigan
- Palisades-Michigan
- Braidwood-Illinois

Medical treatment, radiation activities and research along with manufacturing and transportation of vesicles carrying radiation material through the district occur daily. Transportation is both on major thoroughfares and rail.

THREAT ASSESSMENTS

The following local risks may reasonably impact District 2's radiation capacity rapidly.

- Source contamination (localized and downwind particulate deposition – terrorism/explosives; research, radioisotopes, biological, toxic industrial)
- Ionizing radiation exposure (industrial)
- Transportation Incidents (motor vehicle, air, rail, waterway)

RADIATION CARE PLANNING ASSUMPTIONS

1. Radiological incidents may involve no exposed individuals or hundreds of thousands; and may be presented to the emergency department with little or no warning.
2. Non-RITN facilities (local hospitals and/or medical centers) will receive patients from mass casualty incidents.
3. The mode of radiological material dispersal may cause a variety of non-radiological damages. The most common of these is the psychological damage sustained by those in the affected and surrounding communities. The psychological effects of a radiological event may require both emergency and long-term mental health services.
4. Affected critical facilities may be out of service for extended periods of time. These facilities must be decontaminated and determined to be safe prior to reoccupation.
5. Treatment of radiation patients is resource intensive. Treatment may last for weeks/months after the incident.
6. Emergency Medical Services (EMS) personnel will triage victims using the START/SALT methods in a mass-casualty situation.
7. District 2 hospitals activate their Hospital Command Centers (HCC) in a large-scale disaster.
8. District 2 hospitals utilize established communication tools including Preparis, SERV-IN, EMResource, WEBEOC, and/or 800 MHz radios in a disaster to share information.
9. The Regional Healthcare Coordinator (RHC) will serve as a clearing house for information, assist with coordinating resources among SW/R6 hospitals/coalition, and procure additional resources for the region as needed.
10. Radiation incidents may be accidental in nature (e.g., industrial or transportation accident) or purposeful and require a prolonged response and extensive resource management challenges.
11. Substantial differences in response protocols and priorities exist between power plant / industrial, terrorist (e.g., RDD/dirty bomb), and nuclear bomb detonation.
12. The coalition annex does not replace the need for protocols at each hospital and EMS agency.
13. Different agencies may have authority over the management of power plants, transportation, and terrorist incidents, including the authority to implement shelter-in-place and evacuation orders.
14. The roles and responsibilities of agencies and organizations will change depending on the severity and scale of the incident and the respective level of activation by impacted jurisdictions.
15. Fear of the incident will cause a worried-well surge in the emergency departments and pharmacies. Consider how a limited understanding of radiation and nuclear contamination will contribute to public anxiety and will require multi-modal solutions.
16. Public safety (e.g., police, fire, EMS) and other first responder personnel are considered a high-risk population; the implementation of protocols for monitoring control zones and effective contamination control measures will be essential for workforce protection.
17. Federal resources (e.g., ambulance contracts, and National Disaster Medical System [NDMS] teams) cannot be relied upon to mobilize and deploy for the first 72 hours.

18. Management of contaminated waste from decontamination efforts should be managed in consultation with SMEs, EPA, and local water authorities.
19. The District 2 hospitals could receive patients from other regions during a radiological mass casualty event.

RADIATION TRIGGERS

- Report on radiation emergency
- Local EOCs and State emergency operation centers are fully activated statewide to respond to catastrophic incidents.
- Damage to infrastructure, transportation, and/or utilities and communications
- Healthcare assets in the local jurisdiction are experiencing a surge and require the participation of additional healthcare assets within and outside the local jurisdiction
- Increased patient encounters or hospital census
- Hospital activating their EOC. Eds requesting additional medical staff or are on diversion (>20-30%)
- Medication supplies limited or distribution in medical supply chain
- Unable to track or locate all patients impacted by the incident
- Public information hotlines needed
- Community based intervention required

OPERATIONAL/LOGISTICS

General

This Radiation Surge Annex serves as the operational framework for coordinating coalition-level response and recovery activities for radiation surge within the region through the following:

- The Regional Healthcare Coordinator will serve as the base of direction, control, and coordination of coalition-level support, in coordination with the local jurisdiction's EOC, when activated.
- Local governments are responsible under all applicable laws, executive orders, proclamations, rules, regulations, and ordinances for a response within their respective jurisdiction(s).
- Upon activation in support of radiation surge operations, the agencies and organizations identified within this plan will ensure the necessary personnel and resources are available to achieve the operational objectives.
- Personnel from supporting agencies will operate in accordance with the rules, regulations, and capabilities of their respective agency or organization.
- Patient transfer operations will be coordinated through the local EOCs in coordination with the state EOC, when feasible.

CONCEPT of OPERATIONS

Notification/Activation

The HCC would expect local EMS providers to have a plan to address the items in this table:

Medical Surge Elements to Incorporate into EMS Operations Plans	
Area	Area Description
Dispatch	<ul style="list-style-type: none"> • Identify procedures to: <ul style="list-style-type: none"> – Alert hospitals of an emergency per local protocol. – Communicate hospital capacity and capability to EMS providers. – All EMS surge requests utilize mutual aid response plans per local protocol.
Response	<ul style="list-style-type: none"> • Match appropriate specialized providers and equipment with the nature of the emergency (e.g., hazardous materials [HAZMAT] trained crews during a chemical spill). • Consider surge strategies such as changing shift lengths or crew configurations, using alternate vehicles, using community paramedicine, or other non-ambulance responses in coordination with dispatch priorities.
Pre-hospital triage and treatment	<ul style="list-style-type: none"> • Implement disaster triage procedures and other standard operating procedures (e.g., eliminate the requirement for verbal orders). • Consider processes that allow for expanded scope of practice. • Plan for specialty responses, such as HAZMAT, highly infectious disease, mass burn, mass trauma, and mass pediatric emergencies.
Transportation	<ul style="list-style-type: none"> • Identify procedures to surge the number of patients transported by vehicle or aircraft. • Identify procedures for changing preferred destination facilities (e.g., trauma center, pediatric hospital) or not using the closest hospital. • Identify procedures for type and level of pre-hospital care delivery and mode of transport (ground and air medical). • Develop and implement EMS patient distribution strategies to avoid overloading any single hospital. • Identify procedures for transporting patients to alternate care sites.
Supplies and Equipment	<ul style="list-style-type: none"> • Utilize physical resources including supplies, equipment, and cached materials to support a medical surge.

TRACKING

Patient tracking refers to several types of processes and documentation across the patient movement. These types consist of:

- **Pre-Hospital Tracking**
Currently, EMS within District 2 tracks patients via paper methods during a surge event. There is not an established or consistent process in place.
- **Patient Movement Tracking**
Each agency providing inpatient, or outpatient care shall establish a means for tracking patients both within their facility and include a method for tracking when a patient is transferred from the facility.
- **Unidentified Patient Tracking**
Each member agency should have in place a method for tracking and identifying those patients who arrive and are non-communicative or have no identification.
The HCC may be asked to assist with Family Reunification and shall work collaboratively with the EOC and ESF-8 officer to assist if a Family Assistance Center is established. The HCC may also request lists of patient names in accordance with HIPPA from member agencies to assist with family reunification.

TRANSPORTATION

The on-scene command will work with the hospital House Supervisor or designated employee to coordinate appropriate transportation assets and staffing.

Follow EOP for coordination of other transportation and staging, other needs, and issues.

If patients require a higher level of acuity and are needing transport, Hospitals will utilize internal procedures for transferring those patients. Conference calls may be made with hospitals, RHC/team, and the state to determine the appropriate level of care.

Transportation could take hours for certain patients depending on their condition and where EMS services come from. In the event of patients needing inter or intra-facility transport within the region and/or neighboring states, MOUs will be activated, and transport of these patients will start locally and advance to state facilities if required due to surge.

ROLES AND RESPONSIBILITIES

Healthcare Coalition (HCC)

HCC Regional Healthcare Coordinator will be activated when a radiation surge incident occurs in the district and/or this annex has been activated. HCC has access/training in the use of communication and alerting systems: Preparis, SERV-IN, and 800MHz radios. Using these communication tools will enable the team to quickly disseminate information to the coalition members to aid in the response.

Primary functions of the team:

- The current availability of district medical resources.
- The availability of state and/or federal medical resources.
- The coordination of requests and receipt of extra-regional medical resources, including submission of 213 RRs to the state/federal level for equipment/supplies/medication.
- To serve as an interface between hospitals, Homeland Security Districts, local Emergency Operations Centers (EOCs), Indiana Department of Health (IDOH), and if needed Emergency Operations Centers (EOCs) as part of ESF #8.
- It serves as an information interface between coalition members to help determine the severity of the incident. Information will come from core members and partners and will include:
 - How many were affected?
 - Location?
 - Shelter in place?
 - Hospital capabilities and bed availability?
 - Alternate Care Center needed (ACC)?
 - Activate the multi-agency coalition (MAC) Or Incident Management Team (IMT)?
 - HCC will utilize communication platforms to assist in disseminating information and to assess the ongoing situation to determine resource needs.

Fire and Emergency Medical Services

- Manages the scene per the incident command structure (ICS).
- Provide incident briefing to hospitals during the response via Hospital IHERN including:
 - Incident/radiation type.
 - Expected/estimated number of patients injured by triage category.
 - Special needs requirements (e.g., pediatrics, burn, OB, etc.).
 - Number of patients transported (with destination) prior to activation of the Net.
 - Triage areas are set up to determine who requires transport to the hospital or to a CRC.
- Collaborate with the Medical Director related to patient routing during a radiation event.
- Support hospital decontamination operations if requested and able.
- Assist/operate radiation-specific equipment on scene triage.
- Maintain communication with the EOC to determine where to send “worried well” and family members to the family reunification location.

Emergency Management Agencies

- Provide the Executive Director to act for the Governor to provide direction and control, and to carry out the state’s response to protect the public’s health, safety, and property during an incident at a commercial nuclear power plant affecting District 2.
- Serve as the primary agency for (Emergency Support Function) ESF-2, Communications, and Information Technology; ESF-5, Information and Planning; ESF-6, Mass Care; ESF-7, Resource Support, and Logistics; ESF-14, Recovery and Mitigation; and ESF-15, Emergency Public Information, and External Affairs.
- Assign the Radiological Branch Chief responsibility for maintaining 24-hour communication capabilities in conjunction with the County EMA Office.

- Serve as the general coordination point for utility, private and non-profit organizations, and local, state, and federal governments.
- Request restriction of air, rail, and water traffic, as necessary
- Designate a Public Information Officer(s) who will be located at the district JIC and/or Utility JIC/JPIC.
 - Provide situational reports.
- Notify key state partner agencies, including FEMA Region V.
- Assist in the distribution of Direct Reading Dosimeters (DRD), Thermoluminescent Dosimeters (TLD) or Optically Stimulated Luminescent Dosimeters (OSLD), and Potassium Iodide (KI) to state responders as part of the emergency worker exposure control program.
- Local EMA – use of WebEOC for assistance with patient tracking and resource requests.
 - Activation of county EOC.
 - Coordinate data collection, community needs, and any requests for a countywide emergency declaration.
 - Coordinates mass care and CRC and activities working with other private agencies.

Public Health Departments

Public health’s initial responsibility during a radiation emergency is population monitoring. For the purposes of this response plan, population monitoring considerations will be made in the context of first local Assembly Centers (AC) then Community Reception Center (CRC) operations. AC are expected to be set up 24-48 hours after an event has occurred to serve as initial assessments, provide immediate triage and gross decontamination centers. Based on findings at the AC, local jurisdictional authorities where the incident occurred will lead and direct activation and operation of a CRC in partnership with regional, state, and federal partners as needed. The affected jurisdiction’s public health agency will collaborate with partners to support the operation of a CRC. Operation of a CRC will require a multi-agency response incorporating all levels of government. The extent of the public health response role may vary from jurisdiction to jurisdiction across the district.

Population monitoring is a process that begins soon after a radiation incident is reported and continues until all potentially affected people have been monitored and evaluated for the following:

- Needed medical treatment.
- The presence of radioactive contamination on the body or clothing (external contamination)
- The intake of radioactive materials into the body (internal contamination)
- The removal of external or internal contamination (decontamination)
- The radiation dose received and the resulting health risk from the exposure.
- Long-term health effects.

In addition to CRC operations, local public health agencies, in collaboration with partners and stakeholders and per local response plans, will activate the following responsibilities as necessary:

- Protecting the public’s health and safety.
- Monitoring workers’ health and safety.
- Ensuring the provision of health and medical services.
- Ensuring the safety of food and water supplies.
- Coordinating sampling and laboratory analysis of clinical, agricultural, and environmental samples.

- Conducting field investigations.
- Conducting or assisting in decontamination as able.
- Developing criteria for temporary re-entry, operations within, and permanent return to the incident site.
- Recommending disease prevention and control measures.
- Recommending management protocols for affected populations or individuals.
- Communicating necessary information to medical providers.
- Communicating situation assessments and required safety measures to the public.
- Assisting law enforcement agencies with criminal investigation.

REUNIFICATION

- Parents with colored bands matching may retrieve the child from the pediatric safe area when they can do so or work with the coordinator to arrange a safe place to stay if they require hospitalization and cannot for the child.
- Children with colored bands should have an Unaccompanied Child Form filled out and a digital photo was taken. This information should be collected and shared with the Hospital Command Center.
- Hospital Command Center will establish a Hospital Support Center location.
- Family Support Center will determine ‘matches’ for children in the Safe Area. Parents should be able to produce a picture of the child with them or other concrete identifiers prior to any reunion/release if the child is not able to identify their parent and provide assent.
- The hospital support center should plan to demobilize the safe area and work with the local Emergency Operations Center (EOC) to determine plans for children remaining unaccompanied after 12 hours.
- Any child without an apparent match at 12 hours should be reported to the clearinghouse of the National Center for Missing and Exploited Children as well as the Hospital Command Center, jurisdictional EOC, and Red Cross or other assisting community agencies. At this time, the child should undergo a physical and behavioral health screening per the usual facility policy. Deactivation and Recovery.

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	Surge Capacity Bed Count
Beacon Granger Hospital	Acute Care	St Joseph	11
Memorial Hospital of South Bend	Acute Care	St Joseph	348
St Joseph Health Mishawaka	Acute Care	St Joseph	129
Beacon Elkhart General	Acute Care	Elkhart	174
Goshen Hospital	Acute Care	Elkhart	116
St Joseph Health Plymouth	Acute Care	Marshall	46
Bremen Community	Critical Access	Marshall	33
Unity Med and Surg	License Only	St Joseph	11
Northwest Health-Starke	Critical Access	Starke	25
Pulaski Memorial	Critical Access	Pulaski	29
Woodlawn Hospital	Critical Access	Fulton	42
Kosciusko Community	Acute Care	Kosciusko	76
Parkview Warsaw	ER Only	Kosciusko	0

HCC hospital members have the responsibility to maintain their own internal facility-specific radiation treatment and response plans. At a minimum:

- Care of patients in/during an (emergency or disaster) radiation situation, including a radiation MCI
- Maintenance/usage of disaster equipment purchased with ASPR and/or (equipment can/should be operated by nuclear medicine personnel and/or other qualified staff)
- Utilization of an internal incident command system based on the principles of the Hospital Incident Command System (HICS)
- Notification of RHC when HCC is activated.
- Medical countermeasures (MCM) dispensing plans.
- Provide resources/treatment from the oncology centers if/when the situation permits.

LOGISTICS

Strategies to Develop ED and Inpatient Pediatric Surge Capacity and Capability	
Area	Area Description
Emergency Department	<ul style="list-style-type: none"> • Make beds and surge spaces rapidly available for initial triage and stabilization, and obtain additional staff, equipment, and supplies.
General medical, general surgical, and monitored beds	<ul style="list-style-type: none"> • Ensure IBA (at least 20 percent additional acute hospital inpatient capacity within the first four hours following an emergency) by rapidly prioritizing patients for discharge, maximizing the use of staffed beds, and using non-traditional spaces (e.g., observation areas).
Critical care	<ul style="list-style-type: none"> • Rapidly expand capacity (for those facilities that provide it) by adapting procedural, pre-and post-operative, and other areas for critical care. • Assess staff, equipment, and supply needs for these spaces to facilitate requests.
Surgical intervention	<ul style="list-style-type: none"> • Secure resources, such as operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide time-sensitive, immediate surgical interventions to patients with life-threatening injuries.
Clinical laboratory and radiology	<ul style="list-style-type: none"> • Rapidly expand basic laboratory services (e.g., hematology, chemistries, Gram stain, blood cultures), including mechanisms for staff augmentation and rapid reporting. • Consider the use of point-of-care testing. • Rapidly expand radiology services (e.g., diagnostic radiology, ultrasound, computed tomography [CT]), including mechanisms for staff augmentation and rapid reporting.
Staffing	<ul style="list-style-type: none"> • Call back clinical and non-clinical staff; utilize staff in non-traditional roles. • Adjust staffing ratios and shifts as required and implement HCC member staff-sharing plans.
Healthcare volunteer management	<ul style="list-style-type: none"> • Identify situations that would necessitate the need for volunteers in hospitals. • Identify processes to assist with volunteer coordination. • Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility.

	<ul style="list-style-type: none"> • Identify and address volunteer liability issues, the scope of practice issues, and third-party reimbursement issues that may deter volunteer use. • Leverage existing government and non-governmental volunteer registration programs (e.g., State Emergency Registry of Volunteers for Indiana [SERV-IN] and Medical Reserve Corps [MRC]). • Develop rapid credential verification processes to facilitate emergency response.
Equipment and supplies	<ul style="list-style-type: none"> • Implement emergency equipment, supplies and stocking strategies, and HCC resource-sharing agreements.

State Agencies

A radiation MCI incident will involve a state response. The Indiana Department of Homeland Security (IDHS) and Indiana Department of Health (IDOH) have State Liaisons locally that are activated via emergency dispatch and can assist public safety with detection, control, and recovery. Consult with state support plans in reference to the roles and responsibilities of IDHS and IDOH.

Public Information

During a radiation event, each hospital will utilize its internal public information officer (PIO) to manage its internal messaging. Local and state EMA's will activate a joint information center (JIC) to coordinate the messages that will be shared with the public. The Healthcare Coalition will assist the JIC via our district communications team.

Situational Awareness

- a. Core member coalition agencies assigned a lead role during a radiation surge will maintain situational awareness through communication with their respective counterparts and keep the RHC/designee, Local EOC, and applicable ESFs aware of current conditions in the impacted area.
- b. Event/incident-related information will be submitted to the RHC/designee and/or EOC. Information may be obtained from:
 - Briefings
 - Prepara
 - SERV-IN
 - Impact Assessments
 - Incident Action Plans
 - Situation Reports
 - Situational updates
 - Information Sharing Platforms (WebEOC, EMResource)

Volunteer Management

- Local Communities Active in Disasters (COAD)- activation of COAD members and respective subcommittees to assist with requested resources to include volunteers.
- Medical Reserve Corps (MRC) – Activation of MRC volunteers occur through the District Public Health Coordinator and the RHC can help support this process. MRC volunteers may perform medical and non-medical duties within an established community reception center (CRC), and Family Assistance Center (FAC). Emergency credentialing is the responsibility of the facility in charge of the CRC.
- Salvation Army activation could be through local COAD or individually if COAD does not exist.
- American Red Cross (ARC) - The ARC operates a Northern Indiana Chapter and has a disaster response team that can be activated for disaster responses, including a possible radiation event. ARC volunteers would assist at CRC or FAC. Activation would occur with the local EMA.
- CERT – Community Emergency Response Teams – activated via local EMA.
- U.S. Department of Health & Human Services Emergency System for Advanced Registration of Volunteer Health Professionals: <https://www.phe.gov/esarvhp/Pages/registration.aspx>

Just-in-time training is available through state and federal agencies. Each facility should have an approved policy that clearly defines what volunteers are permitted to do.

***See Coalition ERP for details on volunteer management for all-hazards disaster services.*

Deactivation/Recovery

Following a radiation surge incident, the hospitals will follow their internal processes to recover from the event.

The HCC RHC/team will remain activated during the recovery phase as required, but not necessarily during the recovery of equipment and supplies as this may be ongoing for an extended period. The RHC/team will coordinate with the appropriate response agencies, including ESF agencies, to determine deactivation. The HCC will ensure an “All Clear” regarding the event is communicated with all members involved.

After-action reports (AAR) and hot washes will be completed along with inventory assessments in coordination with coalition member agencies to evaluate and document response activities utilizing the HSEEP model. AAR/IPs will be finalized within 120 days after the conclusion of the incident.

DECONTAMINATION/WASTE

Radioactive waste and decontamination procedures within healthcare/hospital facilities will be handled internally in accordance with regulatory compliance codes and procedures from the state. The facility Radiation Safety Officer/teams along with any internal facility environmental divisions are responsible for proper disposal, labeling, and oversight of radioactive waste. Any type of radioactive waste is separated from non-radioactive waste (large-scale and daily accumulations). All hospital

healthcare personnel are required to receive training that commensurate with their exposure/work detail to radiation.

For emergency scenes involving the public and first responders, some counties within the district have decontamination/hazmat trailers available upon request. These trailers provide equipment and resources for trained emergency personnel/technicians to safely dispose of any contaminated waste and to decontaminate any person(s) who may require it. Technicians who operate the trailers have protocols for the decontamination activities and disposal of waste.

Activation of these trailers can be requested through local emergency dispatch and/or local EMA. The storage locations of these trailers and equipment/supplies are the keepers of any MOUs required.

MANAGEMENT OF ACCESS AND FUNCTIONAL NEEDS POPULATION

The HCC has an ongoing collaboration with coalition members who can provide specific services for the access and functional needs population (AFN) during any type of event, including a radiation event.

The HCC uses the CMIST framework for integrating considerations for at-risk individuals with access and functional needs. The coalition also utilizes empowered data to determine who is at risk of electricity-dependent Medicare beneficiaries in our region. In combination with this data and framework, the coalition works with core members and partners to determine the potential needs of the AFN population for each hazard – including incorporating mass care planning to CRCs, which may include providing regional cache equipment/resources to manage the specific needs.

The D2 HCC *At-Risk Individuals with Access and Functional Needs Plan* provides detailed demographic data about the population with access and functional needs.

Individuals with Disabilities in Indiana D2 Counties (2024 Estimate)								
DISABILITY		ELKHART	PULASKI	ST JOSEPH	FULTON	KOSCIUSKO	MARSHALL	STARKE
Under 5 years								
Hearing Difficulty		572.5	24	643	45	194	111	49
Vision Difficulty		371	16	418	29	126	72	32
5-17 years								
Hearing Difficulty		7,062	432	9,414	694	2,746	1,600	802
Vision Difficulty		4580	281	6,106	450	1,781	1,038	520
Cognitive Difficulty		10,688	655	14,248	1,050	4,156	2,422	1,213
Ambulatory Difficulty		13,933	854	18,573	1,369	5,418	3,157	1,581
Self-Care Difficulty		5,153	316	6,870	506	2,004	1,168	585
18+ years								

Disability	Elkhart	Pulaski	St Joseph	Fulton	Kosciusko	Marshall	Starke
Hearing Difficulty	12,413	749	16,334	1,220	4,850	2,780	1,395
Vision Difficulty	10,345	624	13,612	1,016	4,041	2,317	1,163
Cognitive Difficulty	28,965	1748	38,113	2,846	11,316	6,486	3,256
Ambulatory Difficulty	26,896	1623	35,390	2,643	10,507	6,023	3,024
Self-Care Difficulty	6,207	375	8,167	610	2,425	1,390	698

HCC Emergency Management Agency members have identified locations of generators and plan to tap local resources in the event electricity is all that is needed to charge equipment. This will reduce the surge in hospitals if there is no medical necessity.

HCC has resources that can help support mental and behavioral health:

Tele-psych services are available through some providers and facilities.

The HCC works with ancillary member organizations and providers, such as daycares and educational facilities, to consider how they can keep special education children safe during an incident and/or public health emergency, and provide care and services to injured, ill and well children to reduce surge on the hospitals if there is no medical necessity.

Special Education (2024) ¹	
District 2	
Elkhart	4992
St Joseph	6333
Kosciusko	1851
Marshall	944
Pulaski	330
Fulton	359
Starke	468

Radiation Injury Treatment Network (RITN)

RITN is a national network of *medical centers with expertise in the management of bone marrow failure and works with partners from other medical specialties to assist with managing acute radiation syndrome (ARS) and its health-related consequences. The mission of the RITN is to maximize health-*

¹ <https://datacenter.kidscount.org/data/tables/1178-special-education-students?loc=16&loct=5#detailed/5/2292-2383/false/871,870,573,869,36,868,867,133,38,35/any/2563>

related outcomes among casualties with ARS following a mass casualty disaster involving radiological, nuclear, or chemical agents with marrow toxicity.

The RITN is activated by the Department of Health and Human Services (HHS)/Administration for Strategic Preparedness and Response (ASPR) and regulated through the National Disaster Management System (NDMS).

- REAC/TS: The Radiation Emergency Assistance Center and Training Site (REAC/TS) is located outside Knoxville, TN, and has been providing crisis response to radiological accidents since 1976. REAC/TS staff include physicians and health physicists. REAC/TS maintains a stockpile of decorporation agents as well (REAC/TS Website: <http://orise.orau.gov/reacts>).
- The REAC/TS just-in-time training videos are intended for emergency medical responders and providers who need rapid information when called to care for individuals who are ill or injured during a radiological incident. This series is divided into multiple videos by subject matter, each 2-3 minutes in length. You can also watch the entire series in approximately 20 minutes, providing valuable information in a short timeframe.

APPENDIX A: Radiation Fundamentals

Radiation: cannot be detected by human senses. A radiological survey conducted with specialized equipment is the only way to confirm the presence of radiation. Radiation survey instruments typically measure mR/hour or R/hour.

Two Forms of radiation:

- Ionizing-most energetic form and used to generate electric power, treat cancer, take x-rays, and disinfect medical instruments.
- Non-ionizing-less energy and used in lasers, microwaves, infrared lamps and radio waves.

Time, Distance, and Shielding minimize your exposure to radiation:

- *Time*: Limit or minimize the exposure time reduces the dose from the radiation source.
- *Distance*: Dose of radiation decreases dramatically as you increase your distance from the source.
- *Shielding*: Barriers of lead, concrete or water provide protection from penetrating gamma rays and x-rays.

Contamination: occurs externally when loose particles of radiation material are deposited on surfaces, skin, or clothing. Internal contamination occurs when radioactive particles are inhaled, ingested, or lodged in an open wound. Contamination should not be suspected unless radioactive material packages are damaged and/or you suspected they have been breached. Contamination survey instruments typically measure in counts per minute (CPM) or kilo counts per minute (kCPM).

Decontamination: It involves removing radioactive contamination from personnel or equipment. Patient treatment takes over radiological controls.

APPENDIX B: Legal Authorities and References

Radiation Surge Emergency Legal Authorities and References		
Code	Usage	Description
IC 10-14-3-11	<i>Governor's Emergency Powers</i>	<p>If an emergency is beyond local control, the governor can:</p> <ul style="list-style-type: none"> ○ Assume operational control of all or part of emergency management functions. ○ Make, amend or restrict orders, rules and regulations. ○ Coordinate with other states or federal government. ○ Employment measures regarding recommendations from IDOH or local health departments. ○ Use resources from state and local governments. ○ Establish agencies, offices and appoint personnel.
IC 10-16-7-7	<i>Activation of National Guard</i>	Governor can activate the Indiana National Guard in cases including public disasters and any time the Governor considers necessary.
IC 5-10-13	<i>Death and Disability Benefits for Emergency and Public Safety Employees</i>	<ul style="list-style-type: none"> • "Exposure Risk Disease" including anthrax and smallpox. • Applies to state and local employees, including individuals at high risk for occupational exposure to an exposure risk disease in the line of duty. • Applies to employees diagnosed with health condition caused by exposure risk disease which employees were exposed to while in the line of duty.
Disaster Declaration/Proclamations		
Code	Usage	Description
IC 10-14-3-12	<i>Disaster Declaration; Governor's Powers under a Disaster Declaration</i>	<ul style="list-style-type: none"> • Disaster declaration procedure. • Under a disaster declaration the governor can: <ul style="list-style-type: none"> ○ Suspend provisions of regulatory statutes. ○ Use state and local resources. ○ Use state agencies and personnel for emergency services. ○ Commander or use private property. ○ Assist in evacuations.

		<ul style="list-style-type: none"> ○ Suspend or limit the sale of alcohol. ○ Make provisions for temporary emergency housing. ○ Allow out-of-state health practitioners to practice in Indiana. ○ Give authority to allocate drugs, food, other resources, and services.
IC 16-19-4-10 IC 16-41-7.5	<i>Public Health Emergency Declaration</i>	State Health Commissioner has the authority to declare a public health emergency.
IC 15-17-10-11	<i>Animal Health Emergency Declaration</i>	The Board of Animal Health has the authority to request emergency funding to address animals that are deemed hazardous to citizens or animals of Indiana.
IC 10-14-3-29	<i>Local Disaster Emergency</i>	Local disaster declarations can be made by the principal executive of the local government. Local governments cannot use a disaster declaration to prohibit individuals employed in emergency public service from traveling on highways within the local jurisdiction.
IC 10-14-3-33.5	<i>Regulation of Firearms during Emergencies</i>	<ul style="list-style-type: none"> ● State and local governments cannot prohibit or restrict lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. ● Exceptions include: <ul style="list-style-type: none"> ○ School property. ○ Property used for school functions. ○ School buses. ○ Post-secondary education institutions. ○ Emergency shelter care child caring institutions. ○ Domestic violence shelters.
Radiation Control for Public Health		
Code	Usage	Descriptions
IC 16-41-35	<i>Radiation Control</i>	Addresses machines produce radiation (Dx/Tx), licensing operators of x-ray machines and registering facilities with x-ray machines. There are no references in IC 16-41-35 anymore to byproduct materials or transportation of nuclear waste. There are some general radiation protection statements which probably make this the appropriate code. This is the only radiation Code for IDOH. In 2015, all references to radioactive material were moved to IDHS (IC 10-19-11).

