

# Utah Department of Health Healthcare Preparedness Program Hospital 2012-13 Grant Deliverables Guidance (Phase II Update)

The purpose of this document is to provide information to Utah hospital HPP sub-grantees on the completion of required project deliverables for the **Phase I period (July 1, 2012-December 31, 2012)** and **Phase II period (January 1, 2013 – April 30, 2013)** of the current budget period of **July 1, 2012 – June 30, 2013**. This document offers instructions for each of the Phase I and II program deliverable templates that sub-grantees will utilize to complete program elements:

## Phase I – Ended 12/31/12

- **Deliverable 1 - NIMS Compliance Templates**
  - Template for fully compliant facilities, or
  - Template for facilities with NIMS elements in progress or incomplete;
- **Deliverable 2 - Interoperable Communications Drill Template**
  - For two drills conducted during Phase I;
- **Deliverable 3 - Facility Survey/Workplan and Budget**
- **Deliverable 4 - Emergency Operations Plan sections**
  - Medical Evacuation/Shelter In Place Plan, or
  - Active Shooter/Workplace Violence Plan, or
  - Decontamination/Hazmat Plan.

**Phase II – Deliverables are discussed in detail below, and in Hospital Grant Provisions, located here - [http://health.utah.gov/preparedness/downloads/hppsection3/fy12\\_hospital\\_special\\_provisions.pdf](http://health.utah.gov/preparedness/downloads/hppsection3/fy12_hospital_special_provisions.pdf)**

- **Deliverable 5- Complete two Interoperable Communication Drill Templates**
  - Record of 2 communication tests conducted between 1/1/13-4/30/13
  - Completion of this deliverable provides hospital access to 10% of total funding award.
- **Deliverable 6 – 80% compliance with UHRMS bed availability tests**
  - UT DOH maintains a running record of UHRMS monthly tests
  - The testing period is July 2012 – April 2013 (10 months)
  - Success on this deliverable is 8/10 completed tests during the period, and provides hospital access to 10% of total funding award.
- **Deliverable 7 – Complete UT DOH online hospital preparedness survey**
  - The survey will be released by March 1, 2013, grantees will have 45 days to complete.
  - The survey topics will include a NIMS compliance update, a HPP program projections assessment, and other topics TBD.
  - Completion of this deliverable provides hospital access to 10% of total funding award.

- **Deliverable 8 – Participation in Regional Medical Surge Coalitions at 75% or above**
  - UT DOH HPP will work with Regional Coalition Coordinators to determine participation level of grantee hospitals
  - Regional Coalition attendance rolls will be one tool used to determine active participation by hospitals
  - Completion of this deliverable provides hospital access to 20% of total funding award.
- **Deliverable 9 - Emergency Operations Plan sections – submit one of the following plan sections (a section that was not submitted during Phase I)**
  - Medical Evacuation/Shelter In Place Plan, **or**
  - Active Shooter/Workplace Violence Plan, **or**
  - Decontamination/Hazmat Plan.
  - If two EOP sections were submitted during Phase I by hospital, this element will be noted as complete.
  - Completion of this deliverable provides hospital access to 10% of total funding award.

**Reminder - All program documents are now posted to the UDOH website at <http://health.utah.gov/preparedness/?formname=preparedness>**

### **Timelines/Important Dates**

#### **November 2012**

Hospital technical assistance webinars and individual technical assistance provided  
 Completion of contracts, FFATA, Grantee Assurances, and Tax forms

#### **December 2012**

All Phase I deliverables are due by December 31, 2012

#### **January 2013**

Additional individual technical assistance provided as needed  
 Phase I funding distributions will be processed by UDOH  
 This Deliverables Guidance document will be amended to explain Phase II deliverables.

#### **February 2013**

~~Phase II online survey open 2/15/13, until 4/15/13~~

#### **March 2013**

Phase II deliverable online survey will be distributed by March 1, 2013 and open until April 15, 2013  
~~Tentative Date for UDOH ASPR HPP Summit – Mid-Late March 2013~~ Moved to June 2013.

#### **April 2013**

All Phase II deliverables are due to UDOH by April 30, 2013  
 Distribution of grant close out documentation packet  
 Ten month tracking period ends for UHRMS Bed Tracking (7/1/12-4/30/13)  
 Ten month tracking period ends for Regional Coalition participation (7/1/12-4/30/13)

## May 2013

Phase II funding distributions will be processed by UDOH, upon receipt of close out documentation. This will be an addendum to the Workplan/Budget document completed during Phase I to include the actual expenditures under the program award. The final funding distribution will equal the total amount spend by the grantee minus the Phase I funding distribution.