IC 10-19-11	<i>Radiation and Radioactive Material Control</i>	Under the Indiana Department of Homeland Security (IDHS). Includes considerations regarding inspection, investigation, regulation of byproduct materials, and special nuclear materials, agreement with the Nuclear Regulatory Commission, duty to register sources of radiation. registration or licensing of person that produces, uses, stores, or disposes of radioactive materials. and defines duty of person transporting, handling, using or storing ionizing radiation sources.
IC 10-19-12	<i>Nuclear Regulatory Agreement</i>	Under the Indiana Department of Homeland Security (IDHS). Includes components of the Nuclear Regulatory Agreement.
Emergency Rulemaking and Suspension of Laws		
Code	Usage	Description
IC 10-14-3-11 IC 10-14-3-12	<i>Governor suspending laws</i>	<ul style="list-style-type: none"> The governor may make, amend, or restrict orders, rules, and regulations during an emergency. The governor may suspend provisions of regulatory statutes during a disaster declaration.
IC 10-14-3-22	<i>State agencies suspending laws</i>	Indiana state agencies may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes.
IC 10-14-3-22	<i>Local governments suspending laws</i>	Local governments may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes.
Limiting Transmission		
Code	Usage	Description
IC 16-18-2-91	<i>Dangerous Communicable Disease</i>	Definition of dangerous communicable disease.
IC 16-41-6-2	<i>Compulsory Testing for Communicable Diseases</i>	Upon court order, the State Health Commission or local health officer can compel examination of an individual who may have a communicable disease or other diseases that are a serious and present danger to health.
IC 16-18-2-302.6 IC 16-19-3-9 IC 16-41-9	<i>Quarantine</i>	<ul style="list-style-type: none"> Definition of quarantine. SHC and local health officers have the authority to quarantine and take measures to prevent and suppress disease. Quarantine procedure.
IC 16-18-2-194.5	<i>Isolation</i>	<ul style="list-style-type: none"> Definition of isolation. Isolation procedures.
IC 16-41-9-5	<i>Mentally ill, Dangerous, or Gravely Disabled Disease Carrier</i>	State or local health officers may detain an individual carrying a dangerous communicable

		disease if he/she is deemed mentally ill, dangerous, or gravely disabled.
IC 16-19-3-10 IC 16-20-1-24	<i>Closing Schools and Churches and Banning Public Gatherings</i>	<ul style="list-style-type: none"> • IDOH has the authority to order schools and churches to close and forbid public gatherings to prevent or stop epidemics. • Local health officers have the authority to order schools and churches to close or forbid public gatherings to prevent or stop epidemics.
IC 16-41-9-3	<i>Excluding Infected Students from Attending School</i>	<ul style="list-style-type: none"> • Local health officers may exclude a student from school if he/she has a dangerous communicable disease that is transmitted through normal school-related contacts, and the disease poses a substantial threat to the school. • Students deemed to no longer have the dangerous communicable disease shall be given a certificate of health and readmitted to school.
IC 16-20-1-21 IC 16-20-4-18	<i>Local Health Department Communicable Disease Control</i>	Local health departments have a duty and authority to take any action authorized by law or IDOH to control communicable diseases.
IC 15-17-10	<i>Diseased Animals</i>	State and federal governments can examine, quarantine, and condemn diseased or dangerous animals.
IC 16-41-5	<i>IDOH Inspection of Private Property</i>	IDOH has situational authority to enter private property to conduct an inspection of communicable disease.
IC 16-20-1-23	<i>Local Health Department Inspection of Private Property</i>	Local health departments have situational authority to enter any premise to inspect, investigate, evaluate, conduct tests, or take samples to determine compliance with public health laws/rules and for the prevention and suppression of disease.
IC 10-46-2	<i>Use of State Funds to Prevent Disease</i>	The Governor may draw state funds at any time to prevent the introduction or spread of contagious and infectious diseases in Indiana.
Treatment		
Code	Usage	Description
IC 16-41-9-1.7	<i>Immunizations</i>	<ul style="list-style-type: none"> • Immunization programs must include information on the benefits and risks of immunization. • No adult can be immunized without his/her consent. • No child can be immunized without his/her parent/guardian's consent.

		<ul style="list-style-type: none"> Individuals who refuse immunization can be subjected to isolation or quarantine.
IC 16-19-4-11 IC 25-0.5-11	<i>Administration of Immunizations by Healthcare Providers</i>	The State Health Commissioner has the authority to issue a standing order, prescription, or protocol allowing pharmacists and providers regulated by any of the license boards listed in IC 25-0.5-11 to administer immunizations.
IC 16-38-5-2	<i>Documentation of Immunizations</i>	<ul style="list-style-type: none"> Providers administering immunizations or their designee must provide immunization data to the immunization data registry. No emergency exception.
IC 10-14-3-23 IC 16-31-1-3 IC 16-41-1-1	<i>Exception to compulsory medical treatment</i>	The government cannot compel an individual to submit to physical examinations, medical treatment, or immunization if the individual or his/her guardian decides to rely on spiritual means or prayer to prevent or cure disease or suffering.
IC 16-41-16	<i>Infectious Waste</i>	Instructions for handling infectious waste.
Points of Distribution (POD)		
Code	Usage	Description
IC 16-19-11-1 IC 16-19-11-2 IC 16-19-11-3	<i>Security of IDOH Property</i>	<ul style="list-style-type: none"> The State Health Commissioner can appoint security officers to protect properties owned or occupied by IDOH, including the streets passing through or adjacent to those properties. Appointed security officers to have general police powers, including the authority to arrest. IDOH can control traffic and parking around IDOH properties.
IC 10-14-3-33.5	<i>Regulation of Firearms during Emergencies</i>	State and local governments cannot prohibit or restrict the lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. Some exceptions: are school property, postsecondary education institutions, emergency shelter care child caring institutions, private secure facilities, emergency shelter care group homes, domestic violence shelters, etc.
Surveillance		
Code	Usage	Description
IC 16-19-10-8	<i>Counterterrorism Surveillance</i>	IDOH must report and monitor data on symptoms and health syndromes for outbreaks of dangerous diseases and health conditions.

IC 16-41-2 IC 16-41-3 410 IAC 1-2.5	<i>Communicable Disease Surveillance</i>	IDOH has the authority to make rules establishing reporting, monitoring, and preventing communicable disease.
512 IAC 1-2-1 512 IAC 1-2-2	<i>School Attendance Reporting System for Outbreaks</i>	<ul style="list-style-type: none"> School corporations and accredited nonpublic schools must develop an attendance system for reporting symptoms and health syndromes From outbreaks or suspected outbreaks of disease or other health conditions that are a danger to public health. When the percentage of student's absent equals or is greater than 20%, schools must report the percentage of students absent to the local health department.
IC 10-14-3-15	<i>Exceptions to Licensure Requirements for Emergency Management Workers</i>	Professional, mechanical, or other skill-related licensure requirements do not apply to emergency management workers.
IC 16-31-3-3	<i>Exceptions to EMS Certifications or Licensure Requirements</i>	Certification or licensure is not required for an emergency ambulance service, EMT, ambulance, EMS non-transport vehicle, or ALS when providing EMS services during a major catastrophe or disaster when EMS resources are insufficient.
IC 16-31-3.5-2	<i>Exceptions to Emergency Medical Dispatch Requirements</i>	Training requirements for emergency medical dispatchers do not apply during a major catastrophe or disaster when emergency medical dispatch resources are sufficient.
IC 10-14-5-5	<i>Exceptions to Licensure Requirements related to EMAC resources</i>	<ul style="list-style-type: none"> Individuals with professional, mechanical, and other skills who are requested through EMAC member state. The governor of the receiving state can put limitations and conditions on the scope of practice of these individuals.
IC 10-14-6.5-5	<i>Exceptions to Licensure Requirements related to interstate mutual aid resources</i>	<ul style="list-style-type: none"> Emergency responders licensed in another state are licensed in Indiana when providing aid related to an interstate mutual aid agreement. The emergency responders' scope of practice is limited to the responders' license and the equivalent license in Indiana.
Legal Immunities		
Code	Usage	Description
PREP ACT	<i>Immunity for Administration or Use of Countermeasures</i>	<ul style="list-style-type: none"> Federal law that provides immunity from liability for claims of loss related to the administration or use of countermeasures.

		<ul style="list-style-type: none"> • The Secretary of Health and Human Services can issue a PREP Act declaration at any time, not just during emergencies. • Excludes acts of willful misconduct. • Current declarations include pandemic influenza countermeasures.
IC 34-30-13.5	<i>Immunity for Healthcare Providers and Facilities</i>	<ul style="list-style-type: none"> • Only applies when the governor has declared a disaster. • Applies to health care services, provided before, after, or during the disaster declarations, in response to an event that resulted in a disaster declaration. • Health care providers must be licensed in Indiana.
IC 34-30-12.5	<i>Immunity for Healthcare Provider Providing Smallpox Immunization</i>	<ul style="list-style-type: none"> • Healthcare Provider includes physicians, healthcare facilities, nurses, paramedics and EMTs, and their medical staff. • Healthcare Provider administering medical countermeasure against an actual or potential bioterrorist incident or public health emergency is immune from civil liability for any injury or damage resulting from the administration of the medical countermeasure. • Applies only when federal government authorities IDOH to administer medical countermeasures.
IC 16-31-6-4	<i>Immunity for Paramedics and EMTs</i>	EMS, government, and healthcare individuals/entities are not liable for acts or omissions by paramedics or EMTs while treating a patient in good faith in connection with a disaster declaration for the act of terrorism.
IC 16-39-7-1	<i>Immunity for Destruction of Health Records</i>	A provider is not liable for destroying or failing to maintain a health record, in good faith, in connection with an emergency declaration or other disaster.
IC 25-38.1-4-7	<i>Immunity for Veterinarians</i>	Veterinarians and veterinary technicians are immune from damage to the owner of an animal, the veterinarian or veterinarian technician provides emergency treatment to, including euthanasia.

Emergency Mutual Aid		
Code	Usage	Description
IC 10-14-3-10.8 IC 10-14-3-16 IC 10-14-3-17 844 IAC 5-9-8	<i>Indiana Intrastate Mutual Aid Compact</i>	Creates a mutual aid compact between participating local governments, fire departments, and private individuals in Indiana.
IC 10-14-5	<i>Emergency Management Assistance Compact (EMAC)</i>	<ul style="list-style-type: none"> • Indiana may request emergency resources from and provide emergency resources to other states participating in EMAC. • The requesting state will reimburse the providing state for any loss, damage, or expense related to provided resources, unless the providing state determines reimbursement is unnecessary.
IC 10-14-6.5	<i>Interstate Mutual Aid Agreement</i>	State and local governments may enter into mutual aid agreements with state or local governments of other states for emergency declaration is in effect.
IC 10-14-3.5	<i>Uniform Emergency Volunteer Health Practitioners Act</i>	Registered volunteer health and veterinary health practitioners licensed in Indiana, or another state can provide services in Indiana while an emergency declaration is in effect.

ACRONYM LIST

The following is a list of commonly used acronyms in preparedness/response plans. Not all acronyms in this list may have been used in this document.

Acronym	Meaning
AAR/IP	After-Action Report/Improvement Plan
ACC	Alternate Care Center
ADA	Americans with Disabilities Act
ARC	American Red Cross
ASPR	Administration for Strategic Preparedness & Response
BP	Budget Period
BHP	Bureau of Health Preparedness
BOAH	Board of Animal Health
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
CDC	Centers for Disease Control and Prevention
CRI	Cutaneous Radiation Injuries
CSC	Crisis Standards of Care
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Program
ERC	Emergency Response Coordinator
ESF	Emergency Support Function
EPA	Environmental Protection Agency
EUA	Emergency Use Authorization
CDC	Centers for Disease Control
CERT	Community Emergency Response Team
COAD	Community Organizations Active in Disasters
CRC	Community Reception Center
DHHS	Department of Health and Human Services
DPIC	Drug & Poison Information Center
DRD	Direct Reading Dosimeters

Acronym	Meaning
EMS	Emergency Medical Services
EOC	Emergency Operations Center
HAN	Health Alert Network
HCC	Healthcare Coalition
HICS	Hospital Incident Command System
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act
HPP	Hospital Preparedness Program
ICS	Incident Command System
IND	Improvised Nuclear Device
JIC	Joint Information Center
KI	Potassium Iodide
LHD	Local Health Department
LTC	Long Term Care
MAC	Multi-Agency Coalition
MCI	Mass Casualty Incident
MRC	Medical Reserve Corp
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NGO	Non-Governmental Organization
OSLD	Optically Stimulated Luminescent Dosimeters
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PUI	Person Under Investigation
RDD	Radiological Dispersal Device
RED	Radiological Exposure Device
RHC/RRC	Regional Healthcare Coordinator/Readiness & Response Coordinator
RITN	Radiation Injury Treatment Network
RSA	Radiation Surge Annex
RSE	Radiation Surge Event
SFY	State Fiscal Year
SOP	Standard Operating Procedure
SME	Subject Matter Expert

Acronym	Meaning
SITREP	Situation Report
THC	The Health Collaborative
TLD	Thermoluminescent Dosimeters
WENS	Wireless Emergency Notification System

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HEALTHCARE COALITION CHEMICAL SURGE PLAN ANNEX

District 2 Healthcare Coalition

January 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)	Name
5/2025	Random	Review/Update	Jennifer Tobey
1/2026	Random	Review/Updates	Jennifer Tobey

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OVERVIEW

HCC MEMBER ORGANIZATIONS - CORE MEMBERS IN BOLD

1. **Hospitals (a minimum of two acute care hospitals)**
2. **Emergency Management Agency (EMA)**
3. **Emergency Medical Services (EMS) (including facility and other non-EMS patient transport systems)**
4. **Local Public Health Department(s) (LHD)**
5. Behavioral Health Services and organizations
6. Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
7. Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks
8. State and Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indiana Health Service facilities, military treatment facilities)
9. Home health agencies (including home and community-based services)
10. Infrastructure companies (e.g., utility and communication companies)
11. Jurisdictional partners, including cities, counties, and tribes.
12. Local chapters of health care professional organizations (e.g., medical society, professional society, hospital association)
13. Local public safety agencies (e.g., law enforcement and fire services)
14. Medical and device manufacturers and distributors
15. Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
16. 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)
17. Primary care providers, including pediatric and women's health care providers.
18. Schools and universities, including academic medical centers.
19. Skilled nursing, nursing, and long-term care facilities
20. Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
21. Medical examiners/coroners and funeral homes
22. Agency/facility public information specialists
23. Agencies that support an Emergency Support Function (ESF)
24. Other (e.g., childcare services, dental clinics, social work services, faith-based organizations)

PURPOSE

The purpose of this support plan is to supplement existing planning and response guidance with specific information regarding the management of patients during a Chemical Surge Event. The District 2 Healthcare Coalition (HCC) Chemical Surge Annex will describe guidance and processes to improve capacity and capabilities to manage many casualties affected by a large chemical surge event. According to the 2017-2024 Healthcare Preparedness and Response Capabilities, Healthcare Coalitions (HCC) “are groups of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location that plays a critical role in developing health care delivery system preparedness and response capabilities.”

HCCs serve as multiagency coordination groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities. HCCs coordinate activities among healthcare organizations and other community stakeholders; these entities comprise HCC members who actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained healthcare personnel. The actions described here are intended to support, not replace, any existing facility, agency policy, or plan.

SCOPE

This annex is intended to be a high-level response plan describing the following:

- Coalition coordination and support in chemical outbreaks/releases
- Identification of experts and specialized resources that exist within the HCC
- Tracking of patients throughout an incident
- Identification of strategies to manage surges and scarce resources
- Coordination support for transferring acutely ill patients as indicated by the incident
- Coordination support for the decompression of acute care/free-standing facilities to increase specialty bed availability

This plan is a supplement to, not a replacement for, the response actions and resources described in the coalition, facility, or agency Emergency Operations Plan and provides additional details relevant to an incident that involves significant numbers of victims and is not intended to describe or define processes of individual hospital operations nor supersede hospital plans and processes. Each agency in the HCC is encouraged to develop more detailed plans that support their operations and supplement this annex.

For this plan and for HCC planning and response, a chemical surge event (CSE) is defined as:

A chemical incident includes a wide scope of events and refers to the release, or potential release, of a chemical substance:

- 1. that harms people, animals, and/or the environment, regardless of accidental or deliberate cause, and/or*
- 2. for which response needs have the potential to overwhelm state and local resources (both governmental and private sector), and/or*
- 3. for which the Environmental Protection Agency (EPA) and/or the United States Coast Guard (USCG), co-Chairs of the National Response Team (NRT) for Oil and Chemical Spills under the National Oil and Hazardous Substances Pollution Contingency Plan (NCP),¹ deems that support is or will be required.*

MAINTENANCE

The HCC will conduct an annual review of this annex in coordination with the member agencies and organizations as appropriate. Additional reviews may be conducted after an exercise, a significant incident/event occurs, or regulatory changes indicate a need. The HCC Planning Section Chief (PSC) will track and distribute any needed changes to this plan using the Document Change Record in Table 1.

SITUATION OVERVIEW

The HCC serves as a formal entity for healthcare preparedness planning in the Midwest /Region 5. There are 13 acute care hospitals within the district. The following resources exist in the region:

- Memorial Hospital of South Bend: Level II Trauma Center, Level II Newborn ICU, Therapeutic Stroke Center
- St Joseph Regional Medical Center: Level III Newborn ICU, Stroke Center
- Elkhart General Hospital: Level III Trauma Center

Chemical patients could easily overwhelm existing resources in the region. All hospitals are recommended to have surge plans in place for a chemical release/event, to increase bed capacity. The entire Northern top of Indiana Region 5 is subject to chemical incidents that may result from a deliberate act or an unintentional release. Generally, greater regulatory control, safeguards, and security accompany larger quantities of chemical materials, which pose a greater potential threat to human health and the environment. Virtually any facility or industrial practice (including transportation of materials) may be vulnerable to a deliberate act or unintentional act that could release chemical material.

SITUATION OVERVIEW

A chemical emergency occurs when a hazardous material (HAZMAT) has been released, and the release has the potential to harm people's health. HAZMATs include substances such as toxic chemicals, fuels, nuclear waste products, and biological, chemical, and radiological agents. HAZMATs may be released as liquids, solids, gases, or a combination or form of all three, including dust, fumes, gas, vapor, mist, and smoke.

PLANNING ASSUMPTIONS

1. Chemical incidents may involve no exposed individuals or hundreds of thousands; and may be presented to the emergency department with little or no warning.
2. Local hospitals and/or medical centers will receive patients from mass casualty incidents.
3. Each facility or healthcare organization should understand expectations specific to them as part of the coalition, especially within the first minutes and hours of a large-scale chemical incident.
4. Hospitals may need to shelter in place (or, less likely, evacuate) in response to a chemical release or plume.
5. There should be an understanding of the general expectations for EMS and fire and rescue personnel during a chemical incident response that is appropriate to regional resources.
6. Hospitals must have appropriate plans, PPE, and equipment to receive and decontaminate patients as self-referral is common.
7. On-duty staff will need to quickly evaluate many real versus possible exposures.
8. Job aids will be needed to help initiate response, decontamination, and treatment guidance for these uncommon events.
9. Specialty consultation (for example, poison control center, regional HAZMAT experts) will be needed quickly to provide specific care recommendations for agent type and magnitude of release.
10. Depending on the scale of the chemical incident, the establishment of alternate decontamination or screening locations may be required to assess low-risk patients and provide basic decontamination needs.
11. There may not be an adequate local supply of specific countermeasures and antidotes for a large-scale chemical emergency.
12. Health concerns, prolonged response requirements, fatigue, difficult work environments, and stress may contribute to behavioral health challenges among coalition members and the public.
13. Depending on the scale, severity, and type of chemical emergency, it may be necessary to contract private organizations to assist with large-scale containment and clean-up efforts.
14. Affected critical facilities may be out of service for extended periods. These facilities must be decontaminated and determined to be safe before reoccupation.

15. Emergency Medical Services (EMS) personnel will triage victims using the START/SALT methods (or local protocol methods) in a mass-casualty situation.
16. District 2 hospitals activate their Hospital Command Centers (HCC) in a large-scale disaster.
17. District 2 hospitals utilize established communication tools including PreparaIS, EMResource, WEBEOC, SERV-IN, and/or 800 MHz radios in a disaster to share information.
18. The Regional Healthcare Coordinator (RHC) will serve as a clearing house for information and assist with coordinating resources.
19. The coalition annex does not replace the need for protocols at each hospital and EMS agency.
20. Different agencies may have authority over the management of agencies, transportation, and terrorist incidents, including the authority to implement shelter-in-place and evacuation orders.
21. The roles and responsibilities of agencies and organizations will change depending on the severity and scale of the incident and the respective level of activation by impacted jurisdictions.
22. Fear of the incident will cause a worried-well surge in the emergency departments and pharmacies.
23. Public safety (e.g., police, fire, EMS) and other first responder personnel are considered a high-risk population; the implementation of protocols for monitoring control zones and effective contamination control measures will be essential for workforce protection.
24. Federal resources (e.g., ambulance contracts, and National Disaster Medical System [NDMS] teams) cannot be relied upon to mobilize and deploy for the first 72 hours.
25. Management of contaminated waste from decontamination efforts should be managed in consultation with subject matter experts, EPA, and local water authorities.
26. The District 2 hospitals could receive patients from other regions during a chemical mass casualty event.

CHEMICAL TRIGGERS

- Report on chemical emergencies.
- Local EOCs and or State emergency operation centers are fully activated statewide to respond to catastrophic incidents.
- Damage to infrastructure, transportation, and or utilities and communications.
- Healthcare assets in the local jurisdiction are experiencing a surge and require the participation of additional healthcare assets within and outside the local jurisdiction.
- Increased patient encounters or hospital census.
- Hospital activating their EOC. EDs requesting additional medical staff or are on diversion (>20-30%).

- Medication supplies are limited or distributed in the medical supply chain.
- Unable to track or locate all patients impacted by the incident.
- Public information hotlines needed.
- Community-based intervention required.

Concept Of Operations

General

A chemical HAZMAT event may occur from any of the incidents listed in the background section of this plan, however, not all chemical HAZMAT incidents may cause a medical surge. Before the activation of surge activities, the following occurs:

- Patients may present to medical facilities by EMS services or as walk-ins to a facility.
- Patients may seek out medical care for illness or exposure to a chemical.
- HAZMAT event, injury due to a chemical HAZMAT event, or illness or injury not related to a chemical HAZMAT event.

Note: EMS performs decontamination, triage, and stabilization care of patients following normal trauma guidelines and determines the transportation destination of patients based on the chief complaint and local hospital capabilities. EMS, or incident command on behalf of EMS, may contact the Chemical Emergencies and Natural Disasters On-Call Team, Healthcare Emergency Response Committee (HERC), or local and Tribal health department (LTHD) if there are concerns about chemical exposure.

- The local hospital performs decontamination, triage, testing, and stabilization of walk-in and EMS-transported patients and determines if there is concern for chemical HAZMAT contamination. Hospitals contact the Chemical Emergencies and Natural Disasters On-Call Team, HERC, or the LTHD for situational awareness and subject matter expert support.
- Chemical Emergencies and Natural Disasters On-Call Team, HERC, or LTHD receives a report of a chemical HAZMAT event and conducts normal operations including sharing information with relevant partners. The Chemical Emergencies and Natural Disasters On-Call Team may provide subject matter expertise as needed.
- The local hospital determines if they are capable of handling patient needs without causing stress on their resources or if patients can be transferred to a higher level of care following normal transfer procedures. If neither of these scenarios can be met, a surge event is indicated.

Note: Requests for surge support can be made from hospitals, Chemical Emergencies, and Natural Disasters On-Call Teams, HERCs, or LTHDs. Surge plans may be activated at the local, regional, or state level.

Notification/Activation

The HCC would expect local EMS providers to have a plan to address the items in this table:

Medical Surge Elements to Incorporate into EMS Operations Plans	
Area	Area Description
Dispatch	<ul style="list-style-type: none"> • Identify procedures to: <ul style="list-style-type: none"> – Alert hospitals of an emergency per local protocol. – Communicate hospital capacity and capability to EMS providers. – All EMS surge requests, utilize mutual aid response plans per local protocol.
Response	<ul style="list-style-type: none"> • Match appropriate specialized providers and equipment with the nature of the emergency (e.g., hazardous materials [HAZMAT] trained crews during a chemical spill). • Consider surge strategies such as changing shift lengths or crew configurations, using alternate vehicles, using community paramedicine, or other non-ambulance responses in coordination with dispatch priorities.
Pre-hospital triage and treatment	<ul style="list-style-type: none"> • Implement disaster triage procedures and other standard operating procedures (e.g., eliminate the requirement for verbal orders). • Consider processes that allow for an expanded scope of practice. • Plan for specialty responses, such as HAZMAT, highly infectious disease, mass burn, mass trauma, and mass pediatric emergencies.
Transportation	<ul style="list-style-type: none"> • Identify procedures to surge the number of patients transported per vehicle or aircraft. • Identify procedures for changing preferred destination facilities (e.g., trauma center, pediatric hospital) or not using the appropriate hospital. • Identify procedures for type and level of pre-hospital care delivery and mode of transport (ground and air medical). • Develop and implement EMS patient distribution strategies to avoid overloading any single hospital. • Identify procedures for transporting patients to alternate care sites.
Supplies and Equipment	<ul style="list-style-type: none"> • Utilize physical resources including supplies, equipment, and cached materials to support a medical surge.

TRACKING

Patient tracking refers to several types of processes of documentation across the patient movement. These types consist of:

- **Pre-Hospital Tracking**

Currently, EMS within District 2 tracks patients via paper methods during a surge event. There is not an established or consistent process in place.

- **Patient Movement Tracking**

Each agency providing inpatient, or outpatient care shall establish a means for tracking patients both within their facility and include a method for tracking when a patient is transferred from the facility.

- **Unidentified Patient Tracking**

Each member agency shall have in place a method for tracking and identifying those patients who arrive and are non-communicative or have no identification.

The HCC may be asked to assist with Family Reunification and shall work collaboratively with the EOC and ESF-8 officer to assist if a Family Assistance Center is established. The HCC may also request lists of patient names following HIPAA from member agencies to assist with family reunification.

TRANSPORTATION

The on-scene command will work with the hospital House Supervisor or designated employee to coordinate appropriate transportation assets and staffing.

Follow EOP for coordination of other transportation and staging, other needs, and issues.

If patients require a higher level of acuity and need transport, hospitals will utilize internal procedures for transferring those patients. Conference calls may be established with hospitals, RHC/team, and the state to determine the appropriate level of care.

Transportation could take hours for certain patients depending on their condition and where EMS services come from. In the event of patients needing inter or intra-facility transport within the region and/or neighboring states, MOUs will be activated, and transport of these patients will start locally and advance to state facilities if required due to surge.

ROLES AND RESPONSIBILITIES

Healthcare Coalition (HCC)

HCC Readiness and Response Coordinator will be activated when a chemical surge incident occurs in the district and/or this annex has been activated. HCC has access/training in the use of communication and alerting systems: Preparis, SERV-IN, and 800MHz radios. Usage of these communication tools will enable the team to quickly disseminate information to the coalition members to aid in the response.

Primary functions of the team:

- The current availability of district medical resources.
- The availability of state and/or federal medical resources.
- The coordination of requests and receipt of extra-regional medical resources, including submission of 213 RRs to the state/federal level for equipment/supplies/medication.
- To serve as an interface between hospitals, Homeland Security Districts, local Emergency Operations Centers (EOCs), Indiana Department of Health (IDOH), and if needed Emergency Operations Centers (EOCs) as part of ESF #8.
- Serves as an information interface between coalition members to help determine the severity of the incident. Information will come from core members and partners and will include:
 - How many were affected?
 - Location?
 - Shelter in place?
 - Hospital capabilities and bed availability?
 - Alternate Care Center needed (ACC)?
 - Activate the multi-agency coalition (MAC) Or Incident Management Team (IMT)?
 - HCC will utilize communication platforms to assist in disseminating information and to assess the ongoing situation to determine resource needs.

Fire and Emergency Medical Services

- Manages the scene per the incident command structure (ICS).
- Provide incident briefing to hospitals during the response via Hospital IHERN including:
 - Incident/chemical type
 - Expected/estimated number of patients injured by triage category.
 - Special needs requirements (e.g., pediatrics, burn, OB, etc.).
 - Number of patients transported (with destination) before activation of the Net.
 - Triage areas are set up to determine who requires transport to the hospital or a CRC.
- Collaborate with the Medical Director related to patient routing during a chemical event.
- Support hospital decontamination operations if requested and able.
- Assist/operate chemical-specific equipment on scene triage.

- Maintain communication with the EOC to determine where to send “worried well” and family members to the family reunification location.

Emergency Management Agencies

- Provide the Executive Direction to act for the Governor to provide direction and control, and to carry out the state’s response to protect the public’s health, safety, and property during an incident at a commercial nuclear power plant affecting District 2.
- Serve as the primary agency for (Emergency Support Function) ESF-2, Communications, and Information Technology; ESF-5, Information and Planning; ESF-6, Mass Care; ESF-7, Resource Support, and Logistics; ESF-14, Recovery and Mitigation; and ESF-15, Emergency Public Information, and External Affairs.
- Assign the Chemical Branch Chief responsibility for maintaining 24-hour communication capabilities in conjunction with the County EMA Office.
- Serve as the general coordination point for utility, private and non-profit organizations, and local, state, and federal governments.
- Request restriction of air, rail, and water traffic, as necessary.
- Designate a Public Information Officer(s) who will be located at the district JIC and/or Utility JIC/JPIC.
 - Provide situational reports.
- Notify key state and federal partner agencies, including FEMA Region V.
- Local EMA – use of WebEOC for assistance with patient tracking and resource requests.
 - Activation of county EOC.
 - Coordinate data collection, community needs, and any requests for a countywide emergency declaration.
 - Coordinates mass care and CRC and activities working with other private agencies.