## June 2013

Equipment – Update to HPP Inventory based on equipment and supply purchases  
Training/Education – Complete Training tracker document  
Exercises – Complete Exercise tracker document, submit any After Action Reports.  
UT DOH HPP Grantee Summit will be held June 10-June 11 in Salt Lake City, location TBA.

## July 2013

The start of the second budget period for the UT DOH HPP begins (July 1, 2013-June 30, 2014)

## Phase II Deliverables \_\_1/1/13-4/30/13 \_\_\_\_\_

**5. Interoperable Communications** – Hospitals shall record the type of test, test partners, outcome, and improvement elements identified through at minimum, two communication drills conducted during Phase II. These tests are intended to verify ongoing testing of communication equipment with external partners. Most hospitals conduct more than the two required tests, however for the purposes of the HPP, only two must be recorded and submitted to UDOH. The drill template can be located here - [http://health.utah.gov/preparedness/downloads/hppsection2/communications\\_drill\\_template.doc](http://health.utah.gov/preparedness/downloads/hppsection2/communications_drill_template.doc)

Horizontal tests include communication with other healthcare partners, such as other hospitals, long term care facilities, community clinics, and/or support services partners.

Vertical tests include communication with local jurisdictional, county, regional, and/or state partners. Examples of vertical partners include local health departments, local emergency management, local fire, EMS or police, Regional Coalition Coordinators, Utah Department of Health, and/or state Emergency Management.

To complete the communications test template, the hospital shall:

- Indicate a name for the drill and date on which the drill occurred
- Indicate the type(s) of communication equipment that was tested
- Indicate if the drill was horizontal, vertical, or both (such as a Regional radio check)

- Provide a list of partner agencies with whom the drill was conducted
- Briefly note 1-3 improvement elements that were identified as a result of drill participation
- Cut and paste template into facility letterhead, sign and date

Email to [kmcculley@utah.gov](mailto:kmcculley@utah.gov), or [healthcarepreparedness@utah.gov](mailto:healthcarepreparedness@utah.gov), or mail to Utah Department of Health; Healthcare Preparedness Program; PO Box 142006; Salt Lake City, UT 84114-2006, or fax to 801-273-4152.

**6. Available Bed Tracking** – The Utah Health Resources Management System (UHRMS) is used by the UT DOH to collect, aggregate, and report available beds within participating Utah hospitals. The UHRMS fulfills UT DOH obligation to maintain a state HAvBED (Hospital Available Beds for Emergencies and Disasters) network, and participation by grantee hospitals is required through accepting facility funding awards. In addition, the ASPR requires all states to be able to report available beds to the federal HHS operations center, using the following grant benchmark definition-

*“The State EOC can electronically report available and staffed beds according to HAvBED definitions by sub-state regions to the HHS SOC within 4 hours or less of a request, during an incident or exercise at least once during the current grant year. These reports should reflect bed data from at least 75% of participating facilities in the state.”*

Success in this deliverable will be expressed by completion of 8 of 10 months of bed tracking requests, which are typically conducted on the first Tuesday of each month. The testing period will be the ten months of July 2012 to April 2013.

In May 2013, hospitals will be provided with a report that details their reporting rate as recorded by UT DOH through the UHRMS system.

-If the report indicates 80% or greater successful test rate for the hospital, the deliverable is complete, and no additional action is needed.

-If the report indicates less than 80% successful test rate over the 10 months, grantees will need to submit a brief (1 page) performance improvement report that provides action steps to improve bed reporting compliance. A template will be provided.

**7. Facility Survey** – By March 1, 2013, an online (Survey Monkey) survey will be distributed to participating hospitals. Hospitals will have up to 45 days to complete, and the survey will close on or around April 15, 2013.

The survey topics will include a reassessment of NIMS compliance status. The ongoing assessment may seem repetitive; however this is a UT DOH ASPR HPP grant benchmark, as evidenced in the HPP program guidance as –

*“Awardees (states) will submit a comprehensive inventory that lists each of its participating hospitals by name and by National Provider Identifier (NPI) (formerly known as HIPAA ID); identifies each of the 11 NIMS implementation activities that have been achieved; and identifies each activity*

*still in progress. This must also include the plans to address the gaps for the identified hospitals that are not 100% compliant with NIMS requirements.”*

Additional survey topics will include-

Program projections – Hospitals will be queried as to the timing of completion of program activity as expressed in the Budget Workplan.  
Other topics TBD.