Public Health Departments

Public health’s initial responsibility during a chemical emergency is population monitoring. For this response plan, population monitoring considerations will be made in the context of first local Assembly Centers (AC) and then Community Reception Center (CRC) operations. ACs are expected to be set up 24-48 hours after an event has occurred to serve as initial assessments and provide immediate triage and gross decontamination centers. Based on findings at the AC, local jurisdictional authorities where the incident occurred will lead and direct activation and operation of a CRC in partnership with regional, state, and federal partners as needed. The affected jurisdiction’s public health agency will collaborate with partners to support the operation of a CRC. Operation of a CRC will require a multi-agency response incorporating all levels of government. The extent of the public health response role may vary from jurisdiction to jurisdiction across the district.

Population monitoring is a process that begins soon after a chemical incident is reported and continues until all potentially affected people have been monitored and evaluated for the following:

- Needed medical treatment.
- The presence of chemical contamination on the body or clothing (external contamination).
- The intake of chemical materials into the body (internal contamination).
- The removal of external or internal contamination (decontamination).
- The chemical dose received and the resulting health risk from the exposure.
- Long-term health effects.

In addition to CRC operations, local public health agencies, in collaboration with partners and stakeholders and per local response plans, will activate the following responsibilities as necessary:

- Protecting the public's health and safety
- Monitoring workers' health and safety
- Ensuring the provision of health and medical services
- Ensuring the safety of food and water supplies
- Coordinating sampling and laboratory analysis of clinical, agricultural, and environmental samples
- Conducting field investigations
- Conducting or assisting in decontamination as able
- Developing criteria for temporary re-entry, operations within, and permanent return to the incident site
- Recommending disease prevention and control measures
- Recommending management protocols for affected populations or individuals.
- Communicating necessary information to medical providers
- Communicating situation assessments and required safety measures to the public
- Assisting law enforcement agencies with the criminal investigation

REUNIFICATION

- Parents with colored bands matching the child's band may retrieve the child from the pediatric safe area when they can do so or work with the coordinator to arrange a safe place for the child to stay if they require hospitalization and cannot retrieve the child.
- Children with colored bands should have an Unaccompanied Child Form filled out and a digital photo taken. This information should be collected and shared with the Hospital Command Center.
- The Hospital Command Center will establish a Hospital Support Center location.

- Family Support Center will determine ‘matches’ for children in the Safe Area. Parents should be able to produce a picture of the child or other concrete identifiers before any reunion/release if the child is not able to identify their parent and provide assent.
- The hospital support center should plan to demobilize the safe area and work with the local Emergency Operations Center (EOC) to determine plans for children remaining unaccompanied after 12 hours.
- Any child without an apparent match at 12 hours should be reported to the clearinghouse of the National Center for Missing and Exploited Children as well as the Hospital Command Center, jurisdictional EOC, and Red Cross or other assisting community agencies. At this time, the child should undergo a physical and behavioral health screening per the usual facility policy.

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	Surge Capacity Bed Count
Beacon Granger Hospital	Acute Care	St Joseph	11
Memorial Hospital of South Bend	Acute Care	St Joseph	348
St Joseph Health Mishawaka	Acute Care	St Joseph	129
Elkhart General	Acute Care	Elkhart	174
Goshen Hospital	Acute Care	Elkhart	116
St Joseph Health Plymouth	Acute Care	Marshall	46
Bremen Community	Critical Access	Marshall	33
Unity Med and Surg	License Only	St Joseph	11
Northwest Health-Starke	Critical Access	Starke	25
Pulaski Memorial	Critical Access	Pulaski	29
Woodlawn Hospital	Critical Access	Fulton	42
Kosciusko Community	Acute Care	Kosciusko	76
Parkview Warsaw	ER Only	Kosciusko	0

Coalition hospital members have the responsibility to maintain their own internal facility-specific chemical treatment and response plans. At a minimum:

- Care of patients in/during an (emergency or disaster) chemical situation, including a chemical MCI
- Maintenance/usage of disaster equipment purchased with ASPR and/or (equipment can/should be operated by nuclear medicine personnel and/or other qualified staff).
- Utilization of an internal incident command system based on the principles of the Hospital Incident Command System (HICS).
- Notification of RHC when HCC is activated.
- Medical countermeasures (MCM) dispensing plans.
- Provide resources/treatment from the oncology centers if/when the situation permits.

LOGISTICS

Strategies to Develop ED and Inpatient Pediatric Surge Capacity and Capability	
Area	Area Description
Emergency Department	<ul style="list-style-type: none"> • Make beds and surge spaces rapidly available for initial triage and stabilization, and obtain additional staff, equipment, and supplies.
General medical, general surgical, and monitored beds	<ul style="list-style-type: none"> • Ensure IBA (at least 20 percent additional acute hospital inpatient capacity within the first four hours following an emergency) by rapidly prioritizing patients for discharge, maximizing the use of staffed beds, and using non-traditional spaces (e.g., observation areas).
Critical care	<ul style="list-style-type: none"> • Rapidly expand capacity (for those facilities that provide it) by adapting procedural, pre-and post-operative, and other areas for critical care. • Assess staff, equipment, and supply needs for these spaces to facilitate requests.
Surgical intervention	<ul style="list-style-type: none"> • Secure resources, such as operating rooms, surgeons, anesthesiologists, operating room nurses, and surgical equipment and supplies to provide time-sensitive, immediate surgical interventions to patients with life-threatening injuries.

Clinical laboratory and radiology	<ul style="list-style-type: none"> • Rapidly expand basic laboratory services (e.g., hematology, chemistries, Gram stain, blood cultures), including mechanisms for staff augmentation and rapid reporting. • Consider the use of point-of-care testing. • Rapidly expand radiology services (e.g., diagnostic radiology, ultrasound, computed tomography [CT]), including mechanisms for staff augmentation and rapid reporting.
Staffing	<ul style="list-style-type: none"> • Call back clinical and non-clinical staff; utilize staff in non-traditional roles. • Adjust staffing ratios and shifts as required, and implement HCC member staff-sharing plans.
Healthcare volunteer management	<ul style="list-style-type: none"> • Identify situations that would necessitate the need for volunteers in hospitals. • Identify processes to assist with volunteer coordination. • Estimate the anticipated number of volunteers and health professional roles based on identified situations and resource needs of the facility. • Identify and address volunteer liability issues, scope of practice issues, and third-party reimbursement issues that may deter volunteer use. • Leverage existing government and non-governmental volunteer registration programs (e.g., State Emergency Registry of Volunteers for Indiana [SERV-IN] and Medical Reserve Corps [MRC]). • Develop rapid credential verification processes to facilitate emergency response.
Equipment and supplies	<ul style="list-style-type: none"> • Implement emergency equipment, supplies and stocking strategies, and HCC resource-sharing agreements.

State Agencies

A chemical MCI incident will involve a state response. The Indiana Department of Homeland Security (IDHS) and Indiana Department of Health (IDOH) have State Liaisons locally that are activated via emergency dispatch and can assist public safety with detection, control, and recovery. Consult with state support plans about the roles and responsibilities of IDHS and IDOH.

Public Information

During a chemical event, each hospital will utilize its internal public information officer (PIO) to manage its internal messaging. Local and state EMA's will activate a joint information center (JIC) to coordinate the messages that will be shared with the public. The Healthcare Coalition will assist the JIC via our district communications team.

Situational Awareness

- a. Core member coalition agencies assigned a lead role during a chemical surge will maintain situational awareness through communication with their respective counterparts and keep the RHC/designee, Local EOC, and applicable ESFs aware of current conditions in the impacted area.
- b. Event/incident-related information will be submitted to the RHC/designee and/or EOC. Information may be obtained from:
 - Briefings
 - Preparis
 - SERV-IN
 - Impact Assessments
 - Incident Action Plans
 - Situation Reports
 - Situational updates
 - Information Sharing Platforms (WebEOC, EMResource)

Volunteer Management

- Local Communities Active in Disasters (COAD)- activation of COAD members and respective subcommittees to assist with requested resources to include volunteers.
- Medical Reserve Corps (MRC) – Activation of MRC volunteers occur through the District Public Health Coordinator and the RHC can help support this process. MRC volunteers may perform medical and non-medical duties within an established community reception center (CRC), and Family Assistance Center (FAC). Emergency credentialing is the responsibility of the facility in charge of the CRC.
- Salvation Army activation could be through local COAD or individually if a COAD does not exist.
- American Red Cross (ARC) - The ARC operates a Northern Indiana Chapter and has a disaster response team that can be activated for disaster responses, including a possible chemical event. ARC volunteers would assist at CRC or FAC. Activation would occur with the local EMA.
- CERT – Community Emergency Response Teams – activated via local EMA.
- U.S. Department of Health & Human Services Emergency System for Advanced Registration of Volunteer Health Professionals: <https://www.phe.gov/esarvhp/Pages/registration.aspx>

Just-in-time training is available through state and federal agencies. Each facility should have an approved policy that clearly defines what volunteers are permitted to do.

**See Coalition ERP for details on volunteer management for all-hazards disaster services.

Deactivation/Recovery

Following a chemical surge incident, the hospitals will follow their internal processes to recover from the event.

The HCC RHC/team will remain activated during the recovery phase as required, but not necessarily during the recovery of equipment and supplies as this may be ongoing for an extended period. The RHC/team will coordinate with the appropriate response agencies, including ESF agencies, to determine deactivation. The D2HCC will ensure an “All Clear” regarding the event is communicated with all members involved.

After-action reports (AAR) and hot washes will be completed along with inventory assessments in coordination with coalition member agencies to evaluate and document response activities utilizing the HSEEP model. AAR/IPs will be finalized within 120 days after the conclusion of the incident.

DECONTAMINATION/WASTE

Chemical waste and decontamination procedures within healthcare/hospital facilities will be handled internally following regulatory compliance codes and procedures from the state. The facility Chemical Safety Officer/teams along with any internal facility environmental divisions are responsible for proper disposal, labeling, and oversight of chemical waste. Any type of chemical waste is separated from non-chemical waste (large-scale and daily accumulations). All hospital healthcare personnel are required to receive training commensurate with their exposure/work detail to the chemical.

For emergency scenes involving the public and first responders, some counties within the district have decontamination/hazmat trailers available upon request. These trailers provide equipment and resources for trained emergency personnel/technicians to safely dispose of any contaminated waste and to decontaminate any person(s) who may require it. Technicians who operate the trailers have protocols for the decontamination activities and disposal of waste.

Activation of these trailers can be requested through local emergency dispatch and/or local EMA.

The storage locations of these trailers and equipment/supplies are the keepers of any MOUs required.

- Elkhart County Emergency Management Agency
- Elkhart City Fire Department
- South Bend Fire Department

MANAGEMENT OF ACCESS AND FUNCTIONAL NEEDS POPULATION

The HCC has an ongoing collaboration with coalition members who can provide specific services for the access and functional needs population (AFN) during any type of event, including a chemical event.

The HCC uses the communication, maintaining health, independence, support and safety, and transportation (CMIST) framework for integrating considerations for at-risk individuals with access and functional needs. The coalition also utilizes EMpower data to determine who is at risk of electricity-dependent Medicare beneficiaries in our region. In combination with this data and framework, the coalition works with core members and partners to determine the potential needs of the AFN population for each hazard – including incorporating mass care planning to CRCs, which may include providing regional cache equipment/resources to manage the specific needs.

The HCC *At-Risk Individuals with Access and Functional Needs Plan* provides detailed demographic data about the population with access and functional needs.

Individuals with Disabilities in Indiana D2 Counties (2024 Estimate)								
DISABILITY		ELKHART	PULASKI	ST JOSEPH	FULTON	KOSCIUSKO	MARSHALL	STARKE
Under 5 years								
Hearing Difficulty		572.5	24	643	45	194	111	49
Vision Difficulty		371	16	418	29	126	72	32
5-17 years								
Hearing Difficulty		7,062	432	9,414	694	2,746	1,600	802
Vision Difficulty		4580	281	6,106	450	1,781	1,038	520
Cognitive Difficulty		10,688	655	14,248	1,050	4,156	2,422	1,213
Ambulatory Difficulty		13,933	854	18,573	1,369	5,418	3,157	1,581
Self-Care Difficulty		5,153	316	6,870	506	2,004	1,168	585
18+ years								
Disability		Elkhart	Pulaski	St Joseph	Fulton	Kosciusko	Marshall	Starke
Hearing Difficulty		12,413	749	16,334	1,220	4,850	2,780	1,395
Vision Difficulty		10,345	624	13,612	1,016	4,041	2,317	1,163

Cognitive Difficulty		28,965	1748	38,113	2,846	11,316	6,486	3,256
Ambulatory Difficulty		26,896	1623	35,390	2,643	10,507	6,023	3,024
Self-Care Difficulty		6,207	375	8,167	610	2,425	1,390	698

HCC Emergency Management Agency members have identified locations of generators and plan to tap local resources in the event electricity is all that is needed to charge equipment. This will reduce the surge in hospitals if there is no medical necessity.

HCC has resources that can help support mental and behavioral health:

- *Tele-psych services are available through some providers and facilities.*

The HCC works with ancillary member organizations and providers, such as daycare facilities and educational facilities, to consider how they can keep special education children safe during an incident and/or public health emergency, and provide care and services to injured, ill, and well children to reduce surge on the hospitals if there is no medical necessity.

Special Education (2024) ¹	
District 2	
Elkhart	4992
St Joseph	6333
Kosciusko	1851
Marshall	944
Pulaski	330
Fulton	359
Starke	468

¹ <https://datacenter.kidscount.org/data/tables/1178-special-education-students?loc=16&loct=5#detailed/5/2292-2383/false/871,870,573,869,36,868,867,133,38,35/any/2563>

APPENDIX A : Hazmat Response Resources

Elkhart City Fire Hazardous Materials Team Activation

Emergency: Call 911

Non-Emergency: 574-293-2175

South Bend Fire Hazardous Materials Team Activation

Emergency: Call 911

Non-Emergency: 574-252-3600

CHEMTREC

800-262-8200

Indiana Department of Environmental Management (IDEM)

24 hr. Spill line 888-233-7745

Indiana Department of Transportation (INDOT)

855-463-6848

APPENDIX B: Legal Authorities and References

Chemical Surge Emergency Legal Authorities and References		
Code	Usage	Description
IC 10-14-3-11	<i>Governor's Emergency Powers</i>	<p>If the emergency is beyond local control, the governor can:</p> <ul style="list-style-type: none"> ○ Assume operational control of all or part of emergency management functions. ○ Make, amend, or restrict orders, rules, and regulations. ○ Coordinate with other states or the federal government. ○ Employ any measure regarding recommendations from IDOH or local health departments. ○ Use resources from state and local governments. ○ Establish agencies, and offices and appoint personnel.
IC 10-16-7-7	<i>Activation of National Guard</i>	The governor can activate the Indiana National Guard in cases including public disasters and any time the Governor considers necessary.
IC 5-10-13	<i>Death and Disability Benefits for Emergency and Public Safety Employees</i>	<p>"Exposure Risk Diseases" including anthrax and smallpox.</p> <ul style="list-style-type: none"> ● Applies to state and local employees including individuals at high risk for occupational exposure to an exposure risk disease in the line of duty. ● Applies to employees diagnosed with health conditions caused by exposure risk disease which employees were exposed to while in the line of duty.
Disaster Declaration/Proclamations		
Code	Usage	Description
IC 10-14-3-12	<i>Disaster Declaration; Governor's Powers under a Disaster Declaration</i>	<p>Disaster declaration procedure</p> <ul style="list-style-type: none"> ● Under a disaster declaration the governor can: <ul style="list-style-type: none"> ○ Suspend provisions of regulatory statutes. ○ Use state and local resources. ○ Use state agencies and personnel for emergency services. ○ Commander or use private property. ○ Assist in evacuations.

		<ul style="list-style-type: none"> ○ Suspend or limit the sale of alcohol. ○ Make provisions for temporary emergency housing. ○ Allow out-of-state health practitioners to practice in Indiana. ○ Give authority to allocate drugs, food, other resources, and services.
IC 16-19-4-10 IC 16-41-7.5	<i>Public Health Emergency Declaration</i>	The State Health Commissioner has the authority to declare a public health emergency.
IC 15-17-10-11	<i>Animal Health Emergency Declaration</i>	The Board of Animal Health has the authority to request emergency funding to address animals that are deemed hazardous to citizens or animals of Indiana.
IC 10-14-3-29	<i>Local Disaster Emergency</i>	Local disaster declarations can be made by the principal executive of the local government. Local governments cannot use a disaster declaration to prohibit individuals employed in emergency public service from traveling on highways within the local jurisdiction.
IC 10-14-3-33.5	<i>Regulation of Firearms during Emergencies</i>	<ul style="list-style-type: none"> ● State and local governments cannot prohibit or restrict lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. ● Exceptions include: <ul style="list-style-type: none"> ○ School property ○ Property used for school functions ○ School buses ○ Postsecondary education institutions ○ Emergency shelter care child caring institutions ○ Domestic violence shelters
Emergency Rulemaking and Suspension of Laws		
Code	Usage	Description
IC 10-14-3-11 IC 10-14-3-12	<i>Governor suspending laws</i>	<ul style="list-style-type: none"> ● The governor may make, amend, or restrict orders, rules, and regulations during an emergency. ● The governor may suspend provisions of regulatory statutes during a disaster declaration.
IC 10-14-3-22	<i>State agencies suspending laws</i>	Indiana state agencies may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes.

IC 10-14-3-22	<i>Local governments suspending laws</i>	Local governments may make, amend, and rescind orders, rules, and regulations when necessary for emergency management purposes
Limiting Transmission		
Code	Usage	Description
IC 16-18-2-91	<i>Dangerous Communicable Disease</i>	Definition of dangerous communicable disease
IC 16-41-6-2	<i>Compulsory Testing for Communicable Diseases</i>	Upon court order, the State Health Commission or local health officer can compel examination of an individual who may have a communicable disease or other diseases that is a serious and present danger to health
IC 16-18-2-302.6 IC 16-19-3-9 IC 16-41-9	<i>Quarantine</i>	<ul style="list-style-type: none"> • Definition of quarantine • SHC and local health officers have the authority to quarantine and take measures to prevent and suppress disease. • Quarantine procedure
IC 16-18-2-194.5	<i>Isolation</i>	<ul style="list-style-type: none"> • Definition of isolation • Isolation procedures
IC 16-41-9-5	<i>Mentally ill, Dangerous, or Gravely Disabled Disease Carrier</i>	State or local health officers may detain an individual carrying a dangerous communicable disease if he/she is deemed mentally ill, dangerous, or gravely disabled.
IC 16-19-3-10 IC 16-20-1-24	<i>Closing Schools and Churches and Banning Public Gatherings</i>	<ul style="list-style-type: none"> • IDOH has the authority to order schools and churches to close and forbid public gatherings to prevent or stop epidemics. • Local health officers have the authority to order schools and churches to close or forbid public gatherings to prevent or stop epidemics
IC 16-41-9-3	<i>Excluding Infected Students from Attending School</i>	<ul style="list-style-type: none"> • Local health officers may exclude a student from school if he/she has a dangerous communicable disease that is transmitted through normal school-related contacts and the disease poses a substantial threat to the school. • Students deemed to no longer have the dangerous communicable disease shall be given a certificate of health and readmitted to school.
IC 16-20-1-21 IC 16-20-4-18	<i>Local Health Department Communicable Disease Control</i>	Local health departments have the duty and authority to take any action authorized by law or IDOH to control communicable diseases.
IC 15-17-10	<i>Diseased Animals</i>	State and federal governments can examine, quarantine, and condemn diseased or dangerous animals.

IC 16-41-5	<i>IDOH Inspection of Private Property</i>	IDOH has situational authority to enter private property to inspect communicable diseases.
IC 16-20-1-23	<i>Local Health Department Inspection of Private Property</i>	Local health departments have situational authority to enter any premise to inspect, investigate, evaluate, conduct tests, or take samples to determine compliance with public health laws/rules and for the prevention and suppression of disease.
IC 10-46-2	<i>Use of State Funds to Prevent Disease</i>	Governor may draw state funds at any time to prevent the introduction or spread of contagious and infectious diseases in Indiana.
Treatment		
Code	Usage	Description
IC 16-41-9-1.7	<i>Immunizations</i>	<ul style="list-style-type: none"> • Immunization programs must include information on the benefits and risks of immunization. • No adult can be immunized without his/her consent. • No child can be immunized without his/her parent/guardian's consent. • Individuals who refuse immunization can be subjected to isolation or quarantine.
IC 16-19-4-11 IC 25-0.5-11	<i>Administration of Immunizations by Healthcare Providers</i>	The State Health Commissioner has the authority to issue a standing order, prescription, or protocol allowing pharmacists and providers regulated by any of the license boards listed in IC 25-0.5-11 to administer immunizations.
IC 16-38-5-2	<i>Documentation of Immunizations</i>	<ul style="list-style-type: none"> • Providers administering immunizations or their designee must provide immunization data to the immunization data registry. • No emergency exception.
IC 10-14-3-23 IC 16-31-1-3 IC 16-41-1-1	<i>Exception to compulsory medical treatment</i>	The government cannot compel an individual to submit to physical examinations, medical treatment, or immunization if the individual or his/her guardian decides to rely on spiritual means or prayer to prevent or cure disease or suffering.
IC 16-41-16	<i>Infectious Waste</i>	Instructions for handling infectious waste.
Points of Distribution (POD)		
Code	Usage	Description
IC 16-19-11-1 IC 16-19-11-2 IC 16-19-11-3	<i>Security of IDOH Property</i>	<ul style="list-style-type: none"> • The State Health Commissioner can appoint security officers to protect properties owned or occupied by IDOH, including the streets passing through or adjacent to those properties. • Appointed security officers to have general police powers, including the authority to arrest.

		<ul style="list-style-type: none"> • IDOH can control traffic and parking around IDOH properties.
IC 10-14-3-33.5	<i>Regulation of Firearms during Emergencies</i>	State and local governments cannot prohibit or restrict the lawful possession, transfer, sale, transportation, storage, display, or use of firearms or ammunition during a disaster emergency, energy emergency, or local disaster emergency. Some exceptions: are school property, postsecondary education institutions, emergency shelter care child caring institutions, private secure facilities, emergency shelter care group homes, domestic violence shelters, etc.
Surveillance		
Code	Usage	Description
IC 16-19-10-8	<i>Counterterrorism Surveillance</i>	IDOH must report and monitor data on symptoms and health syndromes for outbreaks of dangerous diseases and health conditions.
IC 16-41-2 IC 16-41-3 410 IAC 1-2.5	<i>Communicable Disease Surveillance</i>	IDOH has the authority to make rules establishing reporting, monitoring, and preventing communicable diseases.
512 IAC 1-2-1 512 IAC 1-2-2	<i>School Attendance Reporting System for Outbreaks</i>	<ul style="list-style-type: none"> • School corporations and accredited nonpublic schools must develop an attendance system for reporting symptoms and health syndromes from outbreaks or suspected outbreaks of disease or other health conditions that are a danger to public health. • When the percentage of students absent equals or is greater than 20%, schools must report the percentage of students absent to the local health department.
IC 10-14-3-15	<i>Exceptions to Licensure Requirements for Emergency Management Workers</i>	Professional, mechanical, or other skill-related licensure requirements do not apply to emergency management workers.
IC 16-31-3-3	<i>Exceptions to EMS Certifications or Licensure Requirements</i>	Certification or licensure is not required for an emergency ambulance service, EMT, ambulance, EMS non-transport vehicle, or ALS when providing EMS services during a major catastrophe or disaster when EMS resources are insufficient.
IC 16-31-3.5-2	<i>Exceptions to Emergency Medical Dispatch Requirements</i>	Training requirements for emergency medical dispatchers do not apply during a major catastrophe or disaster when emergency medical dispatch resources are sufficient.
IC 10-14-5-5	<i>Exceptions to Licensure Requirements related to EMAC resources</i>	<ul style="list-style-type: none"> • Individuals with professional, mechanical, and other skills are requested through the EMAC member state.

		<ul style="list-style-type: none"> The governor of the receiving state can put limitations and conditions on the scope of practice of these individuals.
IC 10-14-6.5-5	<i>Exceptions to Licensure Requirements related to Interstate Mutual Aid Resources</i>	<ul style="list-style-type: none"> Emergency responders licensed in another state are licensed in Indiana when providing aid related to an interstate mutual aid agreement. The emergency responders' scope of practice is limited to the responders' license and the equivalent license in Indiana.
Legal Immunities		
Code	Usage	Description
PREP ACT	<i>Immunity for Administration or Use of Countermeasures</i>	<ul style="list-style-type: none"> Federal law that provides immunity from liability for claims of loss related to the administration or use of countermeasures. The Secretary of Health and Human Services can issue a PREP Act declaration at any time, not just during emergencies. Excludes acts of willful misconduct. Current declarations include pandemic influenza countermeasures.
IC 34-30-13.5	<i>Immunity for Healthcare Providers and Facilities</i>	<ul style="list-style-type: none"> Only applies when the governor has declared a disaster. Applies to health care services, provided before, after, or during disaster declarations, in response to an event that resulted in a disaster declaration. Health care providers must be licensed in Indiana.
IC 34-30-12.5	<i>Immunity for Healthcare Provider Providing Smallpox Immunization</i>	<ul style="list-style-type: none"> Healthcare Provider includes physicians, healthcare facilities, nurses, paramedics and EMTs, and their medical staff. Healthcare Providers administering medical countermeasures against an actual or potential bioterrorist incident or public health emergency is immune from civil liability for any injury or damage resulting from the administration of the medical countermeasures. Applies only when the federal government authorizes IDOH to administer medical countermeasures.
IC 16-31-6-4	<i>Immunity for Paramedics and EMTs</i>	EMS, government, and healthcare individuals/entities are not liable for acts or omissions by paramedics or EMTs while treating a

		patient in good faith in connection with a disaster declaration for the act of terrorism.
IC 16-39-7-1	<i>Immunity for Destruction of Health Records</i>	A provider is not liable for destroying or failing to maintain a health record, in good faith, in connection with an emergency declaration or other disaster.
IC 25-38.1-4-7	<i>Immunity for Veterinarians</i>	Veterinarians and veterinary technicians are immune from damages to the owner of an animal the veterinarian or veterinarian technician provides emergency treatment to, including euthanasia.
Emergency Mutual Aid		
Code	Usage	Description
IC 10-14-3-10.8 IC 10-14-3-16 IC 10-14-3-17 844 IAC 5-9-8	<i>Indiana Intrastate Mutual Aid Compact</i>	Creates a mutual aid compact between participating local governments, fire departments, and private individuals in Indiana.
IC 10-14-5	<i>Emergency Management Assistance Compact (EMAC)</i>	<ul style="list-style-type: none"> • Indiana may request emergency resources from and provide emergency resources to other states participating in EMAC. • The requesting state will reimburse the providing state for any loss, damage, or expense related to provided resources unless the providing state determines reimbursement is unnecessary.
IC 10-14-6.5	<i>Interstate Mutual Aid Agreement</i>	State and local governments may enter into mutual aid agreements with state or local governments of other states if an emergency declaration is in effect.
IC 10-14-3.5	<i>Uniform Emergency Volunteer Health Practitioners Act</i>	Registered volunteer health and veterinary health practitioners licensed in Indiana, or another state can provide services in Indiana while an emergency declaration is in effect.

ACRONYM LIST

The following is a list of commonly used acronyms in preparedness/response plans. Not all acronyms in this list may have been used in this document.

Acronym	Meaning
AAR/IP	After-Action Report/Improvement Plan
ACC	Alternate Care Center
ADA	Americans with Disabilities Act
ARC	American Red Cross
ASPR	Administration for Strategic Preparedness & Response
BP	Budget Period
BHP	Bureau of Health Preparedness
BOAH	Board of Animal Health
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
CDC	Centers for Disease Control and Prevention
CERT	Community Emergency Response Team
CMS	Centers for Medicare and Medicaid Services
COAD	Community Organizations Active in Disasters
CRC	Community Reception Center
CSC	Crisis Standards of Care
CSE	Chemical Surge Event
DHHS	Department of Health and Human Services
DPIC	Drug & Poison Information Center
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ERC	Emergency Response Coordinator
ESF	Emergency Support Function
EPA	Environmental Protection Agency
EUA	Environmental Protection Agency

Acronym	Meaning
HAN	Health Alert Network
HCC	Healthcare Coalition
HICS	Hospital Incident Command System
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act
HPP	Hospital Preparedness Program
ICS	Incident Command System
IND	Improvised Nuclear Device
JIC	Joint Information Center
KI	Potassium Iodide
LHD	Local Health Department
LTC	Long Term Care
MAC	Multi-Agency Coalition
MCI	Mass Casualty Incident
MRC	Medical Reserve Corp
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NGO	Non-Governmental Organization
OSLD	Optically Stimulated Luminescent Dosimeters
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PUI	Person Under Investigation
RHC/RRC	Regional Healthcare Coordinator/Readiness & Response Coordinator
SFY	State Fiscal Year
SOP	Standard Operating Procedure
SME	Subject Matter Expert
SITREP	Situation Report
THC	The Health Collaborative
WENS	Wireless Emergency Notification System

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HEALTHCARE COALITION RESOURCE MANAGEMENT PLAN ANNEX

District 2 Healthcare Coalition

January 2026

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RECORD OF CHANGES

The Healthcare Coalition Planning Coordinator 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)	Name
6/2025	Random	Added avian influenza	Jennifer Tobey
1/2026	Random	Updates	Jennifer Tobey

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OVERVIEW

HCC MEMBER ORGANIZATIONS - CORE MEMBERS IN BOLD

1. **Hospitals (a minimum of two acute care hospitals)**
2. **Emergency Management Agency (EMA)**
3. **Emergency Medical Services (EMS) (including facility and other non-EMS patient transport systems)**
4. **Local Public Health Department(s) (LHD)**
5. Behavioral Health Services and organizations
6. Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
7. Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks
8. State and Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indiana Health Service facilities, military treatment facilities)
9. Home health agencies (including home and community-based services)
10. Infrastructure companies (e.g., utility and communication companies)
11. Jurisdictional partners, including cities, counties, and tribes.
12. Local chapters of professional healthcare organizations (e.g., medical society, professional society, hospital association)
13. Local public safety agencies (e.g., law enforcement and fire services)
14. Medical and device manufacturers and distributors
15. Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
16. 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)
17. Primary care providers, including pediatric and women's health care providers.
18. Schools and universities, including academic medical centers.
19. Skilled nursing, nursing, and long-term care facilities
20. Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
21. Medical examiners/coroners and funeral homes
22. Agency/facility public information specialists
23. Agencies that support an Emergency Support Function (ESF)
24. Other (e.g., childcare services, dental clinics, social work services, faith-based organizations)

PURPOSE

The purpose of this support plan is to supplement existing planning and response guidance with specific information regarding the management of resources. According to the 2017-2024 Healthcare Preparedness and Response Capabilities, Healthcare Coalitions (HCC) “are groups of individual health care and response organizations (e.g., hospitals, EMS, emergency management organizations, public health agencies, etc.) in a defined geographic location that plays a critical role in developing health care delivery system preparedness and response capabilities.”