**8. Active Participation in Regional Healthcare Coalitions** – The development and sustaining of Regional Healthcare/Medical Surge Coalitions is a centerpiece of the ASPR HPP. The ASPR HPP now requires the development of Coalitions, with hospitals included in its leadership, as evidenced by the following grant language -

*“The State and Healthcare Coalition member organizations encourage the development of essential partner memberships from the community’s healthcare organizations and response partners. These memberships are essential for ensuring the coordination of preparedness, response, and recovery activities. Memberships may be dependent on the area, participant availability, and relevance to the Healthcare Coalition. Prospective partners to engage (assuming they are not already members): **Hospitals and other healthcare providers**, EMS providers, Emergency Management/Public Safety, Long-term care providers, Mental/behavioral health providers, Private entities associated with healthcare (e.g., Hospital associations), Specialty service providers (e.g., dialysis, pediatrics, woman’s health, stand alone surgery, urgent care), Support service providers (e.g., laboratories, pharmacies, blood banks, poison control), Primary care providers, Community Health Centers, Public health, Tribal Healthcare, Federal entities (e.g., NDMS, VA hospitals, IHS facilities, Department of Defense facilities)*

*Note: Active membership from these constituencies are evidenced by written documents such as MOUs, MAAs, IAAs, letters of agreement, charters, or other supporting evidence documents”*

To support this grant deliverable, hospitals, as a condition of receiving preparedness funds, must remain active participants in their designated Regional Coalition.

Active hospital participation is defined as attendance at Regional meetings by the point of contact or designee at a minimum of 75% of Regional Coalition meetings during the program activity period (July 1, 2012 – April 30, 2013), as recorded on attendance rolls by Regional Coordinator.

If hospital attendance at Regional Coalition meetings is less than 75%, then the hospital shall submit a 1 page improvement plan that describes how compliance will be improved. A template will be provided.

**9. Planning – Submission of facility Emergency Operations Plan Sections** – Hospitals shall submit a second EOP section that was not submitted during Phase I. The plans selected for this budget period are – Decontamination/HazMat; Evacuation/Shelter in Place; and Active Shooter/Workplace Violence.

- If two of the three EOP sections were submitted during Phase I, the hospital is complete for this deliverable.
- A plan is considered current if it has been revised or appended since 2011, or if plan revisions have been included as a result of an exercise AAR or real-life event.
- A plan is considered approved if it has been signed off on by whatever hospital team approves such plans, such as Emergency Management Committee, Risk Committee, Board of Directors, or Executive Team.
- Plans should be updated to correlate with relevant elements of Regional Medical Surge Plan as appropriate.
- If facility has no current plans matching the required submissions, please contact the HPP.
- Templates for each plan are posted on <http://health.utah.gov/preparedness/?formname=preparedness>

## Phase I Deliverables 7/1/12-12/31/12 Phase I is Complete

**1. NIMS Compliance** – Hospitals completed an online survey for UDOH HPP during April 2012 that assessed the level of compliance with the 11 NIMS compliance elements. For a detailed description of the elements, refer to the following document on the UDOH website - [http://health.utah.gov/preparedness/downloads/hppsection1/nims\\_guidance\\_2012.pdf](http://health.utah.gov/preparedness/downloads/hppsection1/nims_guidance_2012.pdf)

For the 11 elements of NIMS compliance, facilities indicated “Yes”, “No”, “In-progress” or “Unknown” on the survey. If you need the results of the survey, please contact Kevin at [kmcculley@utah.gov](mailto:kmcculley@utah.gov).

**Fully NIMS Compliant** - For facilities that reported full NIMS compliance (i.e. Yes to all 11 elements), complete the NIMS template for fully compliant facilities at [http://health.utah.gov/preparedness/downloads/hppsection2/nims\\_compliance\\_report.doc](http://health.utah.gov/preparedness/downloads/hppsection2/nims_compliance_report.doc)

This document includes the following two sections – 1. Explain how NIMS compliance will be maintained through the 5 year project period; and 2. Explain how NIMS elements are integrated into facility training and exercise activity.