HCCs serve as multiagency coordination groups that support and integrate with ESF-8 activities in the context of incident command system (ICS) responsibilities. HCCs coordinate activities among healthcare organizations and other community stakeholders; these entities comprise HCC members who actively contribute to HCC strategic planning, operational planning and response, information sharing, and resource coordination and management. As a result, HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and educated and trained healthcare personnel. The actions described here are intended to support, not replace, any existing facility, agency policy, or plan.

SCOPE

This plan explains the processes and techniques available to ensure all necessary resources are identified and available for membership of the District 2 Healthcare Coalition (HCC) use.

This plan is a supplement to, not a replacement for, the response actions and resources described in the coalition, facility, or agency Emergency Operations Plan and provides additional details relevant to an incident that involves significant numbers of victims and is not intended to describe or define processes of individual hospital operations nor supersede hospital plans and processes. Each agency in the HCC is encouraged to develop more detailed plans that support their operations and supplement this annex.

MAINTENANCE

The HCC will conduct an annual review of this annex in coordination with the member agencies and organizations as appropriate. Additional reviews may be conducted after an exercise, a significant incident/event occurs, or regulatory changes indicate a need. The HCC Planning Section Coordinator (PSC) will track and distribute any needed changes to this plan using the Document Change Record in Table 1.

CONCEPT OF OPERATIONS

The HCC will participate in the full spectrum of readiness and preparedness activities to ensure personnel can continue essential functions in an all-hazard/threat environment. (Example: flooding, hazardous materials incident, avian influenza).

If a Facility, Agency, or County is involved in an incident or emergency, resources may be depleted rapidly therefore negatively affecting their ability to respond. These resources may include medical materials and equipment, communication items, decontamination equipment, medical and non-medical personnel, and miscellaneous materials and equipment.

If a District 2 hospital is part of a large healthcare system, it is normal practice that the hospital will use its local resources, including but not limited to its own healthcare system and or sister hospital (both inside and outside of District 2) prior to requesting District 2 resources.

The District concept is designed to supplement resources not only to hospitals but any Facility, Agency, or County within or outside of District 2 that is involved in an emergency and or incident. These are typically types of resources that are more difficult to locate and obtain quickly.

IDENTIFICATION OF DISTRICT 2 RESOURCES / STATE

Per Indiana Department of Health (IDOH), all hospitals within District 2 Healthcare Coalition are required to maintain emergency preparedness items to meet guidelines set forth. These items include but are not limited to pharmaceutical caches, personal protective equipment, decontamination equipment, communication equipment, laboratory supplies, and personnel trained in various aspects of emergency response.

- **Chempack-** contains nerve agent antidote cache. Refer to the D2 HCC Chempack Plan
- **Communications-** D2 Readiness and Response Coordinator maintains a list of formalized communication methods that are prioritized. Refer to *D2 HCC Response Plan Annex A Information Sharing and Annex F Communication Plan*
- **District Resource Trailers-** District 2 has two (2) trailers available upon request. Trailer 1 is in Elkhart County and Trailer 2 is in Kosciusko County. Trailer inventory below:

Item	Description	Vendor	Qty	Location
Trailer	10,000 Road Force with RF-P2 SIDE DOOR AND REAR RAMP DOOR PACKAGE	WELLS CARGO	2	TR1/TR2
Extension Cord	Cord Reel, 2 Outlet, 20 Foot	Grainger	2	TR1/TR2
Generator	Generator, 10,000 Watt	Grainger	1	TR1 Only
Generator	Generator, 2200 Watt			TR1/TR2
Flashlight	Flashlight (D Cell)	Grainger	2	TR1/TR2

Batteries	Duracell D Cell Batteries Pkg of 12	Grainger	2	TR1/TR2
Goggles	Protective Goggle	Grainger	2	TR1/TR2
Tape	Duct Tape	Grainger	2	TR1/TR2
Tools	Tool Set, 30 Pc.	Grainger	2	TR1/TR2
SPHYGMOMANO METER	Sphygmo Elite SRS Aneroid	Grainger	1	TR1/TR2
SPHYGMOMANO METER	Sphygmo Elite SRS Aneroid	Grainger	1	TR1/TR2
O2	Mass Cas. O2 Manifold Hard Case	Grainger	2	TR1 Only
Inflator	Prism Inflatable Light	Grainger	2	TR1/TR2
Commode	Bedside Commode	Grainger	2	TR1/TR2
MOD	ADULT 48 hr MOD - (serves 25)	DQE	2	TR1/TR2
	Absorbent Adult Briefs, Bedding Kits, Bedpans, Biohazard Bags and Dispenser, Blood Pressure Cuff Covers, Dry-it Disposable Towels, Nitrile Exam Gloves, Gown Kits, Hygiene Kits, IV Poles, Lab Coats, Male Urinals, Mylar(R) Blankets, Surgical Masks, Patient Lifters, Post-Mortem Kits, Privacy Curtains, Sani-Bag Commode Liners, Sharps Disposal Containers, Staff Scrubs, StatPaq Standard Precautions Kits, Stethoscopes	Note Some PPE removed during COVID		
MOD	PEDIATRIC 48 hr MOD (Serves 25)	DQE	2	TR1/TR2
	Baby Diapers, Linen Kits, Bedpans, Biohazard Bags and Dispenser, Blankets, Blood Pressure Cuff Covers, Dry-it Disposable Towels, Nitrile Exam Gloves, Gown Kits, Hygiene Kits, Infant Care Kits, IV Poles, Lab Coats, Male Urinals, Mylar(R) Blankets, Surgical Masks, Patient Lifters, Pillows, Post-Mortem Kits, Privacy Curtains, Sani-Bag Commode Liners, Sharps Disposal Containers, Staff Scrubs, StatPaq Standard Precautions Kits, Stethoscopes	Note Some PPE removed during COVID		
Stat-Paq- PPE	Standard Precautions PPE Kit - DQE - Airborne Precautions PPE,	DQE	120	TR1/TR2

	Contact Precautions PPE (dqeready.com)			
	Personal PPE packs. Each StatPaq consists of One fluid-resistant, barrier protective gown Nitrile exam gloves (2 sizes: S, L) Shoe covers One N95 Flat-Fold, Particulate Respirator One pair indirect vent Safety Glasses			
Tent	<u>CUSTOM SURGE SYSTEM</u>	TVI CORPORATION	2	TR1/TR2
	Doors (4)		8	TR1/TR2
	Windows (4)		8	TR1/TR2
	Equipment Hangers, 100 lb. capacity ea. (16)		32	TR1/TR2
	ECU Ports (2)		4	TR1/TR2
	Electrical/Utility Hangers			TR1/TR2
	HVAC Plenum			TR1/TR2
	Ground Cloth Carry Bag Combo			TR1/TR2
Beds	TempBed500 System		4	TR1/TR2
	5 temp beds with triage ID on transport/storage cart w/ dust cover		20 beds	TR1/TR2
	Swing Upside Rails for TB100, pair		20	TR1/TR2
	TB IV Pole		20	TR1/TR2
	TB O2 Holder		20	TR1/TR2
	TB Chart Holder		20	TR1/TR2
	TB Patient Bag		20	TR1/TR2
	TB Closed Cell Mattress		20	TR1/TR2
Location trailer 1: Elkhart County EMA Office 26861 CR 26 Elkhart, IN 46517				
Location trailer 2: Lutheran EMS- 445 Anchorage Road Warsaw, IN 46580				

- **D2 Medical Oxygen Generating System (MOGS)**- In the event of an emergency, incident, or natural disaster, HCC has one (1) MOG located in Elkhart County. This unit can be deployed to generate medical-grade oxygen, in any location, to help any organization administer immediate relief to those in need. All requests will be facilitated by the D2 Readiness and Response Coordinator.
- **State Pharmaceutical Cache**- District 2 can obtain access to prophylactic medications for the purpose of providing prophylaxis to hospital associations and D2 partners in the event of a large-scale incident requiring this medicine. All requests will be facilitated by the D2 Readiness and Response Coordinator (RRC).

D2 PERSONAL PROTECTIVE EQUIPMENT (PPE) CACHE

- The PPE inventory should be adequate to, at minimum, protect healthcare workers to isolate, evaluate, and prepare an infectious patient for transport or treatment.
- The CDC recommends specific amounts of PPE, enough for the type of care provided:
Frontline/First Responder: PPE enough for **12-24 hours** of patient care
Assessment Hospital: PPE enough for **4-5 days** of patient care
Treatment Hospital: PPE enough for at least **7 days** of patient care
- Beacon Health Systems partners with HCC to store and maintain all HCC PPE.
- District 2 and Beacon Health Systems maintain a yearly updated mutual aid agreement for maintaining this cache.
- Inventory list will be maintained by the housing facility and the RRC.

Alert and Notification

The HCC maintains plans and procedures for communicating and coordinating activities with personnel before, during, and after a continuity event.

Before an event, personnel in the HCC will monitor advisory information, including Prepara is notifications. In the event normal operations are interrupted or an incident appears to be imminent, the HCC will take the following steps to communicate the organization's operating status with all staff:

- (1) The HCC Chairperson or designated successor will notify the RRC of the emergency
- (2) The RRC will activate the HCC executive board, facilities, and agencies requesting assistance as deemed by the incident

Report the current status of your facility, agency or County and request specific resources based on the type of incident or emergency. (Example: a large-scale chemical exposure has occurred in your area. There will be many more patients than your decontamination capabilities can accommodate. You request portable decontamination showers and trained

personnel to operate them.) All requests should be specific in nature, amounts, types, and proposed length of use.

DISTRIBUTION OF RESOURCES

- The RRC will contact facilities that are not directly involved in an emergency or incident to obtain a list of supplies, equipment and personnel that may be available to assist in the particular event.
- Facilities, Agencies, and Counties that are closest to the requested location will be contacted first. Depending on the scale of the incident, the closest location may be unable to provide assistance without jeopardizing their ability to operate. In these cases, resources will be requested from locations that are outside of the immediate area of the emergency or incident.
- Transportation of requested resources is the responsibility of the requested facility, agency or county. If the requested facility, agency or county does not have the means to transport the requested resource, the RRC will work with other partners to get said resources delivered.
- If HHC resources are not available, the RRC will work with the County Emergency Management Agency and the IDOH Liaison to coordinate resources from neighboring districts.
- If multiple districts are involved in an emergency or incident, the RRC, Local EMA, and IDOH liaison submit a resource request to the Indiana Department of Homeland Security (IDHS) via WEBEOC or IDHS D2 EMA Liaison.
- The RRC and each facility, agency, or county must maintain documentation of all resources distributed or received by a requested location. (For example: NIMS/ICS form 214) These forms are essential for tracking purposes and billing for items used. These are also acceptable forms when applying for State and or Federal reimbursement.

STRATEGIC NATIONAL STOCKPILE (SNS)

The Indiana Department of Health (IDOH) requires Local Health Departments (LHDs) and Hospitals to follow the steps outlined in this document to request the re-order of SNS material.

Any hospital requiring additional SNS medical supplies to continue treating symptomatic patients must first contact their District Hospital Coordinator to ascertain if their request can be filled at the county or district level. *** Please also notify the RRC for transparency within the District. ***

If not, then:

- The Hospital will need to complete the “SNS Hospital Order (Request)” form. An Authorized Hospital SNS Coordinator (aka BT Coordinator) should complete this SNS Hospital Order form.
- The primary mode to send the completed form is as an attachment by e-mail. In either case, the Hospital should indicate that they “require additional resources in order to maintain their ability to treat symptomatic patients directly affected by the current event” in the body of the E-mail. (Example: state the nature of event- anthrax exposure) *** Recommend first placing a phone call or adding the request to EMResource. ***
- When the Hospital submits an SNS order (request) form, they must send their LHD a copy by E-mail. This step is critical for SNS asset tracking and Federal accountability purposes. (SNS Gatekeepers) *** Recommend first placing a phone call or adding the request to EMResource. ***

The ordering (requesting) Hospital will receive confirmation from IDOH staff that their request was received. All orders (requests), whether approved or suspended, will receive a follow-up phone call to the requesting entities confirming the request’s status. *** Please also notify the RRC of transparency within the Districts. ***

ACRONYM LIST

The following is a list of commonly used acronyms in preparedness/response plans. Not all acronyms in this list may have been used in this document.

Acronym	Meaning
AAR/IP	After-Action Report/Improvement Plan
ACC	Alternate Care Center
ADA	Americans with Disabilities Act
ARC	American Red Cross
ASPR	Administration for Strategic Preparedness & Response
BP	Budget Period
BHP	Bureau of Health Preparedness
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CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosives
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CERT	Community Emergency Response Team
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COAD	Community Organizations Active in Disasters
CRC	Community Reception Center
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CSE	Chemical Surge Event
DHHS	Department of Health and Human Services
DPIC	Drug & Poison Information Center
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ERC	Emergency Response Coordinator
ESF	Emergency Support Function
EPA	Environmental Protection Agency
EUA	Environmental Protection Agency
HAN	Health Alert Network
HCC	Healthcare Coalition
HICS	Hospital Incident Command System

Acronym	Meaning
HIE	Health Information Exchange
HIPAA	Health Insurance Portability & Accountability Act
HPP	Hospital Preparedness Program
ICS	Incident Command System
IND	Improvised Nuclear Device
JIC	Joint Information Center
KI	Potassium Iodide
LHD	Local Health Department
LTC	Long Term Care
MAC	Multi-Agency Coalition
MCI	Mass Casualty Incident
MRC	Medical Reserve Corp
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NGO	Non-Governmental Organization
OSLD	Optically Stimulated Luminescent Dosimeters
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment
PUI	Person Under Investigation
RHC/RRC	Regional Healthcare Coordinator/Readiness & Response Coordinator
SFY	State Fiscal Year
SOP	Standard Operating Procedure
SME	Subject Matter Expert
SITREP	Situation Report
THC	The Health Collaborative
WENS	Wireless Emergency Notification System

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INDIANA DISTRICT 2 HEALTHCARE COALITION

CYBERSECURITY ANNEX



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

May 2026

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I. INTRODUCTION

The 2024-2029 Hospital Preparedness Program (HPP) Funding Opportunity Announcement (FOA) requires Healthcare Coalitions (HCCs) to develop a complementary coalition-level Cybersecurity Annex to its base medical surge/trauma mass casualty response plan to improve capacity and capabilities to manage any incidents that involve cyber.

A. Purpose

The purpose of this annex is to improve the overall cybersecurity protection and resiliency of the District 2 Healthcare Coalition (HCC). The next purpose is to describe the goals, objectives, strategies, roles, and responsibilities within HCC to prioritize the implementation of high-impact cybersecurity practices. Lastly, to describe at a high level the steps they intend to take to address cybersecurity gaps identified in a HCC Cybersecurity Assessment(s) (See Appendix 1)

B. Scope

This plan covers the steps HCC conducts to improve cybersecurity practices in a multi-system preparedness and mitigation approach to emerging cybersecurity threats and attacks. This plan is to be used in concurrence with facility and local public health cybersecurity plans and information technology (IT) practices.

C. Overview/Background of HCC and Situation

Location

Located in the Great Lakes region of the United States, Indiana is the 17th most populous state and 38th in land area. It is comprised of 92 counties. The Indiana District 2 Healthcare Coalition consists of 7 counties: Elkhart, Kosciusko, Marshall, Fulton, Starke, Pulaski, and St Joseph.

Members

The District 2 Healthcare Coalition consists of a variety of healthcare organizations. The District 2 Healthcare Coalition Core members include Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representatives. 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, Indiana 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

D. Planning Assumptions

The following assumptions have been made for planning purposes:

- Each HCC member has primary responsibility for their organization’s IT and Cybersecurity programs
- The HCC cybersecurity program operates solely in the prevention and preparedness phases of Emergency Management
- Cyber-attacks will degrade, disrupt, and potentially terminate the operations for targeted organizations
- Medical organizations and their Electronic Medical Records are prime targets for cyber criminals
- The strength of 3rd party vendor cybersecurity programs represents a vulnerability for HCC members

E. Administrative Support

The Cybersecurity Annex will be reviewed and updated annually by the Policy Committee and or Planning Chief with updates to be approved by the Executive Committee, which consists of the core 4 members (Public Health, Emergency Management Agency (EMA), Hospital, and Emergency Medical Services (EMS) representative), and membership of the coalition.

Additionally, when exercises or real events warrant changes to the plan, the Policies Committee and or Planning Chief will be assigned an additional review at any time during the year. In addition, the following table shall be used to track changes in the document:

Update	Location in Plan	Name
May 2026	Annex complete	Jennifer Tobey

II. CONCEPT OF SUPPORT OPERATIONS

A. Evaluation

In partnership with coalition members, the HCC completed a Cybersecurity Assessment for the HCC's jurisdiction. The assessment informs the prioritization of high-impact cybersecurity practices. The assessment:

- **Assessed use of cybersecurity practices.** Identified, at a high level, the practices and/or systems that the HCC has in place that correspond to the Healthcare and Public Health (HPH) Sector-Specific Cybersecurity Performance Goals ([CPGs](#)) to strengthen cyber preparedness and resiliency
- **Described community impact.** Described the impact of a potential cyber incident on communities most impacted by disasters
- **Identified mitigation strategies.** Based on the ten essential HPH Sector Specific CPGs, determined where the HCC has gaps and identified mitigation strategies that will address the priority areas for cyber preparedness and resiliency. See the following documents for detailed mitigation strategies:
 1. HHS Technical Volume 2: Cybersecurity Practices for Medium and Large Healthcare Organization ([Link](#))

2. HHS Healthcare and Public Health Sector-specific Cybersecurity Performance Goals (CPGs) ([Link](#))

B. Prioritize

HCC will analyze the gaps and mitigation strategies reported in the Cybersecurity Assessment to identify the top three most impactful activities the HCC can conduct to improve cybersecurity protection and resilience. While evaluating the gaps and mitigation strategies, the HCC will consider these factors:

- **High impact.** Identify cybersecurity practices that have the greatest return upon investment of HCC resources: i.e., which practice gives the greatest bang for the buck.
- **Broadest impact.** Consider the percentage of HCC members to benefit from each of the practices, ensuring that the cybersecurity practice serves the largest audience.
- **Access to cybersecurity resources.** Evaluate the technical complexity of a cybersecurity practice against the HCC’s internal level of expertise to identify activities that will require recruitment of external subject matter experts.
- **Existing Resources.** Scrub the HHC cybersecurity gaps and mitigation strategies against available resources and programs from federal and state organizations.

C. Plan High-Impact Activities

The HCC selects and plans the methods to implement each of the top three high-impact activities. While thinking about an education, an exercise or a testing approach, the HCC considers these implementation methods:

Coordinate technical assistance	Connect the HCC to federal resources
Cybersecurity Education	Cybersecurity Exercises
Informational briefings	List federal and state resources
Monitoring federal updates on cyberattacks	Promoting existing programs
Providing situation awareness updates	Training on specific cyber practices
Workshop common cybersecurity gaps	

D. Roles and Responsibilities

D2 HCC/IDOH/IDHS

Role – Regional Coordination of Health Response

Responsibility - Support information sharing and coordination of activities between coalition members, local and state health departments as well as other Indiana District Healthcare Coalitions. Help manage resources between facilities in the district and across the state.

Indiana Department of Health (IDOH)

Role – Lead State agency for health-related issues

Responsibility - Support HCC information exchange and situational awareness needs.

Facilitate health care resource requests to state/inter-state/federal partners. Request State Disaster or Public Health Emergency Declarations and the governor's emergency orders as required to support response. Provide guidance and recommendations for clinicians, local and tribal public health, and community members.

Indiana Department of Homeland Security (IDHS)

Role – Lead State agency for Incident Coordination

Responsibility – Serve as point of contact for resource requests. Request state declaration of emergency, if needed.

E. Command, Control, and Coordination

In Indiana, as it is across the country, emergency incidents are responded to and handled at the lowest jurisdictional level, meaning the city or township, then escalated to the county, and finally escalated to the State.

The State of Indiana is divided into ten Public Health Districts, each with varying emergency response resources. More heavily populated areas have full-time fire departments, police departments, emergency medical services, and abundant hospital and healthcare assets, while other counties are served by part-time or volunteer responders, as well as little to no healthcare resources. The coordination among counties and Districts is critical to the successful response to a burn surge event.

The Healthcare Coalition exists within each District that interfaces with other community response partners to actively assist in information sharing and resource coordination, working closely with the local Emergency Support Function 8 coordinators.

If the incident needs are greater than local resources, the Indiana Department of Homeland Security (EOC) Emergency Operations Center is notified, and the Emergency Support Function #8 (ESF-8) State Coordinator, a representative from the Indiana Department of Health IDOH), shall serve as the coordinator for public health and medical incident response and resource requests.

Cybersecurity Event	Definition	Response Plan
Local	Cybersecurity events in which local resources are overwhelmed, but manageable locally	<ul style="list-style-type: none"> • Individual agencies manage their disaster plans. • Local jurisdictions notify the surrounding area of assistance and notification to surrounding HCC via mutual aid agreements. • Responsible for communicating with team leaders, ensuring an accurate understanding of the issue and the company's status, and communicating with the media and/or informing relevant stakeholders.
District	Cybersecurity event in which district resources are overwhelmed.	<ul style="list-style-type: none"> • D2HCC leadership assists local agencies when requested with incident management and or resources.
State	Cybersecurity events in which State resources are overwhelmed.	<ul style="list-style-type: none"> • State-level activation of the EOC along with supportive agencies for IDOH and IDHS

III. ADDITIONAL CONSIDERATIONS

A. Situational Awareness

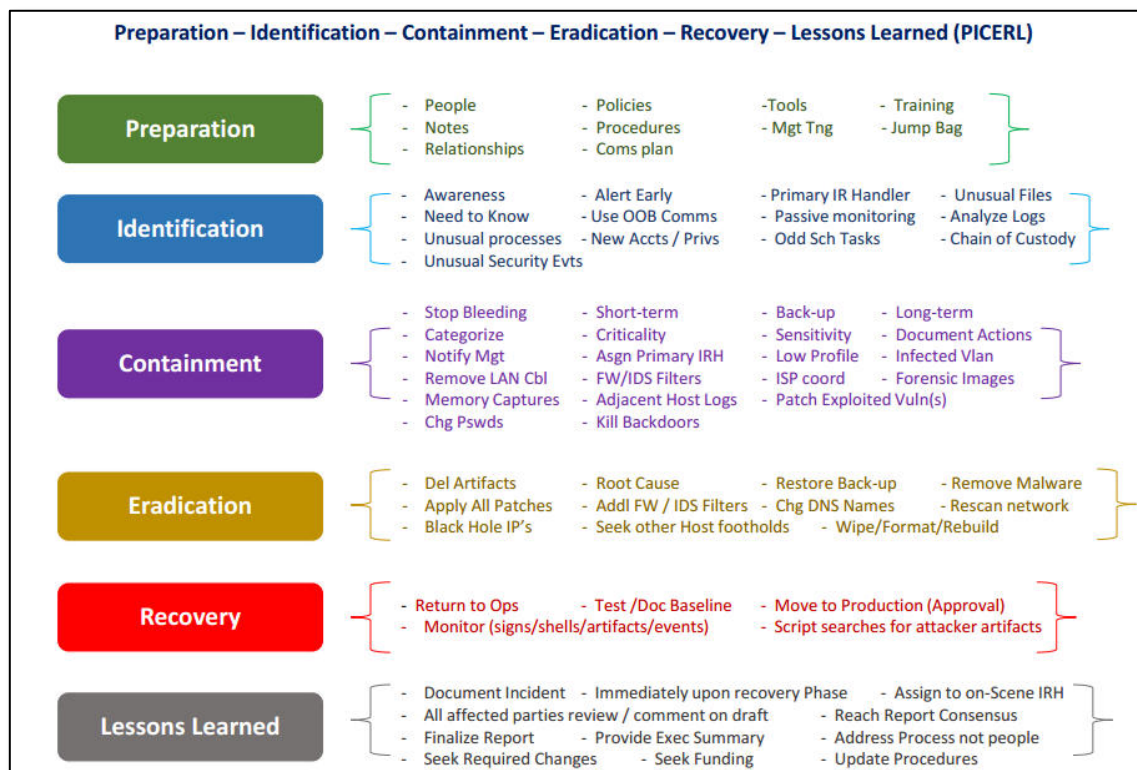
The HCC has a responsibility to monitor and remain informed on current cyber-attacks and activity. The Cyber and Infrastructure Security Agency (CISA) maintains a real time update on cyber threats and attacks: see [CISA Cybersecurity Alerts and Advisories](#). The HCC and members monitor the cybersecurity alerts and advisories.

B. Communications

- When possible, the HCCs adds cybersecurity awareness and updates to coalition monthly meetings.
- As needed the HCC uses email listservs to share ad hoc and time-sensitive cybersecurity information.
- The HCC routinely shares information regarding 1) the current cybersecurity conditions in the community, 2) accurate and up to date cyberattack announcements, and 3) changing federal cyber policies.

C. Response (suggestion)

- High level incident response process
- Quick Start Guide by SANS Institute



D. Severity Rating

	Informational Impact	Functional Impact	Recoverability Impact	User Account Criticality	System Criticality
Level 4: Low Level of Interest	Informational	Informational	None	n/a	n/a
Level 3: Confirmed Threat Event	Informational	Informational	None	n/a	n/a
Level 2: Low Severity Incident	Availability or Integrity Loss	Low	Regular, Supplemented	Non-Essential, Standard Users	Non-Essential, Business Essential
Level 1: Moderate or High Severity Incident	Confidentiality Loss – Personal Data or Proprietary Business Confidential	Medium or High	Unknown, Extended	Privileged Services/Accounts, Business Executives or Key Functional Leads	Mission Critical, Business Critical

INSTRUCTIONS: *Chose the highest severity level based on the applicable impact and criticality factors.*

E. Legal Compliance

- Indiana’s cyber incident reporting statute.
- Indiana Code 4-13.1-1 including HEA 1169 (2021).
- Indiana Office of Technology (IOT) reporting requirements.

APPENDIX 1

HEALTHCARE AND PUBLIC HEALTH SECTOR-SPECIFIC CYBERSECURITY ASSESSMENT

for

District 2 Healthcare Coalition

Goal: To complete a cybersecurity assessment of the Healthcare Coalition’s jurisdiction in accordance with Health and Human Services (HHS) and Assistant Secretary for Preparedness and Response (ASPR) standards. The assessment identifies, at a high level, the practices and/or systems the HCC has in place that they correspond to the Healthcare and Public Health (HPH) Sector-Specific Cybersecurity Performance Goals (CPGs).

Standards:

1. HHS Healthcare and Public Health (HPH) Sector Cybersecurity Performance Goals ([HHS Hospital and Public Health sector CPGs](#))
2. ASPR Hospital Preparedness Program Cooperative Agreement (EP-U3R-24-001) ([FY24 HPP NOFO](#))

Use: This Cybersecurity Assessment form is designed to be completed by a HCC representative during a meeting or workshop of HCC partner organizations. In a group discussion, participants identify their organizations cybersecurity practices for each of the essential and enhanced Cybersecurity Performance Goals. An assessment of the overall HCC status for each goal is recorded. If needed, immediately consider and select appropriate mitigation strategies from the listed strategies.

Healthcare Coalition: _____

Date of Assessment: _____

State and geographic description of the HCC (i.e. Southwest Ohio):

HCC partner organizations participating in the cybersecurity assessment:

Identify mitigation strategies

Based on the **10 Essential Goals** listed below, HCCs identify mitigation strategies that will address their HCC gaps in the goals for cyber preparedness and resiliency. See Appendix 1 of the *HHS Healthcare and Public Health (HPH) Sector Cybersecurity Performance Goals* ([HHS Hospital and Public Health sector CPGs](#)) for detailed mitigation strategies of each performance goal. The identification of mitigation strategies has been incorporated into the 10 Essential Goals cybersecurity assessment in the form of checkbox lists (). If a significant gap is identified, review and checklist and select appropriate mitigation strategies.

10 Essential Goals to help healthcare organizations address common vulnerabilities.

1. Mitigate Known Vulnerabilities

Do organizations of the HCC work to reduce the likelihood of threat actors exploiting known vulnerabilities to breach the organization’s networks that are directly accessible from the Internet?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is mitigating know vulnerabilities a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in mitigating know vulnerabilities:

Identify asset vulnerabilities by:

- Host/Server-Based Scanning
- Scanning of Web Applications

Remote access is managed by:

- Use of Basic Endpoint Protection Controls

2. Email Security

Do organizations of the HCC work to reduce risk from common email-based threats, such as email spoofing, phishing, and fraud?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is email security a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in email security:

Implement email security by:

- Basic Email Protection Controls
- Workforce Education
- Multifactor Authentication for Email Access

3. Multifactor Authentication

Do organizations of the HCC add a critical, additional layer of security, where safe and technically capable, to protect assets and accounts directly accessible from the Internet?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is multifactor authentication a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in multifactor authentication:

- Verify Identities and Issue Credentials
- Authenticate Users, Devices, and Assets
- Implement Multifactor Authentication for Remote Access

4. Basic Cybersecurity Training

Do organizations of the HCC ensure organizational users learn and perform more secure behaviors?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is basic cybersecurity training a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in basic cybersecurity training:

Establish training programs for:

- Initial Workforce Education
- Annual Security Awareness and Training

5. Strong Encryption

Do organizations of the HCC deploy encryption to maintain confidentiality of sensitive data and integrity of Information Technology (IT) and Operational Technology (OT)?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is strong encryption a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps of strong encryption:

Implement Email Encryption

6. Revoke Credentials for Departing Workforce Members (Including Employees, Contractors, Affiliates, and Volunteers)

Do organizations of the HCC prevent unauthorized access to organizational accounts or resources by former workforce members, including employees, contractors, affiliates, and volunteers by removing access promptly?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is revocation of credentials a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in credentials revocation:

Improve identity and access management through:

- Provisioning, Transfers and Deprovisioning Procedures
- Authentication

7. Basic Incident Planning and Preparedness

Do organizations of the HCC ensure safe and effective organizational responses to, restoration of, and recovery from significant cybersecurity incidents?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is basic incident planning and preparedness a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in basic incident planning and preparedness:

Improve security operations center and incident response with:

- Backup Strategies
- Security Operations Policies
- Incident Response Plans

8. Unique Credentials

Do organizations of the HCC use unique credentials inside organizations' networks to detect anomalous activity and prevent attackers from moving laterally across the organization, particularly between IT and OT networks?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is unique credentialing a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the identified gaps in unique credentials:

Improve identity and access management by:

- Identity Verification
- Provisioning, Transfers, and Deprovisioning Procedures
- Authentication
- Multifactor Authentication for Remote Access

9. Separate User and Privileged Accounts

Do organizations of the HCC establish secondary accounts to prevent threat actors from accessing privileged or administrative accounts when common user accounts are compromised?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is separation of user and privileged accounts a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the gap in separation of user and privilege accounts:

Improve identity and access management by:

- Identity Verification
- Provisioning, Transfers, and Deprovisioning Procedures
- Authentication
- Multifactor Authentication for Remote Access

10. Vendor/Supplier Cybersecurity Requirements

Do organizations of the HCC identify, assess, and mitigate risks associated with third-party products and services?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is evaluation and mitigation of third-party cybersecurity risks a significant cybersecurity gap from the perspective of the overall healthcare coalition?

perspective of the overall healthcare coalition?

Yes / No (circle one)

If yes, **select** mitigation strategies that will address the gap in evaluation and mitigation of third-party cybersecurity risks:

- Cybersecurity Risk Assessment and Management

10 Enhanced Goals to help healthcare organizations elevate their cybersecurity capabilities and level of defense.

11. Asset Inventory

Do organizations of the HCC identify known, unknown (shadow), and unmanaged assets to more rapidly detect and respond to potential risks and vulnerabilities?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is asset inventory a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

12. Third Party Vulnerability Disclosure

Do organizations of the HCC establish processes to promptly discover and respond to known threats and vulnerabilities in assets provided by vendors?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is third-party vulnerability disclosure a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

13. Third Party Incident Reporting

Do organizations of the HCC establish processes to promptly discover and respond to known security incidents or breaches across vendors and service providers?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is third-party incident reporting a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

14. Cybersecurity Testing

Do organizations of the HCC establish processes to promptly discover and responsibly share vulnerabilities in assets discovered through penetration testing and attack simulations?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is cybersecurity testing a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

15. Cybersecurity Mitigation

Do organizations of the HCC establish processes internally to act quickly on prioritized vulnerabilities discovered through penetration testing and attack simulations?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is rapid cybersecurity mitigation a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

16. How to Respond to Relevant Threats

Do organizations of the HCC ensure organizational awareness of and ability to detect relevant threats and TTPs at endpoints, ensure organizations are able to secure entry and exit points to its network with endpoint protection?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is detection and response to relevant threats and Tactics, Techniques, and Procedures (TTP) a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

17. Network Segmentation

For organizations of the HCC, are mission critical assets separated into discrete network segments to minimize lateral movement by threat actors after initial compromise?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is network segmentation a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

18. Centralized Log Collection

Do organizations of the HCC collect necessary telemetry from security log data sources within the hospital’s network that maximizes visibility, cost effectiveness, and faster response to incidents?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is centralized log collection a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

19. Centralized Incident Planning and Preparedness

Do organizations of the HCC ensure organizations consistently maintain, drill, and update cybersecurity incident response plans for relevant threat scenarios?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is centralized incident planning and preparedness a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

20. Configuration Management

Do organizations of the HCC define secure device and system settings in a consistent manner and maintain them according to established baselines?

Yes / No (circle one)

Record any significant comments or observations from HCC partners:

Is configuration management a significant cybersecurity gap from the perspective of the overall healthcare coalition?

Yes / No (circle one)

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District 2 HCC Coop/Continuity/Recovery Plan

June 2026

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BASIC PLAN

I. Promulgation

The District 2 Healthcare Coalition's (HCC) mission is to serve as a leadership umbrella over the seven Counties of District 2. To accomplish this mission, the HCC must ensure its operations are performed efficiently with minimal disruption, especially during an emergency. This document provides planning and program guidance for implementing HCC's Continuity of Operations and Recovery Plan (COOP/RP) and programs to ensure the organization can conduct its essential missions and functions under all threats and conditions.

Key HCC personnel who are relocated under this plan are collectively known as HCC Emergency Relocation Group/Contractors (ERG). Upon plan activation, these members **may** deploy to requesting County/Facility. Upon arrival, continuity personnel will establish operational capability and perform essential functions within 12 hours from the time of the activation of the COOP/RP, for up to a 30-day period or until normal operations can be resumed.

II. Overview

HCC Member Organizations - CORE Members in Bold

- 1. Hospitals (a minimum of two acute care hospitals)**
- 2. Emergency Management Agency (EMA)**
- 3. Emergency Medical Services (EMS) (including facility and other non-EMS patient transport systems)**
- 4. Local Public Health Department(s) (LHD)**
5. Behavioral Health Services and organizations
6. Community Emergency Response Team (CERT) and Medical Reserve Corps (MRC)
7. Dialysis centers and regional Centers for Medicare & Medicaid Services (CMS)-funded end-stage renal disease (ESRD) networks
8. State and Federal facilities (e.g., U.S. Department of Veterans Affairs (VA) Medical Centers, Indiana Health Service facilities, military treatment facilities)
9. Home health agencies (including home and community-based services)
10. Infrastructure companies (e.g., utility and communication companies)
11. Jurisdictional partners, including cities, counties, and tribes.
12. Local chapters of professional healthcare organizations (e.g., medical society, professional society, hospital association)
13. Local public safety agencies (e.g., law enforcement and fire services)
14. Medical and device manufacturers and distributors

15. Non-governmental organizations (e.g., American Red Cross, voluntary organizations active in disasters, amateur radio operators, etc.)
16. 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)
17. Primary care providers, including pediatric and women's health care providers.
18. Schools and universities, including academic medical centers.
19. Skilled nursing, nursing, and long-term care facilities
20. Support service providers (e.g., clinical laboratories, pharmacies, radiology, blood banks, poison control centers)
21. Medical examiners/coroners and funeral homes
22. Agency/facility public information specialists
23. Agencies that support an Emergency Support Function (ESF)
24. Other (e.g., childcare services, dental clinics, social work services, faith-based organizations)

RECORD OF CHANGES

Planners should track and record the changes using a record of changes table when changes are made to the Continuity Plan outside the official cycle of plan review, coordination, and update. The record of changes should contain, at a minimum, a change number, the date of the change, the name of the person who made the change, and a description of the change.

The following table shows an example of how to track plan changes.

Date	Page(s)	Revision Description (s)	Name
5/2025	Random	Plan complete	Jennifer Tobey
5/2026	Random	Review/Updates	Jennifer Tobey

I. PURPOSE, SCOPE, SITUATIONS, AND ASSUMPTIONS

A. PURPOSE

The District 2 Healthcare Coalition’s mission is to serve as a leadership umbrella over the seven Counties of District 2. To accomplish this mission, the HCC must ensure its operations are performed efficiently with minimal disruption, especially during an emergency. This document provides planning and program guidance for implementing the HCC’s Continuity Plan and programs to ensure the organization can conduct its essential missions and functions under all threats and conditions. While the severity and consequences of an emergency cannot be predicted, effective contingency planning can minimize the impact on HCC missions, personnel, and facilities.

The overall purpose of continuity planning is to ensure the continuity of the essential functions under all conditions. The current changing threat environment and recent emergencies, including acts of nature, accidents, technological emergencies, and military or terrorist attack-related incidents, have increased the need for viable continuity capabilities and plans that enable organizations to continue their essential functions in an all-hazards environment and across a spectrum of emergencies. These conditions, coupled with the potential for terrorists' use of weapons of mass destruction, have increased the importance of having continuity programs that ensure continuity of essential functions across all levels of government.

B. SCOPE

This Continuity Plan applies to the functions, operations, and resources necessary to ensure the continuation of District 2 Healthcare Coalition's essential functions in the event its normal operations are disrupted or threatened with disruption. This plan applies to all HCC personnel. HCC staff must be familiar with continuity policies and procedures and their respective continuity roles and responsibilities.

This document ensures HCC is capable of conducting its essential missions and functions under all threats and conditions, with or without warning.

C. SITUATION OVERVIEW

According to the National Continuity Policy Implementation Plan, it is the policy of the United States to maintain a comprehensive and effective continuity capability. To that end, by continuing the performance of essential functions through a catastrophic emergency, the non-Federal Government entities support the ability of the Federal Government to perform National Essential Functions (NEFs), continue Enduring Constitutional Government, and ensure that essential services are provided to the Nation's citizens. A comprehensive and integrated continuity capability will enhance the credibility of our national security posture and enable a more rapid and effective response to, and recovery from, an emergency.

Further, continuity planning should assume that organizations will not receive warnings of an impending emergency. As a result, risk assessment is essential to continuity planning. Risk-specific appendices that address the results of the HCC risk assessment are found later in the plan.

The District 2 Healthcare Coalition continuity facilities were selected following an all-hazards risk assessment of facilities for continuity operations use. The HCC risk assessment is found in the HCC Response Plan Appendix B-District Public Health and Medical Risk Assessment. This risk assessment addresses the following for each continuity facility:

- Identification of all hazards as reported by facilities
- A vulnerability assessment to determine the effects of all hazards

- A cost-benefit analysis of implementing risk mitigation, prevention, or control measures
- A formal analysis by management of acceptable risk
- Sufficient distance between each facility location or threatened area and other facilities or locations that are potential sources of disruptions or threats
- Sufficient levels of physical security required to protect against identified threats
- Sufficient levels of security required to protect against identified threats

D. PLANNING ASSUMPTIONS

This COOP/RP is based on the following assumptions:

- Emergency conditions may require the relocation of the HCC Emergency Relocation Group (Contractors) to the continuity facility at the requesting County/Facility.
- The requested County/Facility will support the ERG and the continuation of the essential HCC functions by available communications and information systems within 12 hours from the time the COOP/RP is activated, for potentially up to a 30-day period or until normal operations can be resumed
- The HCC State operations are unaffected and available to support actions directed by the District 2 Chairperson or a successor. However, if ERG deployment is not feasible due to the loss of personnel, the HCC will devolve/demob to the local Indiana Department of Health Public Health Preparedness Coordinator and or the local Indiana Department of Homeland Security Emergency Management Agency Director.

E. OBJECTIVES

- The HCC continuity objectives are listed below:
 1. Ensure essential functions can be performed, if applicable, under all conditions.
 2. Reduce the loss of life and minimize property damage and loss.
 3. Execute a successful order of succession with accompanying authorities in the event a disruption renders that organization's leadership unable, unavailable, or incapable of assuming and performing their authorities and responsibilities of office.
 4. Reduce or mitigate disruptions to operations.
 5. Ensure HCC has facilities where it can continue to perform its essential functions, as appropriate, during a continuity event.
 6. Protect essential facilities, equipment, records, and other assets, in the event of a disruption.
 7. Achieve the organization's timely and orderly recovery and reconstitution from an emergency.

8. Ensure and validate continuity readiness through a dynamic and integrated continuity Training, and Exercise (T&E) program and operational capability.

F. SECURITY AND PRIVACY STATEMENT

This document is **For Official Use Only**. Portions of the Plan contain information that raises personal privacy or other concerns, and those portions may be exempt from mandatory disclosure under the Freedom of Information Act (see 5 United States Code §552, 41 Code of Federal Regulations Part 105-60). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with HCC Executive Board direction and is not to be released without prior approval of the District 2 Healthcare Coalition Chairperson to the public or other personnel who do not have a valid “need to know”.

Some of the information in this Plan, if made public, could endanger the lives and privacy of employees. In addition, the disclosure of information in this plan could compromise the security of essential equipment, services, and systems of the HCC or otherwise impair its ability to carry out essential functions. Distribution of the COOP/RP in whole or part is limited to those personnel who need to know the information in order to successfully implement the plan.

The D2 HCC Contractors will distribute copies of COOP/RP on a need-to-know basis. In addition, copies of the Plan will be distributed to other organizations as necessary to promote information sharing and facilitate a coordinated inter-organization continuity effort. Further distribution of the plan is not permitted without approval from the D2 Healthcare Coalition Chairperson. The HCC contractors will distribute updated versions of the COOP/RP annually or as critical changes occur.

II. CONCEPT OF OPERATIONS

A. PHASE I: READINESS AND PREPAREDNESS

The HCC will participate in the full spectrum of readiness and preparedness activities to ensure personnel can continue essential functions in an all-hazard/threat environment. The HCC readiness activities are divided into two key areas:

- Organization readiness and preparedness
- Staff readiness and preparedness

Organization Readiness and Preparedness

The HCC preparedness incorporates hazard/threat warning systems, which includes ass notification vis Preparis.

Staff Readiness and Preparedness

The HCC contractors will prepare for a continuity event and plan in advance for what to do in an emergency. Personnel will also develop a Family Support Plan to increase personnel and family preparedness. The www.ready.gov website provides guidance for developing a Family Support Plan and includes a “Get Ready Now” pamphlet that explains the importance of planning and provides a template that can be tailored to meet family-specific planning requirements.

The HCC continuity contractors will create and maintain drive-away kits. Continuity personnel are responsible for carrying the kits to the continuity facility or pre-positioning the kits at the continuity facility. A typical drive-away kit should contain those items listed on the table below. HCC will implement the following procedures to maintain currency of the drive-away kits: **HCC will need to establish an acquisition program to regularly replace agency-supplied emergency items.**

Drive-Away Kit:

The following table lists suggested items for continuity drive-away kit contents.

Drive Away Kit	
<ul style="list-style-type: none">• Identification and charge cards<ul style="list-style-type: none">– Organization identification card– Drivers license– Organization travel card– Health insurance card– Personal charge card• Communication equipment<ul style="list-style-type: none">– Pager/BlackBerry– Organization cell phone– Personal cell phone• Hand-carried vital records• COOP/RP• Directions to continuity facility• Maps of surrounding area• Business and leisure clothing• Flashlight	<ul style="list-style-type: none">• Business and personal contact numbers<ul style="list-style-type: none">– Emergency phone numbers and addresses (relatives, medical doctor, pharmacist)• Toiletries• Chargers/extra batteries for phones, GPS, and laptop• Bottled water and non-perishable food (i.e., granola, dried fruit, etc.)• Medical needs<ul style="list-style-type: none">– Insurance information– List of allergies/blood type– Hearing aids and extra batteries– Glasses and contact lenses– Extra pair of eyeglasses/contact lenses– Prescription drugs (30-day supply)– Over-the-counter medications, dietary supplements

In addition, the HCC will conduct the following continuity readiness and preparedness activities: organization readiness and preparedness measures for organization personnel here, such as orientation training, brown bags or working lunch informational sessions, and senior management addresses to the organization regarding continuity, etc.

B. PHASE II: ACTIVATION AND RELOCATION

To ensure the ability to attain operational capability at continuity facilities and with minimal disruption to operations, the HCC will execute activation, and relocation plans as described in the following sections.

Decision Process Matrix

Based on the type and severity of the emergency, the HCC COOP/RP may be activated by one of the following methods:

- (1) The state governor, county executive or county commissioner, local mayor, city mayor, or city administrator may initiate continuity activation
- (2) The D2 Healthcare Coalition Chairperson, or a designated successor, may initiate COOP/RP activation for the entire organization, based on an emergency or threat directed at the organization
- (3) A D2 County Health Department Emergency Preparedness Coordinator and or County Emergency Management Agency Director representing their perspective County

COOP/RP activation and relocation are scenario-driven processes that allow flexible and scalable responses to the full spectrum of all-hazards/threats that could disrupt operations with or without warning and during work or non-work hours. COOP/RP activation will not be required for all emergencies or disruptions, since other actions may be more appropriate.

The decision to activate the D2 HCC COOP/RP and related actions will be tailored for the situation and based on projected or actual impact and whether or not there is warning. To support the decision-making process regarding plan activation, key organization personnel will use the decision matrix below to support that process.

Decision Matrix

Decision Matrix for COOP/RP Implementation		
	Work Hours	Non-Work Hours
Event With Warning	<ul style="list-style-type: none"> • Is the threat aimed at the facility or surrounding area? • Is the threat aimed at organization personnel? • Are employees unsafe remaining in the facility and/or area? 	<ul style="list-style-type: none"> • Is the threat aimed at the facility or surrounding area? • Is the threat aimed at organization personnel? • Who should be notified of the threat? • Is it safe for employees to return to work the next day?

Decision Matrix for COOP/RP Implementation		
	Work Hours	Non-Work Hours
Event Without Warning	<ul style="list-style-type: none"> • Is the facility affected? • Are personnel affected? Have personnel safely evacuated or are they sheltering-in-place? • What are instructions from first responders? • How soon must the organization be operational? 	<ul style="list-style-type: none"> • Is the facility affected? • What are instructions from first responders? • How soon must the organization be operational?

As the decision authority, the HCC Chairperson will be kept informed of the threat environment using all available means, including the HCC Emergency Communications Center, regional notification systems, Preparis system, local operations and State and local reporting channels and news media. The HCC Chairperson will evaluate all available information relating to:

- (1) Direction and guidance from higher authorities
- (2) The health and safety of personnel
- (3) The ability to execute essential functions
- (4) Changes in threat advisories
- (5) Intelligence reports
- (6) The potential or actual effects on communications systems, information systems, office facilities, and other vital equipment
- (7) The expected duration of the emergency situation

Alert and Notification Procedures

The HCC maintains plans and procedures for communicating and coordinating activities with personnel before, during, and after a continuity event.

Before an event, personnel in the HCC will monitor advisory information, including Preparis notifications. In the event normal operations are interrupted or an incident appears to be imminent, the HCC will take the following steps to communicate the organization’s operating status with all staff:

- (1) The HCC Chairperson or designated successor will notify the D2 Readiness and Response Coordinator of the emergency requiring COOP/RP activation
- (2) The Readiness Contractor will activate the HCC executive board, facilities, and agencies requesting assistance as deemed by the incident
- (3) The HCC personnel will notify family members, next of kin, and/or emergency contacts of COOP/RP activation

Upon a decision to activate the COOP/RP, the HCC will notify all District 2 membership personnel, as well as affected and interdependent entities with information regarding continuity activation and relocation status, operational and communications status, and the anticipated duration of relocation. These entities include:

- Continuity facilities and on-site support teams with information regarding continuity activation, relocation status, and the anticipated duration of relocation
- One of the seven District 2 Emergency Operations Center (EOC) via the County Emergency Management Agency Director, the HCC and other applicable elements/entities with information regarding continuity activation and relocation status, operational and communication status, and the anticipated duration of relocation
- All HCC employees with instructions and guidance regarding the continuity activation and relocation
- Organization headquarters, if a subordinate organization
- Subordinate organizations, if an organization headquarters

Relocation Process

Once the COOP/RP is activated and personnel are notified, the HCC will relocate continuity personnel and vital records to the designated location also known as the D2 continuity facility(s). The HCC continuity personnel will deploy/relocate to the continuity facility(s) to perform the HCC essential functions and other continuity-related tasks. A map and directions to the continuity facility will be included as part of the COOP/RP and incident action plan.

Emergency procedures during work hours with or without a warning will be implemented as follows:

- Continuity personnel, including advanced team personnel, if applicable, will depart from the designated continuity facility from the primary operating facility or current location using privately owned vehicles.
- Non-continuity personnel present at the primary operating facility or another location will receive instructions from the D2 Readiness and Response Coordinator. In most scenarios, non-continuity personnel will be directed to proceed to their homes or other District 2 designated facilities to wait for further guidance.
- At the time of notification, if available, information will be provided regarding safety precautions and routes to use when leaving the primary operating facility.

Emergency procedures during non-working hours with or without a warning will be implemented as follows:

- Advance team members, if applicable, will deploy to the designated continuity facility from their current location using privately owned vehicles.

- Continuity personnel will depart to the assigned continuity facility from their current location using privately owned vehicles.
- Non-continuity personnel will remain at their residence or other designated facility to wait for further instructions.
- Any disabled personnel will be transported via council of aging if self-transportation is not available.

Non-continuity personnel may be required to replace or augment continuity personnel during activation. These activities will be coordinated by the D2 Readiness and Response Coordinator with the replacement staff on a case-by-case basis. Non-continuity personnel will remain available to replace or augment continuity personnel, as required.

The jurisdiction having authority will direct the HCC non-continuity personnel to move to designated location or home until further notice.

In the event of an activation of the COOP/RP, HCC may need to procure necessary personnel, equipment, and supplies that are not already in place for continuity operations on an emergency basis. The County, Facility, or Agency maintains the authority for emergency procurement.

C. PHASE III: CONTINUITY OPERATIONS

Upon activation of the COOP/RP, HCC will continue to operate at its primary operating facility until it is ordered to cease operations by the jurisdiction having authority using Preparis via the Readiness Contractor. At that time, essential functions will transfer to the continuity facility. DCC must ensure that the COOP/RP can be operational within 12 hours of plan activation.

The advance team will be first to arrive at the continuity facility to prepare the site for the arrival of the continuity personnel. Upon arrival at the continuity facility, the advance team will:

- Ensure infrastructure systems, such as power and heating, ventilating, and air conditioning are functional
- Prepare check-in duty stations for ERG arrival
- Address telephone inquiries from ERG and non-ERG staff

As continuity personnel arrive, the D2 Incident Commander designee will conduct in-processing to ensure accountability. In-processing procedures are conducted at the designated county location and will be verified through communication with D2 Readiness and Response Coordinator. In addition, the office will identify all organization leadership available at the continuity facility.

Upon arrival at the continuity facility, the HCC continuity personnel will:

- Report immediately to the designated county location for check-in and in-processing
- Receive all applicable instructions and equipment
- Report to their respective workspace as identified or as otherwise notified during the activation process
- Retrieve pre-positioned information and activate specialized systems or equipment
- Monitor the status of HCC personnel and resources
- Continuing HCC essential functions
- Prepare and disseminate instructions and reports, as required
- Comply with any additional continuity reporting requirements with the HCC
- Notify family members, next of kin, and emergency contacts of preferred contact methods and information

A requirement for continuity personnel is to account for all HCC personnel. The HCC will use the following processes to account for all personnel:

- Confirmation with Readiness contractor
- Preparis notification
- Daily ICS/NIMS form 211 and or 214

During continuity operations, HCC may need to acquire necessary personnel, equipment, and supplies on an emergency basis to sustain operations for up to 30 days or until normal operations can be resumed. The requesting County, Facility, or Agency maintains the authority for emergency acquisition. Instructions for these actions are found on a signed Authority having Jurisdiction Form.

D. PHASE IV: RECONSTITUTION OPERATIONS

Within 8-12 hours of an emergency relocation, the following individuals will initiate and coordinate operations to salvage, restore, and recover the HCC primary operating facility after receiving approval from the appropriate State and local law enforcement and emergency services:

- Planning Section Chief will serve as the Reconstitution Manager for all phases of the reconstitution process
- Each HCC subcomponent will designate a reconstitution point-of-contact (POC) to work with the Reconstitution Team and to update office personnel on developments regarding reconstitution and provide names of reconstitution POCs to D2 Incident Commander within 12 hours of the COOP/RP activation

Reconstitution will commence when the D2 Incident Commander or other authorized person ascertains that the emergency has ended and is unlikely to reoccur. These reconstitution plans are viable regardless of the level of disruption that originally prompted implementation of the Continuity Plan. Once the appropriate HCC authority has made this determination in coordination with other State, local and/or other applicable authorities, one or a combination of the following options may be implemented, depending on the situation:

- Continue to operate from the continuity facility
- Begin to establish a reconstitute HCC in another facility or at another designated location

Before relocating to the primary operating facility or another facility, the County Authority having Jurisdiction will conduct appropriate security, safety, and health assessments to determine building suitability. In addition, the D2 Incident Commander will verify that all systems, communications, and other required capabilities are available and operational and that the HCC is fully capable of accomplishing all essential functions and operations at the new or restored primary operating facility.

Upon a decision by the HCC Chairperson or other authorized person that the HCC primary operating facility can be reoccupied or that HCC will be reestablished in a different facility:

- The HCC Continuity Coordinator or other authorized individuals must notify the HCC Contractors and Executive Board members when available, and other applicable operations centers with information regarding continuity activation and relocation status, the HCC continuity facility, operational and communication status, and anticipated duration of relocation. HCC shall submit a NIMS/ICS form 214, only if it contains more information beyond what has been reported, to D2 Readiness and Response Coordinator using the form and procedures provided by the HCC or other specified continuity POC.
- The D2 Readiness and Response Coordinator will develop space allocation and facility requirements.
- The D2 Readiness and Response Coordinator will notify all personnel that the emergency or threat of emergency has passed, and actions required of personnel in the reconstitution process using Preparis.
- The D2 Readiness Contractor will coordinate with HCC and/or other applicable facility management groups to obtain office space for reconstitution, if the primary operating facility is uninhabitable.
- The D2 Readiness Contractor will develop procedures, as necessary, for restructuring staff.

Upon verification that the required capabilities are available and operational and that the HCC is fully capable of accomplishing all essential functions and operations at the new or restored facility, the D2 Readiness and Response Coordinator will begin supervising a return of personnel, equipment, and documents to the primary operating facility or a

move to a temporary or new permanent primary operating facility. The phase-down and return of personnel, functions, and equipment will follow the priority-based plan and schedule outlined below; the HCC will develop return plans based on the incident and facility within 24 hours of plan activation.

HCC will continue to operate at its continuity facility until it is ordered to cease operations by the County jurisdiction having Authority using Prepara. At that time, essential functions will be transferred to the primary operating facility. The HCC has developed plans to instruct personnel on how to resume normal operations as outlined below; the HCC will develop resumption plans based on the incident and facility within 24 hours of plan activation.

The D2 Readiness and Response Coordinator will identify any records affected by the incident by electronic copies on file. In addition, the D2 Readiness Contractor will effectively transition or recover vital records and databases, as well as other records that have not been designated as vital records, using the plan outlined below; the HCC will develop vital records transition and recovery plans based on the incident and facility within 24 hours of plan activation.

When the continuity personnel, equipment, and documents are in place at the new or restored primary operating facility, the remaining HCC staff at the continuity facility or devolution site will transfer essential functions, cease operations, and deploy to the new or restored primary operating facility. The D2 Readiness and Response Coordinator will oversee the orderly transition from the continuity facility of all HCC functions, personnel, equipment, and records to a new or restored primary operating facility. The D2 Readiness Contractor will develop a process for receiving and processing employee claims during the continuity event and replacing lost or broken equipment.

HCC will conduct an After-Action Review (AAR) once back in the primary operating facility or in a new primary operating facility. The D2 Readiness Contractor is responsible for initiating and completing the AAR and all offices within HCC will have the opportunity to provide input for the report. The AAR will address the effectiveness of the COOP/RP and procedures, identify areas for improvement, document these in the HCC corrective action program (CAP), and then develop a remedial action plan as soon as possible after the reconstitution. The D2 Readiness Contractor is responsible for documenting areas for improvement in the CAP and developing a remedial action plan. In addition, the AAR will identify which, if any, records were affected by the incident and will work with HCC to ensure an effective transition or recovery of vital records and databases and other records that had not been designated as vital records. AAR and CAP documentation are maintained by the D2 Readiness and Response Coordinator and are found on the D2 website as an electronic copy.

E. DEVOLUTION/DEMOBILIZATION OF CONTROL AND DIRECTION

HCC is prepared to transfer all its essential functions and responsibilities to personnel at a different location should emergency events render leadership or staff unavailable to support the execution of HCC's essential functions. If deployment of continuity personnel is not feasible due to the unavailability of personnel, temporary leadership of the HCC will devolve to designated County EOC.

The D2 Readiness and Response Coordinator maintain responsibility for ensuring the currency of the HCC devolution/demobilization plan. The HCC devolution plan:

- (1) Includes the elements of a viable continuity capability: program plans and procedures, budgeting and acquisitions, essential functions, orders of succession and delegations of authority specific to the devolution site, interoperable communications, vital records management, staff, TT&E, and reconstitution.
- (2) Identifies prioritized essential functions, defines tasks that support those essential functions, and determines the necessary resources to facilitate those functions.
- (3) Includes a roster that identifies fully equipped and trained personnel who will be stationed at the designated devolution site and have the authority to perform essential functions and activities when the devolution option of the COOP/RP is activated.
- (4) Identifies what would likely activate or "trigger" the devolution option and specifies how and when control and direction of the HCC operations will be transferred to and from the devolution site.
- (5) Lists or references of the necessary resources (i.e., equipment and materials) to facilitate the immediate and seamless transfer of and performance of essential functions at the devolution site.
- (6) Establishes and maintains reliable processes and procedures for acquiring the resources necessary to continue essential functions and to sustain those operations for extended periods. The D2 Readiness Contractor is responsible for acquiring resources during a devolution situation.
- (7) Establishes and maintains a capability to restore or reconstitute the HCC authorities to their pre-event status upon termination of devolution.

HCC conducts and documents annual training of devolution staff and a biennial exercise to ensure essential functions are capable of being performed during devolution. This documentation includes the dates of all TT&E events and names and titles of participating staff. The HCC devolution TT&E documentation is maintained by D2 Readiness Contractor and is found on the D2 Website. Further, the HCC CAP supports the devolution program. The HCC CAP is maintained by D2 Readiness Contractor and CAP documentation is found on the D2 Website.

III. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Key staff positions within the HCC, to include individual continuity members, those identified in the orders of succession and delegation of authority, the HCC Continuity Coordinator, continuity managers, and others possess additional continuity responsibilities.

The following table shows examples of some continuity responsibilities.

Position	Responsibilities
D2 HCC Chairperson or designee	<ul style="list-style-type: none"> • Provide strategic leadership and overarching policy direction for the continuity program • Implement the COOP/RP when necessary, or when directed by a higher authority • Update and promulgate orders of succession and delegations of authority • Ensure adequate funding is available for emergency operations • Ensure all organization components participate in continuity exercises • Update COOP/RP annually
D2 Admin Assistant/Logistics Chief	<ul style="list-style-type: none"> • Update telephone rosters monthly • Conduct alert and notification tests
D2 Readiness and Response Coordinator	<ul style="list-style-type: none"> • Review status of vital records, files, and databases
D2 Training and Exercise Coordinator	<ul style="list-style-type: none"> • Develop and lead Continuity training • Plan Continuity exercises
Planning Coordinator/Continuity Personnel	<ul style="list-style-type: none"> • Be prepared to deploy and support organization's essential functions in the event of COOP/RP implementation • Provide current contact information to manager • Be familiar with continuity planning and know individual roles and responsibilities in the event of COOP/RP activation • Participate in continuity training and exercises as directed • Have a telework agreement for this position, if applicable

IV. DIRECTION, CONTROL, AND COORDINATION

During activation of the COOP/RP, the HCC Chairperson maintains responsibility for control and direction of the HCC. Should the HCC Chairperson become unavailable or incapacitated, the organization will follow the directions laid out in HCC Response Plan Appendix A Healthcare Organizations and Members and D2 Chain of Command Matrix.

V. DISASTER INTELLIGENCE

During a continuity event, the HCC will require the collection and dissemination of critical information. While specific incidents may create additional or specialized reporting requirements, the following table lists examples of the information that would be collected and reported regardless of incident type.

The following table shows examples of some disaster intelligence collection requirements.

Information Element	Specific Requirement	Responsible Element	Deliverables	When Needed	Distribution
Personnel Accountability	Account for all ERG and non-ERG employees Account for all contract personnel	Human Resources Division	Reports Briefings	Status updates hourly following Plan activation	D2 Readiness and Response Coordinator
Operational Status	Percent of ERG personnel arrived at site Ability to conduct each essential function	Continuity Manager Division Representatives	Situation briefings Situation reports	No later than 6 hours after plan activation, then hourly	D2 Readiness and Response Coordinator
Hazard Information	Threat details specific to the continuity facility	Response coordination center or emergency operations center	Situation briefings Situation reports	Two times per day shift change	Planning Manager

VI. COMMUNICATIONS

HCC has identified available and redundant critical communications systems that are located at the primary operating facility and continuity facility. Further, HCC maintains fully capable continuity communications that support organization needs during all hazards/threats, to include pandemic and other related emergencies, and consider supporting social distancing operations including telework and other virtual offices. In addition, HCC maintains communications equipment for use by employees with disabilities and hearing impairment.

All HCC's necessary and required communications and IT capabilities should be operational within 12 hours of continuity activation.

Additional detailed information on HCC's communications systems and requirements is found in HCC Response Plan Annex A Information Sharing and Annex F Communications Plan.

VII. BUDGETING AND ACQUISITION OF RESOURCES

HCC budgets for and acquiring those resources and capabilities essential to continuity operations. A copy of the continuity budget is found on the D2 website. Within this budget, the HCC budgets for continuity resources and capabilities in accordance with District 2 501C3 and other applicable directives and provides for the acquisition of those resources necessary for continuity operations on an emergency basis for up to 30 days or until normal operations can be resumed.

As part of the budget process, HCC uses a risk management methodology to identify, prioritize, and justify the allocation of budgetary resources. The risk management methodology used is via monthly reporting by agencies and facilities and a copy of the risk management documents can be found in the HCC Response Plan-Appendix B District Public Health and Medical Risk Assessment.

For those contracts vital to the support of organization's essential functions, the HCC has ensured contractor statements of work include the provision to provide staffing, services, and resources during emergency conditions. A list of vital contracts is found on the D2 website and maintained by the D2 Readiness and Response Coordinator. During an emergency situation, the D2 Readiness and Response Coordinator is responsible for oversight and handling of emergency work by contractors.

VIII. PLAN DEVELOPMENT AND MAINTENANCE

District 2 membership is responsible for maintaining the HCC COOP/RP.

The COOP/RP, HCC essential functions, and supporting activities, will be reviewed by the D2 HCC Planning Coordinator and updated annually from the date of publication as part of

the maintenance of COOP/RP and procedures. District 2 membership is responsible for the annual plan review and update. In addition, the plan will be updated or modified when there are significant organizational, procedural changes, or other events that impact continuity processes or procedures. Comments or suggestions for improving this plan may be provided to the D2 HCC Planning Coordinator.

IX. AUTHORITIES AND REFERENCES

Healthcare Coalition (HCC)

D2 HCC Readiness and Response Coordinator will be activated when a chemical surge incident occurs in the district and/or this annex has been activated. HCC has access/training in the use of communication and alerting systems: Prepartis and 800MHz radios. Using these communication tools will enable the team to quickly disseminate information to the coalition members to aid in the response.

Primary functions of the team:

- The current availability of district medical resources.
- The availability of state and/or federal medical resources.
- The coordination of requests and receipt of extra-regional medical resources, including submission of 213 RRs to the state/federal level for equipment/supplies/medication.
- To serve as an interface between hospitals, Homeland Security Districts, local Emergency Operations Centers (EOCs), Indiana Department of Health (IDOH), and if needed Emergency Operations Centers (EOCs) as part of ESF #8.
- It serves as an information interface between coalition members to help determine the severity of the incident. Information will come from core members and partners and will include:
 - How many were affected?
 - Location?
 - Shelter in place?
 - Hospital capabilities and bed availability?
 - Alternate Care Center needed (ACC)?
 - Activate the multi-agency coalition (MAC) Or Incident Management Team (IMT)?
 - HCC will utilize communication platforms to assist in disseminating information and to assess the ongoing situation to determine resource needs.

Fire and Emergency Medical Services

- Manages the scene per the incident command structure (ICS).
- Provide incident briefing to hospitals during the response via Hospital IHERN including:
 - Incident/chemical type
 - Expected/estimated number of patients injured by triage category.
 - Special needs requirements (e.g., pediatrics, burn, OB, etc.).
 - Number of patients transported (with destination) before activation of the Net.
 - Triage areas are set up to determine who requires transport to the hospital or a CRC.
- Collaborate with the Medical Director related to patient routing during a chemical event.
- Support hospital decontamination operations if requested and able.
- Assist/operate chemical-specific equipment on scene triage.
- Maintain communication with the EOC to determine where to send “worried well” and family members to the family reunification location.

Emergency Management Agencies

- Provide the Executive Direction to act for the Governor to provide direction and control, and to carry out the state’s response to protect the public’s health, safety, and property during an incident at a commercial nuclear power plant affecting District 2.
- Serve as the primary agency for (Emergency Support Function) ESF-2, Communications, and Information Technology; ESF-5, Information and Planning; ESF-6, Mass Care; ESF-7, Resource Support, and Logistics; ESF-14, Recovery and Mitigation; and ESF-15, Emergency Public Information, and External Affairs.
- Assign the Chemical Branch Chief responsibility for maintaining 24-hour communication capabilities in conjunction with the County EMA Office.
- Serve as the general coordination point for utility, private and non-profit organizations, and local, state, and federal governments.
- Request restrictions on air, rail, and water traffic, as necessary.
- Designate a Public Information Officer(s) who will be located at the district JIC and/or Utility JIC/JPIC.
 - Provide situational reports.
- Notify key state and federal partner agencies, including FEMA Region V.
- Local EMA – use of WebEOC for assistance with patient tracking and resource requests.
 - Activation of county EOC.

- Coordinate data collection, community needs, and any requests for a countywide emergency declaration.
- Coordinates mass care and CRC and activities working with other private agencies.

Public Health Departments

Public health's initial responsibility during a chemical emergency is population monitoring. For this response plan, population monitoring considerations will be made in the context of first local Assembly Centers (AC) and then Community Reception Center (CRC) operations. ACs are expected to be set up 24-48 hours after an event has occurred to serve as initial assessments and provide immediate triage and gross decontamination centers. Based on findings at the AC, local jurisdictional authorities where the incident occurred will lead and direct activation and operation of a CRC in partnership with regional, state, and federal partners as needed. The affected jurisdiction's public health agency will collaborate with partners to support the operation of a CRC. Operation of a CRC will require a multi-agency response incorporating all levels of government. The extent of the public health response role may vary from jurisdiction to jurisdiction across the district.

Population monitoring is a process that begins soon after a chemical incident is reported and continues until all potentially affected people have been monitored and evaluated for the following:

- Needed medical treatment.
- The presence of chemical contamination on the body or clothing (external contamination).
- The intake of chemical materials into the body (internal contamination).
- The removal of external or internal contamination (decontamination).
- The chemical dose received and the resulting health risk from the exposure.
- Long-term health effects.

In addition to CRC operations, local public health agencies, in collaboration with partners and stakeholders and per local response plans, will activate the following responsibilities as necessary:

- Protecting the public's health and safety
- Monitoring workers' health and safety
- Ensuring the provision of health and medical services
- Ensuring the safety of food and water supplies
- Coordinating sampling and laboratory analysis of clinical, agricultural, and environmental samples
- Conducting field investigations
- Conducting or assisting in decontamination as able

- Developing criteria for temporary re-entry, operations within, and permanent return to the incident site
- Recommending disease prevention and control measures
- Recommending management protocols for affected populations or individuals.
- Communicating necessary information to medical providers
- Communicating situation assessments and required safety measures to the public
- Assisting law enforcement agencies with criminal investigation

FUNCTIONAL ANNEXES

I. Essential Functions Annex

A. IDENTIFICATION OF ESSENTIAL FUNCTIONS

HCC has completed the MEF process to identify those functions/objectives that HCC must continue.

State, Territorial, and Tribal Essential Functions

The HCC's MEFs are based on its mission and role in support of the continued performance of State, territorial, or tribal essential functions (STTEFs). These STEFFs, as listed below, represent responsibilities of State, territorial, and tribal government leaders to ensure the well-being of their communities.

The following table is an example of State, Territorial, and Tribal Essential Functions.

State, Territorial, Tribal Essential Functions (STTEFs)
<p>STTEF 1: Maintain Continuity of Government. Focus: Ensure the continued functioning of critical government leadership elements, including: succession to key offices; organizational communications; leadership and management operations; situational awareness; personnel accountability; and functional and judicial organizations (as necessary). Each State, territory and tribe should identify the various subordinate mission essential functions necessary to accomplish this overarching mission. (This STTEF aligns with NEF 1)</p>
<p>STTEF 2: Provide Visible Leadership. Focus: Visible demonstration of leaders effectively dealing with the crisis and leading the response efforts: this assists in providing and monitoring the threat and confidence of established government organizations and the public. (This STTEF aligns with NEF 2)</p>
<p>STTEF 3: Reserved. STTEF 3 is not defined as there is no parallel to NEF 3: Employ the military, including implementing military operations to defend the Nation. While the States, territories, and tribes support this function, the Federal government is solely responsible for performing this function.</p>
<p>STTEF 4: Maintain Effective Relationships with Neighbors and Partners. Focus: Maintain external relationships and agreements with a wide variety of entities; this may vary considerably across the various States, territories, and tribes. This includes communications and interactions, as necessary during a crisis, with critical partners and organizations, including the Federal Government; other State, Territorial, and tribal governments, private sector and non-profit organizations; and may include foreign governments and organizations in some cases. (This STTEF aligns with NEF 4, however, it is recognized that the primary foreign relations responsibility lies with the Federal government.)</p>
<p>STTEF 5: Maintain Law and Order. Focus: Maintain civil order and public safety (protecting people and property, and the rule of law); ensuring basic civil rights, preventing crime, and protecting critical infrastructure. This involves State, territorial, and tribal governments and local law enforcement, and includes calling up of National Guard units to support these efforts. (This STTEF aligns with NEF 5)</p>
<p>STTEF 6: Provide Emergency Services. Focus: Provide critical emergency services, including emergency management, police, fire, ambulance, medical, search and rescue, hazmat, shelters, emergency food services, recovery operations, etc. (This STTEF aligns with NEF 6)</p>
<p>STTEF 7: Maintain Economic Stability. Focus: Manage the overall economy of the State, territorial, or tribal governments. While the Federal government is responsible for protecting and stabilizing the National economy and regulating the currency, State, territorial, and tribal governments have a responsibility to manage their jurisdiction's finances and ensure solvency. During a crisis affecting the economy, maintaining confidence in economic and financial institutions is critical at every level of government. (This STTEF aligns with NEF 7)</p>
<p>STTEF 8: Provide Basic Essential Services. Focus: Ensure provision of basic services, including water, power, health care, communications, transportation services, sanitation services, environmental protection, commerce, etc. These are services that must continue or be restored quickly to provide for basic needs. Other less critical services (recreation, education) may be delayed or deferred at the discretion of the State, territorial, and tribal governments; the focus is on providing those critical services necessary to sustain the population and facilitate the return to normalcy. (This STTEF aligns with NEF 8)</p>

B. IDENTIFICATION OF CONTINUITY PERSONNEL

In order to continue its essential functions, HCC has determined the staff positions necessary to relocate under COOP/RP activation. A copy of the current roster is found on the District 2 website. The D2 Readiness and Response Coordinator is responsible for maintaining roster currency and ensuring personnel are matched against needed positions.

Each continuity member is selected by the D2 Readiness and Response Coordinator based upon:

- The predetermined essential functions that must be performed, regardless of the operational status of HCC's primary operating facility
- The member's knowledge and expertise in performing these essential functions
- The member's ability to rapidly deploy to the relocation site in an emergency

II. Vital Records Management Annex

"Vital records" refers to information systems and applications, electronic and hard copy documents, references, and records, to include classified or sensitive data, needed to support MEFs during a continuity event. HCC has incorporated its vital records program into the overall continuity program, plans, and procedures.

HCC's vital records program incorporates into the overall COOP/RP with clear authority to include:

- Policies
- Authorities
- Procedures
- The written designation of the HCC vital records manager

Within 12 hours of activation, continuity personnel at the continuity facility for the HCC should have access to the appropriate media for accessing vital records, including:

- A local area network
- Electronic versions of vital records
- Supporting information systems and data
- Internal and external email and email archives
- Paper copies of vital records

HCC's official vital records program:

- Identifies and protects those records that specify how the organization will operate in an emergency or disaster
- Identifies those records necessary for the organization's continuing operations
- Identifies those records needed to protect the legal and financial rights of the organization

Identifying Vital Records

HCC has identified the following as vital to its operations and has assigned responsibility for those records to the D2 Readiness Contractor which includes a combination of continuity personnel, personnel in the district membership and records management personnel.

HCC maintains a complete inventory of vital records, along with the locations of and instructions on accessing those records. These records are located on the District 2 website. This inventory will be maintained at a back-up/offsite location with the District 2 Readiness Contractor to ensure continuity if the primary operating facility is damaged, destroyed, or unavailable.

D2 Readiness and Response Coordinator will develop and maintain a vital records plan packet or collection located on the D2 website. The packet or collection includes:

- A paper copy or electronic list of the HCC key organization personnel and continuity personnel with up-to-date telephone numbers
- A vital records inventory with the precise locations of vital records prepared by the D2 Readiness and Response Coordinator
- Updates to the vital records
- Necessary keys or access codes
- Listing of the access requirements and sources of equipment necessary to access the records
- The HCC continuity facility locations
- Lists of records recovery experts and vendors provided by the D2 Readiness Contractor and located on the D2 website.
- A copy of the HCC COOP/RP

For the above items, the D2 Readiness and Response Coordinator is responsible for providing access requirements and lists of sources of equipment necessary to access the records (this may include hardware and software, microfilm readers, Internet access, and/or dedicated telephone lines). These requirements and lists are found on the district 2 website.

This packet will be reviewed annually by the D2 membership with the date and names of the personnel conducting the review documented in writing to ensure that the information is current. A copy will be securely maintained at the HCC continuity facilities and on the District 2 website, so it is easily accessible to appropriate personnel when needed.

Protecting Vital Records

The protection of vital records is essential to ensuring the records are available during a continuity event, thus enabling an organization to perform their MEFs. HCC has conducted vital records and database risk assessments to:

- Identify the risks involved if vital records are retained in their current locations and media, and the difficulty of reconstructing those records if they are destroyed
- Identify offsite storage locations and requirements
- Determine if alternative storage media are available
- Determine requirements to duplicate records and provide alternate storage locations to provide readily available vital records under all conditions

The vital records and database risk assessment were performed by the D2 Readiness Contractor and is located on the D2 website.

Appropriate protection for vital records will be provided by the D2 Readiness Contractor and will include dispersing those records to other organization locations or storing those records offsite.

When determining and selecting protection methods, the HCC considers the specific protection needed by different kinds of storage media. Microforms, paper photographs, computer disks, tapes, and drives all require different methods of protection. Some of these media also may require equipment to facilitate access.

Training and Maintenance

The HCC vital records program includes a training program conducted by the D2 Training and Exercise Coordinator for all staff, to include periodic briefings to managers about the vital records program and its relationship to their vital records and business needs. The HCC staff training focuses on identifying, inventorying, protecting, storing, accessing, and updating the vital records. Training records for vital records are maintained by the D2 Training and Exercising Coordinator.

The HCC vital records program includes an annual review of the program to address new security issues, identify problem areas, update information, and incorporate any additional vital records generated by new agency programs or functions or by organizational changes to existing programs or functions. The review is conducted by the D2 membership. The review provides an opportunity to familiarize staff with all aspects of the vital records program. It is appropriate to conduct a review of the vital records program in conjunction with the HCC continuity exercises. Documents confirming review of the vital records program are maintained by the D2 Planning Coordinator. At a minimum, HCC vital records are annually reviewed, rotated, or cycled so that the latest versions will be available.

The HCC conducts annual testing, documented in the HCC testing records, of the capabilities for protecting classified and unclassified vital records and for providing access to them from the alternate facility. Testing records for vital records are maintained by the D2 Training and Exercising Coordinator.

Vital Record, File, or Database	Support to Essential Function	Form of Record (e.g., hardcopy, electronic)	Pre-positioned at Continuity Facility	Hand Carried to Continuity Facility	Multiple Storage Location(s) Y/N	Maintenance Frequency
Mapping Database	Function #1	Electronic	X		Y	Monthly
Licensed Spill Cleanup Contractors List	Function #1 & 3	Hardcopy		X	N	Quarterly
Regional Dams List	Function #2	Hardcopy		X	N	Annually
Pollution/Chemical Incident Database	Function #3 & 4	Electronic	X		N	Monthly
Public and Private Sewage System Records	Function #3, 4, & 5	Electronic	X		Y	Quarterly

The following table shows examples of vital records, files, and databases.

III. Continuity Facilities Annex

Continuity Facility Information

HCC has designated continuity facility(s) as part of its COOP/RP and has prepared continuity personnel for the possibility of unannounced relocation to the site(s) to continue performance of essential functions

The HCC (does/does not) maintain MOAs/MOUs and reviews the MOAs/MOUs annually, as applicable.

MOA/MOU is necessary because HCC is NGO 501C3. A copy of the MOA/MOU is found and maintained with the D2 Readiness and Response Coordinator.

The HCC continuity facility(s) provide the following in sufficient quantities to sustain operations for up to 30 days or until normal business activities can be resumed:

- (1) Space and equipment, including computer equipment and software. The continuity facility can accommodate up to 10 personnel. Facility floor plans, equipment inventory, and D2 HCC plans are found on the D2 website.
- (2) Capability to perform MEFs within 12 hours of plan activation for up to 30 days or until normal operations can be resumed.
- (3) Reliable logistical support, services, and infrastructure systems.

- (4) Consideration for health, safety, security, and emotional well-being of personnel. Considerations available at the continuity facility include access to mental health organizations within District 2.
- (5) Interoperable communications for effective interaction. Additional information on continuity communications is found in the D2 HCC Response Plan Annex F-HCC Communication Plan.
- (6) Capabilities to access and use vital records.
- (7) Systems and configurations that are used in daily activities. IT support at the continuity facility is site dependent. Details on the systems and configurations are available through the D2 Readiness and Response Coordinator.
- (8) Emergency/back-up power capability.

Continuity Facility Logistics

HCC's continuity facilities maintain pre-positioned or detailed site preparation and activation plans to achieve full operational capability within 12 hours of notification.

The HCC maintains a transportation support plan that describes procedures for no-warning and with-warning events.

- During a no-warning event, advance team and continuity personnel are transported to the continuity facility via private vehicle.
- During a with-warning event, an advanced team and continuity personnel are transported to the continuity facility via private vehicle.

Continuity Facility Orientation

HCC regularly familiarizes its continuity personnel with its continuity facilities. The HCC accomplishes this orientation through means of orientation, such as deployment exercises, orientation sessions at the site, and briefings. This familiarization training is reflected in organization training records located on the D2 website.

Further, HCC annually trains and prepares its ERG personnel for the possibility of an unannounced relocation to all continuity facilities. This training is reflected in organization training records located on the D2 website.

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IV. Continuity Communications Annex

The HCC has identified available and redundant critical communication systems at the continuity facility. Further, HCC maintains fully capable continuity communications that could support organization needs during all hazards/threats, to include pandemic and other related emergencies, and consider supporting social distancing operations including telework and other virtual offices. These systems provide the ability to communicate within and outside the organization and are found on the D2 website.

The following table shows an example of tracking modes of communication systems that support an organization’s essential functions.

Communication System	Support to Essential Function	Current Provider	Specification	Alternate Provider	Special Notes
Non-secure Phones					
Secure Phones					
Fax Lines					
Cellular Phones					
Satellite					
E-mail					
Internet Access					
Data Lines					
Two-way Radios					
GETS Cards					
800 MHz Radios					
Preparis					

All HCC’s necessary and required communications and IT capabilities should be operational within 12 hours of activation.

The HCC possesses communications capabilities to support the organization’s senior leadership while they are in transit to continuity facilities. These capabilities are maintained by the D2 Readiness and Response Coordinator.

V. Leadership and Staff Annex

A. ORDERS OF SUCCESSION

Pre-identifying orders of succession is critical to ensuring effective leadership during an emergency. In the event an incumbent is incapable or unavailable to fulfill essential duties, successors have been identified to ensure there is no lapse in essential decision-making authority. HCC has identified successors for the positions. The D2 Readiness and Response Coordinator is responsible for ensuring orders for succession are up to date. When changes occur, the D2 Readiness and Response Coordinator distributes the changes to D2 membership and will update the D2 website. *See D2 Chain of Command Matrix.*

The HCC’s orders of succession are:

- At least three positions deep, where possible, ensuring sufficient depth to ensure HCC’s ability to manage and direct its essential functions and operations
- Include devolution counterparts, where applicable
- Geographically dispersed, where feasible
- Described by positions or titles, rather than by names of individuals holding those offices
- Reviewed by the organization’s legal department as changes occur
- Included as a vital record, with copies accessible and/or available at both the primary operating facility and continuity facilities.

The following table shows the order of succession for the D2 Leadership for the 501C3

Position	Designated Successors
D2 Chairperson	1. 1 st Vice Chairperson-Hospital Representation
	2. 2 nd Vice Chairperson-Public Health Representation
	3. Readiness and Response Coordinator

In addition, each order of succession identifies the rules and procedures designated officials must follow when facing issues of succession to office during continuity events and reference applicable laws and organization policies.

- D2 HCC Counties: Elkhart, Fulton, Pulaski, Marshall, Kosciusko, Starke, and St. Joseph.

In the event of a change in leadership status, the HCC must notify the successors, as well as internal and external stakeholders. In the event the HCC leadership becomes unreachable or incapable of performing their authorized legal duties, roles, and responsibilities, the D2 Readiness and Response Coordinator will initiate a notification of the next successor in line. The D2 Readiness and Response Coordinator will use Preparis notifications to notify internal and external stakeholders of the change in leadership.

The HCC training records document the annual successor training for all personnel who assume the authority and responsibility of the organization’s leadership to include briefing successors to the position of D2 Incident Commander on their responsibilities and duties as a successor.

B. DELEGATIONS OF AUTHORITY

Generally, the HCC pre-determined delegations of authority will take effect when normal channels of direction are disrupted and terminate when these channels have resumed. Pre-determined delegations of authority may be particularly important in a devolution scenario.

The HCC has identified the following delegations of authority:

- Orderly succession of officials to the position of D2 incident Commander in the case of D2 HCC Chairperson absence, a vacancy at that office, or the inability of the D2 HCC Chairperson to act during an emergency or national security emergency. See the D2 Chain of Command Matrix
- Delegation of Authority can be decided by the requesting Agency, Facility, or County justification having Authority during an emergency incident.

The HCC's delegations of authorities are found at the continuity facility and:

- (1) Are included as vital records
- (2) Are written in accordance with applicable laws and organization policy ensuring that the organization's MEFs are performed
- (3) Outline explicitly in a statement the authority of an official to re-delegate functions and activities, as appropriate
- (4) Delineate the limits of and any exceptions to the authority and accountability for officials
- (5) Define the circumstances, to include a devolution situation if applicable, under which delegations of authorities would take effect and would be terminated

The HCC has informed those officials who might be expected to assume authorities during a continuity situation. Documentation that this has occurred is found with the D2 Readiness and response Coordinator and at the continuity facility. Further, the HCC has trained those officials who might be expected to assume authorities during a continuity situation at least annually for all pre-delegated authorities for making policy determinations and all levels using National Incident Management System (NIMS) or Incident Command System (ICS). This training is reflected in the agency training records located with the D2 Readiness and Response Coordinator.

C. HUMAN CAPITAL

Continuity Personnel

People are critical of the operations of any organization. Selecting the right people for an organization's staff is vitally important, and this is especially true in a crisis situation. Leaders are needed to set priorities and keep focus. During a continuity event, emergency employees and other special categories of employees will be activated by HCC to perform assigned response duties. One of these categories is continuity personnel. In respect to continuity personnel, the HCC has:

- Identified and designated those positions and personnel they judge to be critical to organization operations in any given emergency situation as continuity personnel. A roster of continuity positions is maintained by the D2 Readiness and Response Coordinator.
- Identified and documented its continuity personnel. Continuity personnel possess the skills necessary to perform essential functions and supporting tasks. A roster

- of continuity personnel is maintained by D2 Readiness and Response Coordinator. Officially informed all continuity personnel of their roles or designations by providing documentation in the form of NIMS/ICS forms to ensure that continuity personnel know and accept their roles and responsibilities. Copies of this documentation are maintained by the D2 Readiness and Response Coordinator.
- Ensured continuity personnel participate in the organization's continuity TT&E program, as reflected in training records. Training records are maintained by the D2 Readiness and Response Coordinator.
 - Provided guidance to continuity personnel on individual preparedness measures they should take to ensure response to a continuity event using NIMS/ICS forms. Copies of this guidance are maintained by the D2 Readiness and Response Coordinator.

All Staff

It is important that the HCC keeps all staff, especially individuals not identified as continuity personnel, informed and accounted for during a continuity event. HCC has established procedures for contacting and accounting for employees in the event of an emergency, including operating status.

- HCC's employees are expected to remain in contact with the D2 Readiness and Response Coordinator during any facility closure or relocation situation. Notifications will be updated via PreparaIS.
- The HCC ensures staff are aware of and familiar with Human Capital guidance in order to continue essential functions during an emergency. HCC will use the PreparaIS notifications to increase awareness.

Accounting for all personnel during a continuity event is of utmost importance. In order to account for all staff, the HCC will ensure accountability through NIMS/ICS forms, PreparaIS notifications, Radio check-ins or cell phone/texting. Accountability information is reported to the D2 Readiness and Response Coordinator at **4-hour** increments. The D2 Incident Commander and or D2 Readiness Contractor has the responsibility of attempting contact with those individuals who are unaccounted for.

An event that requires the activation of the COOP/RP may personally affect the HCC staff. Therefore, the D2 Incident Commander has the responsibility to create provisions and procedures to assist all staff, especially those who are disaster victims, with special human capital concerns following a catastrophic disaster.

Human Capital Considerations

The D2 Readiness and Response Coordinator serve as the HCC Human Capital liaison to work with the Continuity Coordinator or Continuity Manager when developing or updating the organization’s emergency plans. HCC has developed organization-specific guidance and direction for continuity personnel on Human Capital issues. This guidance is integrated with Human Capital procedures for its facility, geographic region, and the Office of Personnel Management or similar organization. Further, the D2 Readiness and Response Coordinator communicates Human Capital guidance for emergencies.

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VI. Training and Exercises Program Annex

HCC has established an effective TT&E program to support the organization’s preparedness and validate the continuity capabilities, program, and ability to perform essential functions during any emergency. The testing, training, and exercising of continuity capabilities is essential to demonstrating, assessing, and improving the HCC’s ability to execute the continuity program, plans, and procedures.

- Training familiarizes continuity personnel with their roles and responsibilities in support of the performance of an organization’s essential functions during a continuity event.
- Tests and exercises serve to assess, validate, or identify for subsequent correction, all components of COOP/RP, policies, procedures, systems, and facilities used in response to a continuity event. Periodic testing also ensures that equipment and procedures are kept in a constant state of readiness.

Continuity TT&E Requirements	Monthly	Quarterly	Annually	As Required
Test and validate equipment to ensure internal and external interoperability and viability of communications systems	✓			
Test alert, notification, and activation procedures for all continuity personnel		✓		
Test primary and back-up infrastructure systems and services at continuity facilities			✓	
Test capabilities to perform essential functions			✓	
Test plans for recovering vital records, critical information systems, services, and data			✓	
Test and exercise of required physical security capabilities at continuity facilities			✓	
Test internal and external interdependence with respect to performance of essential functions			✓	
Train continuity personnel on roles and responsibilities			✓	
Conduct continuity awareness briefings or orientation for the entire workforce			✓	
Train organization’s leadership on essential functions			✓	
Train personnel on all reconstitution plans and procedures			✓	
Allow opportunities for continuity personnel to demonstrate familiarity with COOP/RP and procedures and demonstrate organization’s capability to continue essential functions			✓	
Conduct exercise that incorporates the deliberate and preplanned movement of continuity personnel to continuity facilities			✓	

District 2 Healthcare Coalition Continuity of Operations and Recovery Plan

Continuity TT&E Requirements	Monthly	Quarterly	Annually	As Required
Conduct assessment of organization's continuity TT&E programs and COOP/RP and programs			✓	
Report on findings of all annual assessments to the Training and Exercise Coordinator			✓	
Conduct successor training for all organization personnel who assume the authority and responsibility of the organization's leadership if that leadership is incapacitated or becomes otherwise unavailable during a continuity situation			✓	
Train in the identification, protection, and ready availability of electronic and hard-copy documents, references, records, information systems, and data management software and equipment needed to support essential functions during a continuity situation for all staff involved in the vital records program			✓	
Test capabilities for protecting classified and unclassified vital records and for providing access to them from the continuity facility			✓	
Train on an organization's devolution option for continuity, addressing how the organization will identify and conduct its essential functions during an increased threat situation or in the aftermath of a catastrophic emergency			✓	
Conduct personnel briefings on COOP/RP that involve using or relocating to continuity facilities, existing facilities, or virtual offices				✓
Allow opportunity to demonstrate intra- and interagency continuity communications capability				✓
Allow opportunity to demonstrate back-up data and records required for supporting essential functions at continuity facilities are sufficient, complete, and current				✓
Allow opportunity for continuity personnel to demonstrate their familiarity with the reconstitution procedures to transition from a continuity environment to normal activities				✓
Allow opportunities for continuity personnel to demonstrate their familiarity with agency devolution procedures				✓

The HCC formally documents and reports all conduct continuity TT&E events, including the event date, type, and participants. Documentation also includes test results, feedback forms, participant questionnaires, and other documents resulting from the event. Continuity TT&E documentation for HCC is managed by the D2 Readiness and response

Coordinator. Further, the HCC conducts a comprehensive debriefing or hotwash after each exercise, which allows participants to identify systemic weaknesses in plans and procedures and recommend revisions to the organization’s COOP/RP.

TT&E Documentation

The following table shows possible documentation for a TT&E event.

Event	Event Type and Purpose	Date	Confirmation Initials or Signature
Continuity Facility Communications Check	Test and validate equipment to ensure internal and external interoperability and viability of communications systems		
Participants	Office	Phone/Email	

HCC has developed a CAP to assist in documenting, prioritizing, and resourcing continuity issues identified during TT&E activities, assessments, and emergency operations. The HCC CAP incorporates evaluations, AARs, and lessons learned from a cycle of events into the development and implementation of its CAP. The HCC CAP is maintained by the D2 Readiness and Response Coordinator.

Corrective Action Program

The following table shows possible documentation for a CAP entry for a TT&E event.

Capability	Observation	Recommendation	Corrective Action	Capability Element	Primary Responsible Office	Organization POC	Start Date	End Date
Planning	Organization did not conduct a hotwash following March 20xx exercise.	Organization should conduct hotwashes in order to allow participants to provide suggestions on areas of strengths and weaknesses.	The Exercise director will plan and execute hotwash after December 20xx exercise and incorporate comments into AAR.	Planning	HCC	Exercise Director, Jon Doe, (111) 111-1111	Mar. 7, 20xx	Dec. 1, 20xx

HAZARD-SPECIFIC APPENDICES

ANNEX IMPLEMENTING INSTRUCTIONS

- Operational Checklists: A checklist is a simple tool that ensures all required tasks are accomplished so that the organization can continue operations at an alternate location. Checklists may be designed to list the responsibilities of a specific position or the steps required to complete a specific task.

- Emergency Calling Directory
- Emergency Relocation Team Checklist and Essential Functions Checklist
- Continuity Site Acquisition Checklist
- Emergency Operating Records and IT Checklist
- Emergency Equipment Checklist
- Delegations of Authority
- Orders of Succession
- Maps and directions to the continuity facility and seating chart of the facility

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**I. Annex Implementing Instruction #1: Delegation of Authority
(EXAMPLE)**

HCC

Delegation Number: _____

Issue Date: _____

**DELEGATION OF AUTHORITY
AND SUCCESSION FOR THE
D2 CHAIRPERSON (or SUCCESSOR)**

PURPOSE

This is a delegation of authority for the continuity of essential functions through the orderly succession of officials at the HCC to the Office of the **[insert title of organization head]** in case of the **[Organization Head]**'s absence, a vacancy at that office, or the inability of the **[Organization Head]** to act during a disaster or national security emergency.

DELEGATION

I hereby delegate authority to the following officials, in the order listed below, to exercise the powers and perform the duties of the **[insert title of organization head]**, in case of my absence, inability to perform, or vacancy of the office, and until that condition ceases.

If this position is vacant, the next designated official in the order of succession may exercise all the powers, duties, authorities, rights, and functions of the Office of the **[insert title of organization head]** but may not perform any function or duty required to be performed exclusively by the office holder.

Eligibility for succession to the Office of the **[insert title of organization head]** shall be limited to officially assigned incumbents of the positions listed in the order of succession, above. Only officials specifically designated in the approved order of succession are eligible. People appointed on an acting basis, or on some other temporary basis, are ineligible to serve as a successor; therefore, the order of succession would fall to the next designated official in the approved order of succession.

AUTHORITIES

[Insert title of organization policy or directive]

[Insert title of organization policy or directive]

OFFICE OF PRIMARY INTEREST

The Office of the **[insert title of organization head]** is the office of primary interest in this delegation.

CANCELLATION

[Insert previous delegation of authority] to Office of the **[insert title of organization head]** is hereby rescinded.

[Organization Head signs here]

[Enter Organization Head's name here]

[Enter Organization Head's title here]

[Enter HCC here]

[Enter date here]

[Legal Counsel signs here]

[Enter Legal Counsel's name here]

[Enter Legal Counsel's title here]

[Enter HCC here]

[Enter date here]

ANNEX A. GLOSSARY

Activation – Once a continuity of operations plan has been implemented, whether in whole or in part, it is considered “activated.”

Organization Head – The highest-ranking official of the primary occupant organization, or a successor or designee who has been selected by that official.

All-Hazards – The spectrum of all types of hazards including accidents, technological events, natural disasters, terrorist attacks, warfare, and chemical, biological including pandemic influenza, radiological, nuclear, or explosive events.

Alternate Facilities – Locations, other than the primary facility, used to carry out essential functions, particularly in a continuity event. “Alternate facilities” refers to not only other locations, but also nontraditional options such as working at home (teleworking), telecommuting, and mobile-office concepts.

Business Impact Analysis (BIA) – A method of identifying the effects of failing to perform a function or requirement.

Business Process Analysis (BPA) – A method of examining, identifying, and mapping the functional processes, workflows, activities, personnel expertise, systems, data, and facilities inherent in the execution of a function or requirement.

Communications – Voice, video, and data capabilities that enable the leadership and staff to conduct the mission essential functions of the organization. Robust communications help ensure that the leadership receives coordinated, integrated policy and operational advice and recommendations and will provide the ability for governments and the private sector to communicate internally and with other entities (including with other Federal agencies, State, territorial, tribal, and local governments, and the private sector) as necessary to perform their Mission Essential Functions (MEFs).

Continuity – An uninterrupted ability to provide services and support, while maintaining organizational viability, before, during, and after an event.

Continuity Facilities – Locations, other than the primary facility, used to carry out essential functions, particularly in a continuity situation. “Continuity facilities” refers to not only other locations, but also nontraditional options such as working at home (teleworking), telecommuting, and mobile-office concepts.

Continuity of Operations – An effort within individual agencies to ensure they can continue to perform their Mission Essential Functions and Primary Mission Essential Functions during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies.

Continuity Event – Any event that causes an agency to relocate its operations to an alternate or other continuity site to assure continuance of its essential functions.

Continuity Personnel – Those personnel, both senior and core, who provide the leadership advice, recommendations, and functional support necessary to continue essential operations

Corrective Action Program – An organized method to document and track improvement actions for a program. The Corrective Action Program (CAP) system is a web-based tool that enables Federal, State, and local emergency response and homeland security officials to develop, prioritize, track, and analyze corrective actions following exercises or real-world incidents. Users may enter data from a finalized After-Action Report/Improvement Plan, track the progress of corrective action implementation, and analyze and report on trends in improvement plans.

Delegation of Authority – Identification, by position, of the authorities for making policy determinations and decisions at headquarters, field levels, and all other organizational locations. Generally, pre-determined delegations of authority will take effect when normal channels of direction have been disrupted and will lapse when these channels have been reestablished.

Devolution – The capability to transfer statutory authority and responsibility for essential functions from an agency’s primary operating staff and facilities to other agency employees and facilities, and to sustain that operational capability for an extended period.

Essential Functions – The critical activities performed by organizations, especially after a disruption of normal activities. There are three categories of essential functions: National Essential Functions, Primary Mission Essential Functions, and Mission Essential Functions.

Facilities – Locations where an organization’s leadership and staff operate. Leadership and staff may be co-located in one facility or dispersed across many locations and connected by communications systems. Facilities must be able to provide staff with survivable protection and must enable continued and endurable operations.

Interoperable Communications – Communications that provide the capability to perform essential functions, in conjunction with other organizations/entities, under all conditions.

Leadership – The senior decision makers who have been elected (e.g., the President, State governors) or designated to head a branch of government or other organization.

Memorandum of Agreement/Memorandum of Understanding – Written agreement between departments/agencies that require specific goods or services to be furnished or tasks to be accomplished by one organization in support of the other.

Mission Essential Functions – The limited set of agency-level government functions that must be continued throughout, or resumed rapidly after, a disruption of normal activities.

Orders of Succession – Provisions for the assumption by individuals of organization senior leadership positions during an emergency in the event that any of those officials are unavailable to execute their legal duties.

Primary Operating Facility – The site of an organization’s normal, day-to-day operations; the location where the employee usually goes to work.

Reconstitution – The process by which surviving and/or replacement organization personnel resume normal operations from the original or replacement primary operating facility.

Risk Analysis – The process by which risks are identified and evaluated.

Risk Assessment – The identification and assessment of hazards.

Risk Management – The process of identifying, controlling, and minimizing the impact of events whose consequences are or may be unknown, or events that are fraught with uncertainty.

Telework – The ability to work at a location other than the official duty station to perform work or emergency duties. This may include, but is not limited to, using portable computers, personal computers, high-speed telecommunications links, and mobile communications devices.

Testing, Training, and Exercises – Measures to ensure that an agency’s COOP/RP can support the continued execution of the agency’s essential functions throughout the duration of a continuity situation.

Virtual Offices – An environment where employees are not collocated and rely exclusively on information technologies to interact and conduct their work across distance from multiple geographic locations.

Vital Records – Electronic and hardcopy documents, references, and records that are needed to support essential functions during a continuity situation. The two basic categories of vital records are (1) emergency operating records and (2) rights and interests records.

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ANNEX B. AUTHORITIES AND REFERENCES

AUTHORITIES and REFERENCES:

- 1) Directive 51/Homeland Security Presidential Directive 20, *National Continuity Policy*, dated May 9, 2007.
- 2) Continuity Guidance Circular 1, *Continuity Guidance for Non-Federal Entities (States, Territories, Tribal, and Local Government Jurisdictions and Private Sector Organizations)*, dated January 21, 2009.
- 3) Continuity Guidance Circular 2, *Continuity Guidance for Non-Federal Entities: Mission Essential Functions Identification Process (States, Territories, Tribes, and Local Government Jurisdictions)*, dated July 22, 2010.
- 4) FEMA Continuity of Operations Plan Template Instructions.
- 5) FEMA Continuity of Operations Plan Template.
- 6) FEMA Devolution Plan Template.
- 7) FEMA Comprehensive Preparedness Guide 101, *Developing and Maintaining State, Territorial, Tribal, and Local Government Emergency Plans*, dated March 2009.

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ANNEX C. ACRONYMS

AAR	After Action Report
ACC	Alternate Care Center
BIA	Business Impact Analysis
BPA	Business Process Analysis
CAP	Corrective Action Program
CERT	Community Emergency Response Team
CGC	Continuity Guidance Circular
CMS	Center for Medicare and Medicaid Services
CRC	Community Reception Center
HCC	District 2 Healthcare Coalition
EMA	Emergency Management Agency
EMS	Emergency Medical Service
EOC	Emergency Operations Center
ERG	Emergency Relocation Group
ESF	Emergency Support Function
ESRD	End Stage Renal Disease
FQHC	Federally Qualified Health Centers
ICS	Incident Command System
IMT	Incident Management Team
IT	Information Technology
JIC	Joint Information Center
LHD	Local Health Department
MAC	Multi-Agency Coalition
MEF	Mission Essential Function
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
NEF	National Essential Functions
NIMS	National Incident Management System
PIO	Public Information Center
POC	Point of Contact
STTEF	State, Territorial, and Tribal Essential Function
T&E	Training, and Exercise
VA	Veteran Affairs

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APPENDIX A

Healthcare Organizations and Coalition Members



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 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 Memorial Hospital of South Bend	Acute Care	St Joseph	Full
St Joseph Health Mishawaka	Acute Care	St Joseph	Full
Beacon Elkhart General	Acute Care	Elkhart	Full
Goshen Hospital	Acute Care	Elkhart	Full
St Joseph Health Plymouth	Acute Care	Marshall	Full
Beacon Bremen	Critical Access	Marshall	Full
Unity Med and Surg	License Only	St Joseph	Full
Northwest Health Starke Hospital	Critical Access	Starke	Full
Pulaski Memorial	Critical Access	Pulaski	Full
Woodlawn Hospital	Critical Access	Fulton	Full
Lutheran Kosciusko Community	Acute Care	Kosciusko	Full
Beacon Granger	Acute Care	St Joseph	Full
Parkview Warsaw	Acute Care	Kosciusko	Full

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	Full
South Bend Fire	Ground	ALS	St Joseph	Full
Goshen Fire	Ground	ALS	Elkhart	Full
Lutheran EMS	Ground	ALS	Kosciusko/Marshall	Full
Plymouth FD	Ground	ALS	Marshall	Full
Culver EMS	Ground	BLS	Marshall	Full
Clay Fire Department	Ground	ALS	St Joseph	Full

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	Full
Fulton County EMA	Fulton	Full
Kosciusko County EMA	Kosciusko	Full
Marshall County EMA	Marshall	Full
Pulaski County EMA	Pulaski	Full
St Joseph County EMA	St Joseph	Full
Starke County EMA	Starke	Full

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	Full
Fulton County Health Department	Fulton	Full
St Joseph County Health Department	St Joseph	Full
Marshall County Health Department	Marshall	Full
Starke County Health Department	Starke	Full
Pulaski County Health Department	Pulaski	Full

Kosciusko County Health Department	Kosciusko	Full
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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	Full
Four County Counseling	Outpatient	Fulton & Pulaski	Associate
New Avenues Behavioral Health	Outpatient	St Joseph County	Associate
Michiana Behavioral Health Center	PRTF, Outpatient	Marshall	Associate
Bowen Center	PRTF, Outpatient	Kosciusko, Marshall	Associate
Porter Starke Psychiatric Services	PRTF, Outpatient	Starke	Associate

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	Membership
Elkhart County	CERT	Elkhart	N/A
Kosciusko County	CERT	Kosciusko	N/A

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

Dialysis Name	County	Membership
Duneland Dialysis Knox	Starke	Associate
Davita Dialysis	St Joseph, Elkhart	Associate
Fresenius Kidney Care	Elkhart	Associate

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	Membership
Heart City Health	Elkhart	Associate
National Weather Service	District 2	Associate

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

Home Health Name	County	Membership
Total Home Health Services	St Joseph	Associate
Forte Home Health Services	Kosciusko	Associate
CM Sunshine Home Health	Marshall	Associate
Great Lakes Caring Home Health/Hospice	St Joseph (serving all D2)	Associate
Interim Healthcare	St Joseph	Associate
Miami Homecare	St Joseph	Associate
Homepointe Healthcare	D2 (Fort Wayne)	Associate
Kosciusko Home Care-Hospice	Kosciusko	Full
Goshen Homecare/Hospice	Elkhart	Associate
St Joseph VNA	St Joseph	Associate

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

Company	Type	County	Membership
Toll Road	EMA	St Joseph, Elkhart	Associate
INDOT	EMA	St Joseph, Elkhart	Associate
AEP	Public Relations	St Joseph, Elkhart	Associate

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
Pulaski County maintenance Dept	County	Pulaski	Associate
Starke County Council/FD	County	Starke	Full

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	Full
Winamac Police Dept	Police	Pulaski	Associate
South Bend Police Dept	Police	St Joseph	Full
Fulton County 911	Dispatch	Fulton	Associate
St Joseph County 911	Dispatch	St Joseph	Associate
Marshall County Coroner's Office	Coroner	Marshall	Full
Marshall County 911	Police	Marshall	Full
Warsaw-Wayne Fire Territory	Fire Department	Kosciusko	Full
Kosciusko County 911	Dispatch	Kosciusko	Associate
Goshen Fire/EMS	Fire	Elkhart	Full
Elkhart Fire/EMS	Fire	Elkhart	Full

Medical and device manufacturers and distributors

Manufacturer	County	Membership

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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	Membership
American Red Cross	Relief Org.	All D2 Counties	Associate

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.

Outpatient Provider	Type	County	Membership
Parkview Warsaw	Free-Standing ER	Kosciusko	Associate
South Bend Clinic Surgery Center	ASC	St Joseph	Associate
Allied Physicians Surgery Center	ASC	St Joseph	Full
Michiana Surgery Center	ASC	St Joseph	Full
Grossnickle Eye Center	ASC	St Joseph	Full
Knox/Winn Community Health Center	FQHC	Starke/Pulaski	Associate
The Centre LLC	ASC	St Joseph	Full
Heart City Health Center	ASC	Elkhart	Full
OSMC	ASC	St Joseph	Full
Elkhart Day Surgery/Insight Surgery Center	ASC	Elkhart	Full
Riverpointe Surgery Center	ASC	Elkhart	Full

Goshen Hospital Surgery Center	ASC	Elkhart	Full
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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	Associate
IUSB	St Joseph	
Ivy Tech	St Joseph/Elkhart	
Goshen College	Elkhart	

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
Brickyard Healthcare Center	LTC	Elkhart	Full
Millers Merry Manor	LTC	Elkhart, Kosciusko, Marshall, St Joseph	Associate
Holy Cross Village	LTC	St Joseph	Associate
Greenleaf Health	LTC	Elkhart	Associate
West Bend Nursing	LTC	St Joseph	Associate
Pulaski Health Care Center	SNF	Pulaski	Associate
Greencroft	LTC	Elkhart	Associate

Trailpoint Village	LTC	St Joseph	Associate
Waterford Crossing	LTC	Elkhart	Associate
Woodland Manor	LTC	Elkhart	Associate
Cardinal Nursing and Rehab	LTC	St Joseph	Associate
Pilgrim Manor	LTC	Marshall	Associate
Valleyview Healthcare Center	LTC	Elkhart	Associate

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
Pathfinder Services	Social work	Marshall	Associate
Center for Hospice Care	Hospice	St Joseph (All of D2)	Full
ADEC	Adult/Child Services	St Joseph (Serves all D2)	Associate
St Joseph PACE	Adult Services	St Joseph (Serves all D2)	Associate
Logan Center	Disability Services	St Joseph (Serves all D2)	Associate
Comfort1Hospice	Hospice	St Joseph	Associate

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
NWS Northern Indiana	State Response Agency
Indiana Rural Health Association	State Association
Indiana Department of Transportation	State Association
Indiana Department of Environmental Management	State Association/Response Agency
Pokagon Tribal Band	Reservation Partner

APPENDIX B

District Public Health and Medical Risk Assessment



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

Medicare At-Risk Populations: *The map provides a monthly updated total for the number of Medicare beneficiaries who have had an administrative claim for one or more types of electricity-dependent durable medical and assistive equipment (DME) and devices, as well as at-risk combinations data for those who rely on a certain essential health care service(s) and any electricity-dependent DME and devices.*

(Data gathered 12/3/2025)

HHS emPOWER Map

Select a state: Indiana | Select a county: Starke | Select a ZIP Code: Select a ZIP Code | At-Risk Data (Optional): Electricity Dependent DM | DOWNLOAD DATA | RESET

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
Indiana	Elkhart		36,813	1,722
	Fulton		4,957	286
	Kosciusko		17,292	823
	Marshall		10,398	511
	Pulaski		3,309	187
	St Joseph		55,520	2,268
	Starke		5,657	335

Select a state: Indiana | Select a county: Starke | Select a ZIP Code: Select a ZIP Code | At-Risk Data (Optional): Facility ESRD Dialysis An | DOWNLOAD DATA | RESET

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
Indiana	Elkhart		36,813	77
	Fulton		4,957	22
	Kosciusko		17,292	44
	Marshall		10,398	33
	Pulaski		3,309	0
	St Joseph		55,520	176
	Starke		5,657	22

Select a state:
 Select a county:
 Select a ZIP Code:
 At-Risk Data (Optional):

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
			133,946	1,991
<input type="text" value="Indiana"/> x	<input type="text" value="Elkhart"/> x		36,813	542
	<input type="text" value="Fulton"/> x		4,957	97
	<input type="text" value="Kosciusko"/> x		17,292	279
	<input type="text" value="Marshall"/> x		10,398	166
	<input type="text" value="Pulaski"/> x		3,309	82
	<input type="text" value="St Joseph"/> x		55,520	725
	<input type="text" value="Starke"/> x		5,657	100

Select a state:
 Select a county:
 Select a ZIP Code:
 At-Risk Data (Optional):

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
			133,946	652
<input type="text" value="Indiana"/> x	<input type="text" value="Elkhart"/> x		36,813	125
	<input type="text" value="Fulton"/> x		4,957	35
	<input type="text" value="Kosciusko"/> x		17,292	115
	<input type="text" value="Marshall"/> x		10,398	66
	<input type="text" value="Pulaski"/> x		3,309	44
	<input type="text" value="St Joseph"/> x		55,520	234
	<input type="text" value="Starke"/> x		5,657	33

Select a state:
 Select a county:
 Select a ZIP Code:
 At-Risk Data (Optional):

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
			133,946	385
<input type="text" value="Indiana"/> x	<input type="text" value="Elkhart"/> x		36,813	77
	<input type="text" value="Fulton"/> x		4,957	22
	<input type="text" value="Kosciusko"/> x		17,292	55
	<input type="text" value="Marshall"/> x		10,398	44
	<input type="text" value="Pulaski"/> x		3,309	11
	<input type="text" value="St Joseph"/> x		55,520	154
	<input type="text" value="Starke"/> x		5,657	22

Select a state

Indiana

Select a county

Starke

Select a ZIP Code

Select a ZIP Code

At-Risk Data (Optional)

Any Healthcare Service A

DOWNLOAD DATA

RESET

STATE	COUNTY	ZIP CODE	MEDICARE DATA TOTALS	
			BENEFICIARIES	AT-RISK BENEFICIARIES
Indiana	Elkhart		36,813	821
	Fulton		4,957	176
	Kosciusko		17,292	493
	Marshall		10,398	309
	Pulaski		3,309	137
	St Joseph		55,520	1,289
	Starke		5,657	177

Indiana District 2 Public Health and Medical Risk Assessment

County Health Rankings:


<https://www.countyhealthrankings.org/>

† Data updated 09/24/2025







‡ Data updated 11/04/2025




	Elkhart, IN <small>Remove Location</small>	St. Joseph, IN <small>Remove Location</small>	Kosciusko, IN <small>Remove Location</small>	Marshall, IN <small>Remove Location</small>
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Population Health and Well-being

Length of life	Elkhart, IN	St. Joseph, IN	Kosciusko, IN	Marshall, IN	
Premature Death	 8,400 ‡	9,800 ‡	8,900 ‡	9,500 ‡	▼
Quality of life	Elkhart, IN	St. Joseph, IN	Kosciusko, IN	Marshall, IN	
Poor Physical Health Days	4.6	4.4	4.2	4.4	▼
Low Birth Weight	7%	9%	7%	7%	▼
Poor Mental Health Days	5.6	5.5	5.6	5.6	▼
Poor or Fair Health	21%	19%	17%	19%	▼





Community Conditions

Health infrastructure	Elkhart, IN	St. Joseph, IN	Kosciusko, IN	Marshall, IN	
Flu Vaccinations	 52%	56%	49%	47%	▼
Access to Exercise Opportunities	73%	85%	60%	63%	▼
Food Environment Index	7.7	7.5	8.2	8.1	▼
Primary Care Physicians	 1,970:1 †	1,110:1 †	2,250:1 †	2,110:1 †	▼
Mental Health Providers	530:1 †	350:1 †	510:1 †	730:1 †	▼
Dentists	 2,320:1 †	1,540:1 †	2,770:1 †	2,440:1 †	▼
Preventable Hospital Stays	 2,476	3,303	3,504	3,185	▼
Mammography Screening	 42%	45%	46%	40%	▼
Uninsured	 13%	8%	10%	13%	▼

Physical environment	Elkhart, IN	St. Joseph, IN	Kosciusko, IN	Marshall, IN	
Severe Housing Problems	12%	13%	10%	11%	▼
Driving Alone to Work	75%	75%	77%	79%	▼
Long Commute - Driving Alone	22%	24%	22%	33%	▼
Air Pollution: Particulate Matter 	8.2	9.6	8.6	8.7	▼
Drinking Water Violations	No	No	Yes	No	▼
Broadband Access	88%	88%	86%	82%	▼
Library Access	2	4	3	5	▼
Social and economic factors	Elkhart, IN	St. Joseph, IN	Kosciusko, IN	Marshall, IN	
Some College	44%	66%	57%	50%	▼
High School Completion	82%	91%	88%	86%	▼
Unemployment 	4.0%	3.9%	3.4%	3.4%	▼
Income Inequality	4.2	4.5	3.8	3.4	▼
Children in Poverty 	15%	18%	11%	13%	▼
Injury Deaths	70 ‡	87 ‡	75 ‡	87 ‡	▼
Social Associations	13.2	10.1	16.1	14.2	▼
Child Care Cost Burden	35%	37%	33%	32%	▼

† Data updated 09/24/2025

‡ Data updated 11/04/2025

	Starke, IN	Pulaski, IN	Fulton, IN
	Remove Location 	Remove Location 	Remove Location 
Population Health and Well-being			
Length of life	Starke, IN	Pulaski, IN	Fulton, IN
Premature Death 	11,300 ‡	12,300 ‡	10,900 ‡
Quality of life	Starke, IN	Pulaski, IN	Fulton, IN
Poor Physical Health Days	5.0	4.6	4.6
Low Birth Weight	8%	8%	8%
Poor Mental Health Days	6.4	5.9	5.9
Poor or Fair Health	19%	20%	20%

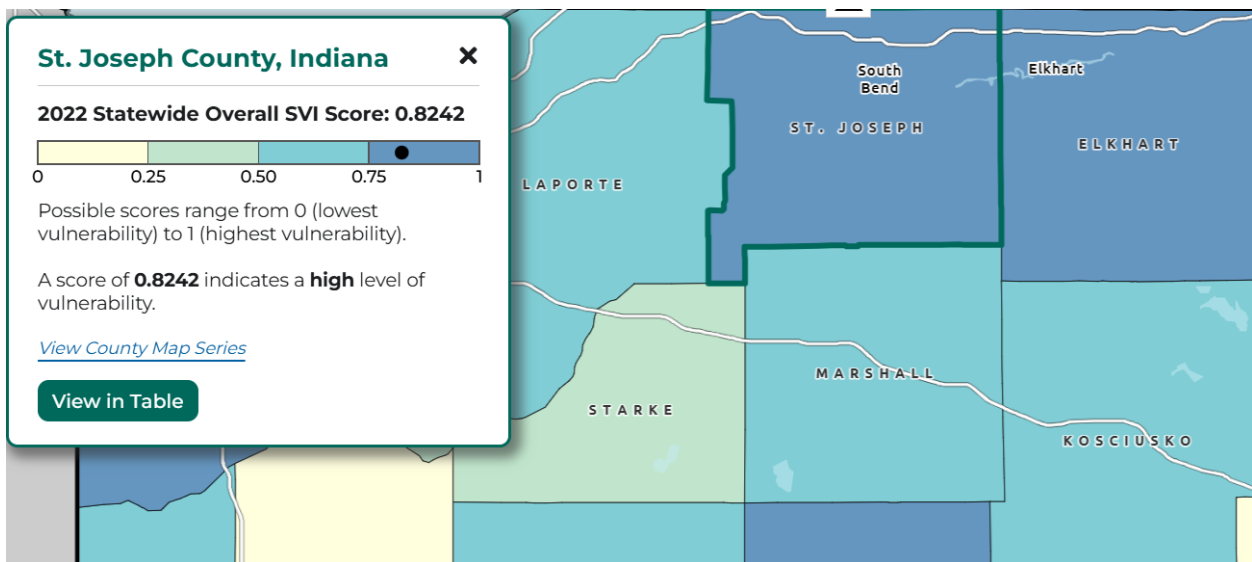
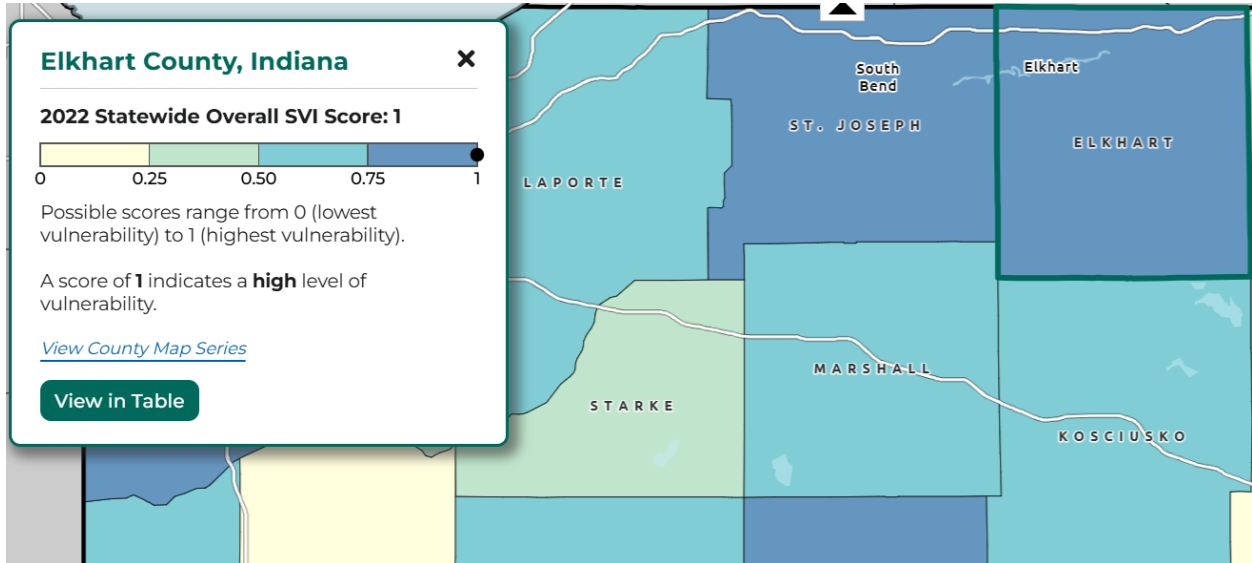
Community Conditions

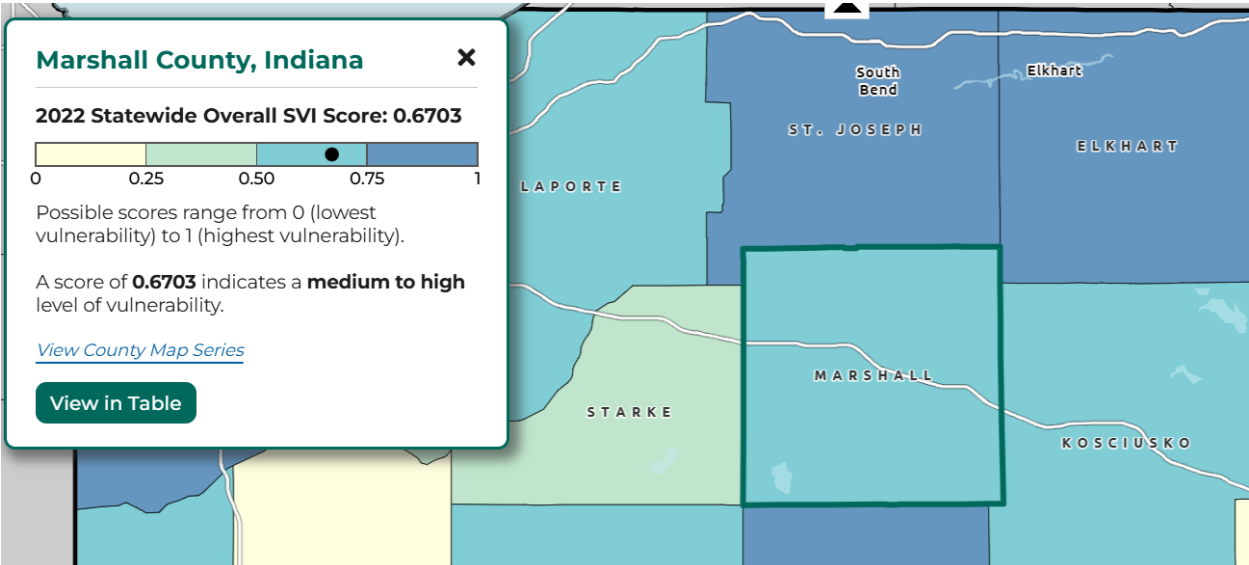
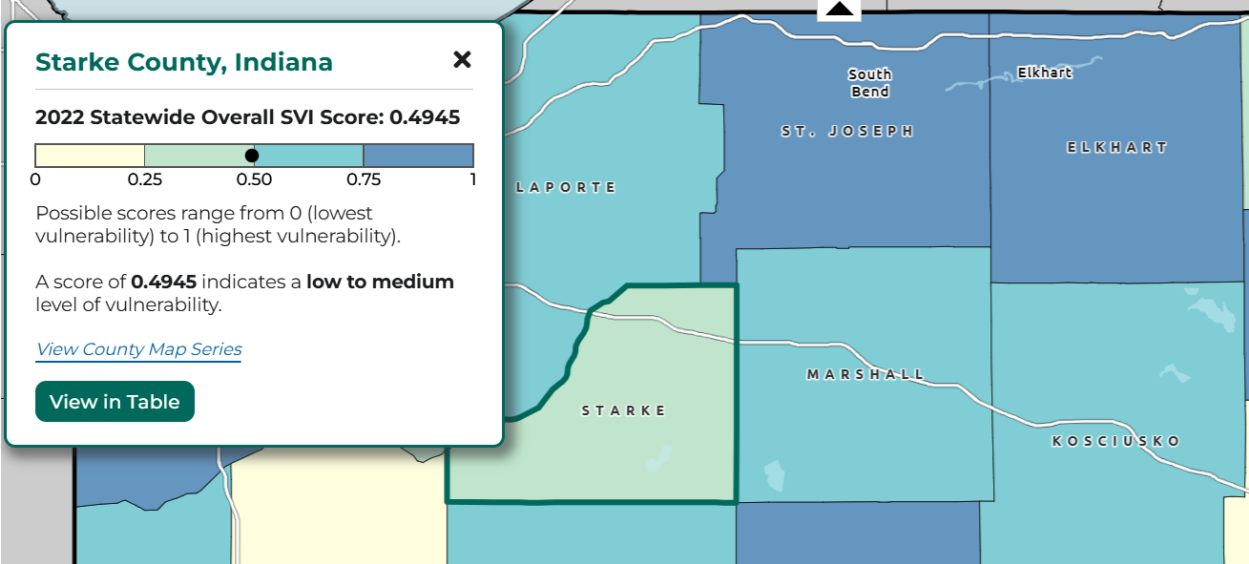
Health infrastructure		Starke, IN	Pulaski, IN	Fulton, IN
Flu Vaccinations		35%	32%	35%
Access to Exercise Opportunities		67%	40%	39%
Food Environment Index		7.9	7.9	7.7
Primary Care Physicians		7,750:1 †	3,120:1 †	1,560:1 †
Mental Health Providers		2,130:1 †	1,550:1 †	1,000:1 †
Dentists		4,640:1 †	12,390:1 †	2,260:1 †
Preventable Hospital Stays		4,469	2,536	2,003
Mammography Screening		37%	40%	42%
Uninsured		9%	9%	9%
<hr/>				
Physical environment		Starke, IN	Pulaski, IN	Fulton, IN
Severe Housing Problems		10%	8%	11%
Driving Alone to Work		82%	76%	78%
Long Commute - Driving Alone		47%	36%	36%
Air Pollution: Particulate Matter		8.5	8.5	8.4
Drinking Water Violations		No	Yes	No
Broadband Access		82%	88%	86%
Library Access		2	3	5
<hr/>				
Social and economic factors		Starke, IN	Pulaski, IN	Fulton, IN
Some College		50%	52%	46%
High School Completion		86%	90%	87%
Unemployment		4.1%	2.9%	3.5%
Income Inequality		4.0	4.2	4.2
Children in Poverty		18%	15%	16%
Injury Deaths		129 ‡	132 ‡	93 ‡
Social Associations		9.9	19.2	18.7
Child Care Cost Burden		27%	24%	34%

Indiana District 2 Public Health and Medical Risk Assessment

Social Vulnerability Index Interactive Map:

[SVI Interactive Map | Place and Health - Geospatial Research, Analysis, and Services Program \(GRASP\) | ATSDR](#)





Kosciusko County, Indiana ✕

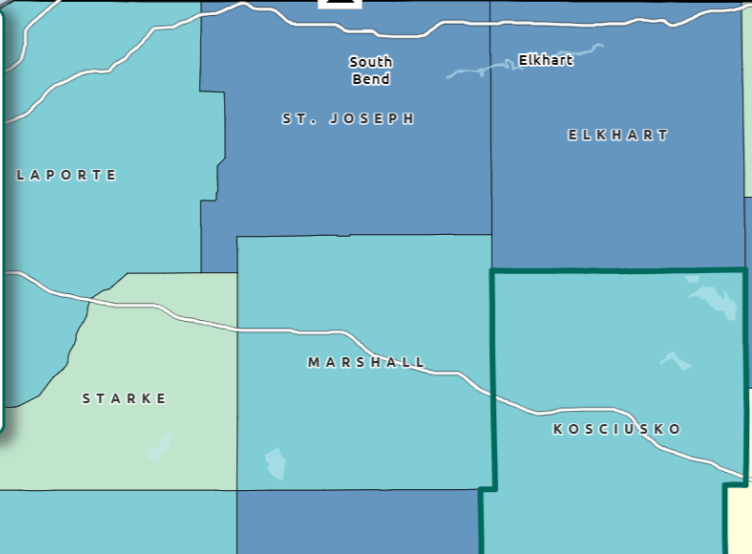
2022 Statewide Overall SVI Score: 0.6264

Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

A score of **0.6264** indicates a **medium to high** level of vulnerability.

[View County Map Series](#)

[View in Table](#)



Fulton County, Indiana ✕

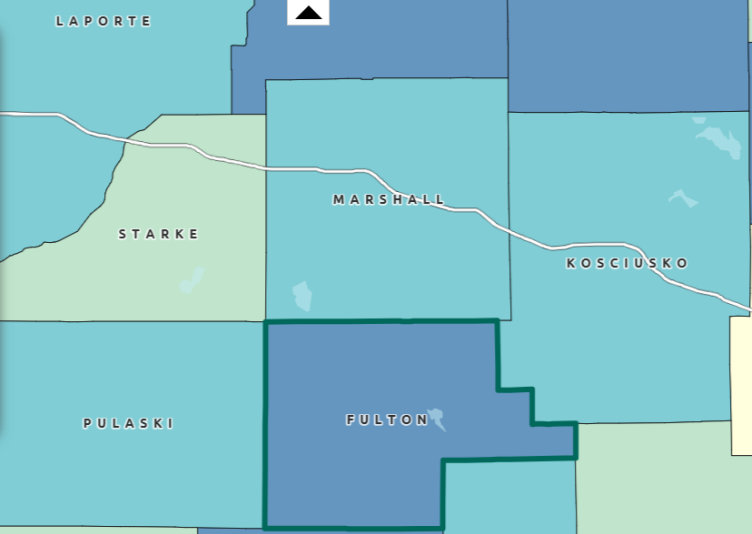
2022 Statewide Overall SVI Score: 0.8791

Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

A score of **0.8791** indicates a **high** level of vulnerability.

[View County Map Series](#)

[View in Table](#)



Pulaski County, Indiana ✕

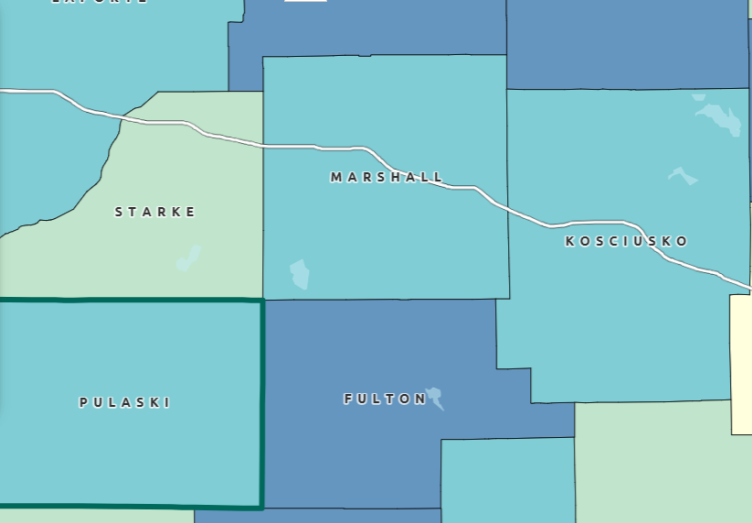
2022 Statewide Overall SVI Score: 0.6484

Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

A score of **0.6484** indicates a **medium to high** level of vulnerability.

[View County Map Series](#)

[View in Table](#)



INDIANA DISTRICT 2 HEALTHCARE COALITION

Job Aids/Position Descriptions Appendix



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

As stated in the D2 HCC Response Plan, the main function of the District 2 Healthcare Coalition (HCC) representative will be to serve as the Liaison Officer who will be responsible for maintaining situational awareness among the member agencies and assisting with responding to resource requests. With that in mind, the job aid enclosed in this section is the HICS Liaison Officer Job Action Sheet.

Additional tools/forms for use in this position are available in Appendix D HCC Additional Required Forms.

LIAISON OFFICER

Mission: Function as the incident contact person in the Hospital Command Center for representatives from other agencies.

Position Reports to: Incident Commander		Command Location: _____	
Position Contact Information: Phone: () - _____		Radio Channel: _____	
Hospital Command Center (HCC): Phone: () - _____		Fax: () - _____	
Position Assigned to:	Date: / /	Start: : hrs.	
Signature: _____	Initials: _____	End: : hrs.	
Position Assigned to:	Date: / /	Start: : hrs.	
Signature: _____	Initials: _____	End: : hrs.	
Position Assigned to:	Date: / /	Start: : hrs.	
Signature: _____	Initials: _____	End: : hrs.	

Immediate Response (0 – 2 hours)	Time	Initial
Receive appointment <ul style="list-style-type: none"> • Obtain briefing from the Incident Commander on: <ul style="list-style-type: none"> ○ Size and complexity of incident ○ Expectations of the Incident Commander ○ Incident objectives ○ Involvement of outside agencies, stakeholders, and organizations ○ The situation, incident activities, and any special concerns • Assume the role of Liaison Officer • Review this Job Action Sheet • Put on position identification (e.g., position vest) • Notify your usual supervisor of your assignment 		
Assess the operational situation <ul style="list-style-type: none"> • Establish contact with local, county, and state emergency organization agencies as appropriate to ascertain current status, contacts, and message routing 		
Determine the incident objectives, tactics, and assignments <ul style="list-style-type: none"> • Determine response objectives, tactics, assignments, and if supporting staff are assigned, document on HICS 204 - Assignment List • Brief liaison team members, if assigned, on current situation, incident objectives and their assignments • Develop response strategy and tactics; outline action plan 		
Activities <ul style="list-style-type: none"> • Obtain initial status and information from the Planning Section Chief to provide surge capacity status; provide an update to external stakeholders and agencies • Establish communication for information sharing with other hospitals and local agencies (e.g., emergency medical services, fire, law, public health, and emergency management) • Respond to information and or resource inquiries from other hospitals and response agencies and organizations 		



LIAISON OFFICER



<p>Documentation</p> <ul style="list-style-type: none"> • HICS 204: Appoint liaison team members, if assigned, and complete the Assignment List • HICS 213: Document all communications on a General Message Form • HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis 		
<p>Resources</p> <ul style="list-style-type: none"> • Consider the need to deploy a liaison representative to the local public health or emergency management Emergency Operations Center (EOC); if warranted, make a recommendation to the Incident Commander • Request one or more recorders as needed from the Logistics Section Labor Pool and Credentialing Unit Leader, if activated, to perform all necessary documentation 		
<p>Communication</p> <p><i>Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners</i></p>		
<p>Safety and security</p> <ul style="list-style-type: none"> • Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques 		

Intermediate Response (2 – 12 hours)	Time	Initial
<p>Activities</p> <ul style="list-style-type: none"> • Transfer the Liaison Officer role, if appropriate <ul style="list-style-type: none"> ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital ○ Address any health, medical, and safety concerns ○ Address political sensitivities, when appropriate ○ Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A) • Attend all briefings and Incident Action Planning meetings to gather and share incident and hospital information • Provide information on local hospitals, community response activities, and Liaison goals to the Incident Action Plan (IAP) • Report to appropriate authorities the following minimum data on HICS 259: Hospital Casualty/Fatality Report: <ul style="list-style-type: none"> ○ Number of casualties received and types of injuries treated ○ Current patient capacity and census ○ Number of patients admitted, discharged home, or transferred to other hospitals ○ Number deceased ○ Individual casualty data: name or physical description, sex, age, address, seriousness of injury or condition 		
<p>Documentation</p> <ul style="list-style-type: none"> • HICS 204: Document assignments and operational period objectives on Assignment List • HICS 213: Document all communications on a General Message Form • HICS 214: Document actions, decisions, and information received on Activity Log • HICS 259: Report data from the Hospital Casualty/Fatality Report 		



LIAISON OFFICER

<p>Resources</p> <ul style="list-style-type: none"> Consider the need to deploy a liaison representative to the local public health or emergency management Emergency Operations Center (EOC); if warranted, make a recommendation to the Incident Commander 		
<p>Communication</p> <p><i>Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners</i></p>		
<p>Safety and security</p> <ul style="list-style-type: none"> Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques Observe all staff and volunteers for signs of stress and inappropriate behavior; report issues to the Safety Officer and Logistics Section Employee Health and Well-Being Unit 		

Extended Response (greater than 12 hours)	Time	Initial
<p>Activities</p> <ul style="list-style-type: none"> Transfer the Liaison Officer role, if appropriate <ul style="list-style-type: none"> Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital Address any health, medical, and safety concerns Address political sensitivities, when appropriate Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A) 		
<p>Documentation</p> <ul style="list-style-type: none"> HICS 204: Document assignments and operational period objectives on Assignment List HICS 213: Document all communications on a General Message Form HICS 214: Document all key activities, actions, and decisions in an Activity Log on a continual basis HICS 259: Report updated data on the Hospital Casualty/Fatality Report 		
<p>Communication</p> <p><i>Hospital to complete: Insert communications technology, instructions for use and protocols for interface with external partners</i></p>		
<p>Safety and security</p> <ul style="list-style-type: none"> Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques Observe all staff and volunteers for signs of stress and inappropriate behavior and report concerns to the Safety Officer and the Logistics Section Employee Health and Well-Being Unit Leader 		

Demobilization/System Recovery	Time	Initial
<p>Activities</p> <ul style="list-style-type: none"> Transfer the Liaison Officer role, if appropriate 		

LIAISON OFFICER

<ul style="list-style-type: none"> ○ Conduct a transition meeting to brief your replacement on the current situation, response actions, available resources, and the role of external agencies in support of the hospital ○ Address any health, medical, and safety concerns ○ Address political sensitivities, when appropriate ○ Instruct your replacement to complete the appropriate documentation and ensure that appropriate personnel are properly briefed on response issues and objectives (see HICS Forms 203, 204, 214, and 215A) • As objectives are met and needs decrease, return liaison team to their usual roles • Coordinate the release of patient information to external agencies with the Public Information Officer • Upon deactivation of your position, brief the Incident Commander on outstanding issues, and follow up requirements • Submit comments to the Planning Section for discussion and possible inclusion in an After Action Report and Corrective Action and Improvement Plan. Topics include: <ul style="list-style-type: none"> ○ Review of pertinent position activities and operational checklists ○ Recommendations for procedure changes ○ Accomplishments and issues • Participate in stress management and after action debriefings 		
<p>Documentation</p> <ul style="list-style-type: none"> • HICS 221 - Demobilization Check-Out • Ensure all documentation is submitted to Planning Section Documentation Unit 		

Documents and Tools
<ul style="list-style-type: none"> <input type="checkbox"/> Incident Action Plan <input type="checkbox"/> HICS 203 - Organization Assignment List <input type="checkbox"/> HICS 204 - Assignment List <input type="checkbox"/> HICS 205A - Communications List <input type="checkbox"/> HICS 213 - General Message Form <input type="checkbox"/> HICS 214 - Activity Log <input type="checkbox"/> HICS 221 - Demobilization Check-Out <input type="checkbox"/> HICS 252 - Section Personnel Timesheet <input type="checkbox"/> HICS 259 - Hospital Casualty/Fatality Report <input type="checkbox"/> Hospital Emergency Operations Plan <input type="checkbox"/> Incident Specific Plans or Annexes <input type="checkbox"/> Hospital policies and procedures <input type="checkbox"/> Hospital organization chart <input type="checkbox"/> Hospital telephone directory <input type="checkbox"/> Telephone/cell phone/satellite phone/internet/amateur radio/2-way radio for communication

INDIANA DISTRICT 2 HEALTHCARE COALITION

Required Forms Appendix



INDIANA DISTRICT 2
HOSPITAL PREPAREDNESS PLANNING COMMITTEE, INC.

Updated January 2026

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*All forms except the resource request form can be found:

<https://emsa.ca.gov/hospital-incident-command-system-forms-2014/>

*Resource request form can be found:

[https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20213rr,%20resource%20request%20message%20\(v3\).pdf](https://training.fema.gov/emiweb/is/icsresource/assets/ics%20forms/ics%20form%20213rr,%20resource%20request%20message%20(v3).pdf)

HICS INCIDENT ACTION PLAN (IAP) QUICK START
 COMBINED HICS 201—202—203—204—215A

5. Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. — HICS 202, 215A —

6. Incident Objectives — HICS 202, 204 —

6a. OBJECTIVES	6b. STRATEGIES / TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO

7. Prepared by PRINT NAME: _____ SIGNATURE: _____
 DATE/TIME: _____ FACILITY: _____

HICS 213 - GENERAL MESSAGE FORM

1. Incident Name		
2. To PRINT NAME: _____ POSITION: _____		
3. From PRINT NAME: _____ POSITION: _____		
4. Subject	5. Date	6. Time
7. Priority <input type="checkbox"/> URGENT - HIGH <input type="checkbox"/> NON URGENT - MEDIUM <input type="checkbox"/> INFORMATIONAL - LOW		
8. Message		<input type="checkbox"/> RESPONSE REQUIRED
9. Approved by	PRINT NAME: _____	SIGNATURE: _____
10. Reply / Action Taken		

RESOURCE REQUEST MESSAGE (ICS 213 RR)

1. Incident Name:				2. Date/Time		3. Resource Request Number:	
Requestor	4. Order (Use additional forms when requesting different resource sources of supply.):						
	Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Arrival Date and Time		Cost
					Requested	Estimated	
5. Requested Delivery/Reporting Location:							
6. Suitable Substitutes and/or Suggested Sources:							
7. Requested by Name/Position:				8. Priority: <input type="checkbox"/> Urgent <input type="checkbox"/> Routine <input type="checkbox"/> Low		9. Section Chief Approval:	
10. Logistics Order Number:						11. Supplier Phone/Fax/Email:	
12. Name of Supplier/POC:							
13. Notes:							
14. Approval Signature of Auth Logistics Rep:						15. Date/Time:	
16. Order placed by (check box): <input type="checkbox"/> SPUL <input type="checkbox"/> PROC							
Finance	17. Reply/Comments from Finance:						
	18. Finance Section Signature:					19. Date/Time:	
ICS 213 RR, Page 1							

HICS 255 - MASTER PATIENT EVACUATION TRACKING

1. Incident Name		2. Operational Period (#) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____				
3. Patient Evacuation Information						
PATIENT NAME		Medical Record #	Evacuation Triage Category <small>IMMEDIATE DELAYED MINOR</small>			Mode of Transport <small>CCT ALS BLS VAN BUS CAR AIRCRAFT</small>
		Disposition <small>DISCHARGE/ TRANSFER/MORGUE</small>	Accepting Hospital or Location			Time hospital contacted & report given
Transfer Initiated (Time/Transport Co./ #)	Medical Record Sent <small>YES NO</small>	Medication Sent <small>YES NO</small>	Family Notified <small>YES NO</small>	Arrival Confirmed <small>YES NO</small>	Admit Location <small>FLOOR ICU ER MORGUE</small>	Expired (time)
PATIENT NAME		Medical Record #	Evacuation Triage Category <small>IMMEDIATE DELAYED MINOR</small>			Mode of Transport <small>CCT ALS BLS VAN BUS CAR AIRCRAFT</small>
		Disposition <small>DISCHARGE/ TRANSFER/MORGUE</small>	Accepting Hospital or Location			Time hospital contacted & report given
Transfer Initiated (Time/Transport Co./ #)	Medical Record Sent <small>YES NO</small>	Medication Sent <small>YES NO</small>	Family Notified <small>YES NO</small>	Arrival Confirmed <small>YES NO</small>	Admit Location <small>FLOOR ICU ER MORGUE</small>	Expired (time)
PATIENT NAME		Medical Record #	Evacuation Triage Category <small>IMMEDIATE DELAYED MINOR</small>			Mode of Transport <small>CCT ALS BLS VAN BUS CAR AIRCRAFT</small>
		Disposition <small>DISCHARGE/ TRANSFER/MORGUE</small>	Accepting Hospital or Location			Time hospital contacted & report given
Transfer Initiated (Time/Transport Co./ #)	Medical Record Sent <small>YES NO</small>	Medication Sent <small>YES NO</small>	Family Notified <small>YES NO</small>	Arrival Confirmed <small>YES NO</small>	Admit Location <small>FLOOR ICU ER MORGUE</small>	Expired (time)
PATIENT NAME		Medical Record #	Evacuation Triage Category <small>IMMEDIATE DELAYED MINOR</small>			Mode of Transport <small>CCT ALS BLS VAN BUS CAR AIRCRAFT</small>
		Disposition <small>DISCHARGE/ TRANSFER/MORGUE</small>	Accepting Hospital or Location			Time hospital contacted & report given
Transfer Initiated (Time/Transport Co./ #)	Medical Record Sent <small>YES NO</small>	Medication Sent <small>YES NO</small>	Family Notified <small>YES NO</small>	Arrival Confirmed <small>YES NO</small>	Admit Location <small>FLOOR ICU ER MORGUE</small>	Expired (time)
4. Prepared by		PRINT NAME: _____		SIGNATURE: _____		
		DATE/TIME: _____		FACILITY: _____		



Purpose: Record information concerning patient disposition during an evacuation
Origination: Situation Unit Leader or designee (Patient Tracking Manager)
Copies to: Planning Section Chief, Documentation Unit Leader

HICS 260 - PATIENT EVACUATION TRACKING FORM

1. Date		2. From (Unit)	
3. Patient Name		4. DOB	5. Medical Record Number
6. Diagnosis		7. Admitting Physician	
8. Family Notified <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: _____ CONTACT INFORMATION: _____			
9. Mode of Transport		10. Accompanying Equipment (check those that apply)	
<input type="checkbox"/> Hospital Bed <input type="checkbox"/> Gurney <input type="checkbox"/> Wheelchair <input type="checkbox"/> Ambulatory <input type="checkbox"/> Other: _____		<input type="checkbox"/> IV Pump(s) <input type="checkbox"/> Oxygen <input type="checkbox"/> Ventilator <input type="checkbox"/> Chest Tube(s) <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Isolette/Warmer <input type="checkbox"/> Traction <input type="checkbox"/> Monitor <input type="checkbox"/> A-Line/Swan <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Foley Catheter <input type="checkbox"/> Halo-Device <input type="checkbox"/> Cranial Bolt/Screw <input type="checkbox"/> Intraosseous Device <input type="checkbox"/> Other: _____	
11. Special Needs			
12. Isolation <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: _____ REASON: _____			
13. Evacuating Clinical Location		14. Arriving Location	
ROOM #	TIME	ROOM #	TIME
ID BAND CONFIRMED BY:	<input type="checkbox"/> YES <input type="checkbox"/> NO	ID BAND CONFIRMED BY:	<input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICAL RECORD SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	MEDICAL RECORD RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
BELONGINGS	<input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE	BELONGINGS RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
VALUABLES	<input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT IN SAFE <input type="checkbox"/> NONE	VALUABLES RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATIONS	<input type="checkbox"/> WITH PATIENT	<input type="checkbox"/> LEFT ON UNIT <input type="checkbox"/> PHARMACY	MEDICATIONS RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
PED S / INFANT S		PED S / INFANT S	
BAG/MASK WITH TUBING SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	BAG/MASK /W TUBING RCVD	<input type="checkbox"/> YES <input type="checkbox"/> NO
BULB-SYRINGE SENT	<input type="checkbox"/> YES <input type="checkbox"/> NO	BULB SYRINGE RECEIVED	<input type="checkbox"/> YES <input type="checkbox"/> NO
15. Transferring to another Facility / Location			
TIME TO STAGING AREA		TIME DEPARTING TO RECEIVING FACILITY	
Destination			
TRANSPORTATION	<input type="checkbox"/> AMBULANCE # _____	AGENCY	<input type="checkbox"/> HELICOPTER <input type="checkbox"/> OTHER
ID BAND CONFIRMED	<input type="checkbox"/> YES <input type="checkbox"/> NO	BY	
DEPARTURE TIME: _____			
16. Prepared by			
PRINT NAME: _____		SIGNATURE: _____	
DATE/TIME: _____		FACILITY: _____	



Purpose: Detail and account for patients transferred to another facility
 Originator: Inpatient/Outpatient Unit Leader or Casualty Care Unit Leader
 Copies to: Patient Tracking Manager, Medical Care Branch Director, evacuating clinical location, and Documentation Unit Leader