**Partial NIMS Compliance** - For facilities that reported any No, In-progress, or Unknown for any NIMS elements in the April survey, complete the NIMS Template for facilities with NIMS elements in progress at

[http://health.utah.gov/preparedness/downloads/hppsection2/nims\\_progress\\_improvement\\_report.doc](http://health.utah.gov/preparedness/downloads/hppsection2/nims_progress_improvement_report.doc)

The document includes tables for each incomplete element, and facilities should utilize the following example for completing the document. If additional tables are needed, simply copy and paste a blank one.

<b>Example NIMS Compliance Element</b> – #4 Participate in interagency mutual aid agreements – noted as In-progress on survey
<b>Example Steps to Reach Compliance</b> - The facility will ensure that it signs on to both the state level Utah Hospital Association Master Mutual Aid Agreement and the Regional Coalition MOU/A, and will amend its emergency operations plan to and program documentation to reflect participation in these agreements.
<b>Example Timeline for Compliance</b> – This activity will be completed by June 1, 2013
<b>Example How facility funds will be used to reach compliance on this element.</b> No funding will be needed to complete this element.

To complete each form, the facility must:

- Copy template into facility letterhead
- Complete each section of the template
- Sign and date the document
- Save and email to [healthcarepreparedness@utah.gov](mailto:healthcarepreparedness@utah.gov), mail to Utah Department of Health; Healthcare Preparedness Program; PO Box 142006; Salt Lake City, UT 84114-2006, or fax to 801-273-4152.

**2. Interoperable Communications** – Hospitals shall record the type of test, test partners, outcome, and improvement elements identified through at minimum, two communication drills conducted during Phase I. These tests are intended to verify ongoing testing of communication equipment with external partners. Most hospitals conduct more than the two required tests, however for the purposes of the HPP, only two must be recorded and submitted to UDOH.

Horizontal tests include communication with other healthcare partners, such as other hospitals, long term care facilities, community clinics, and/or support services partners.

Vertical tests include communication with local jurisdictional, county, regional, and/or state partners. Examples of vertical partners include local health departments, local emergency management, local fire, EMS or police, Regional Coalition Coordinators, Utah Department of Health, and/or state Emergency Management.

To complete the communications test template, the hospital shall:

- Indicate a name for the drill and date on which the drill occurred
- Indicate the type(s) of communication equipment that was tested
- Indicate if the drill was horizontal, vertical, or both (such as a Regional radio check)
- Provide a list of partner agencies with whom the drill was conducted
- Briefly note 1-3 improvement elements that were identified as a result of drill participation
- Cut and paste template into facility letterhead, sign and date
- Email to [healthcarepreparedness@utah.gov](mailto:healthcarepreparedness@utah.gov), mail to Utah Department of Health; Healthcare Preparedness Program; PO Box 142006; Salt Lake City, UT 84114-2006, or fax to 801-273-4152.

**3. Phase I Facility Survey (Workplan and project budget)** – The Workplan and budget Excel spreadsheet will capture essential elements of the facility’s planned program activities and expenditure plan for the current budget period. Important points to note:

- This is the first year Workplan of a five year project, **not all elements must be completed during the first budget period (7/1/12-6/30/13).**
- The grantee should understand that at some point during the five year project period, all elements will need to be addressed, but should **only include in the Workplan those activities and purchases that will take place in the current budget period.**
- Not all elements require funding allocations, especially Planning elements, **however if any activity is planned for an element, it should be noted in the justification column.**
- All Training and Equipment **funding allocations should be based on facility or community needs** identified through an ongoing process of hazards and gap assessment conducted by the facility emergency management team in collaboration with Regional Coalition partners. Additionally, real-life experiences, events, and/or the results of After Action Reports also provide justification for purchasing decisions.

- Any use of funds for equipment also come with the expectation that use policies and protocols will be developed in conjunction with the purchase of equipment, and that staff training will be conducted to develop use competencies.
- **All expenditures must be limited to activities, equipment, fees, and expenses that occur during the current budget period (7/1/12-6/30/13).** Prepayment for services that will not or did not occur during the current budget period are not allowed costs. Prepayment for equipment that will not be delivered during the current budget period are not allowed. Contact the HPP Manager if questions arise.
- Any equipment purchased, with the exception of communications equipment, shall be cached and maintained separately from day-to-day hospital equipment, except for the purpose of testing and training events. **Communication equipment should be used regularly and tested** often to ensure proficiency is maintained under crisis conditions.
- Provide enough detail to allow HPP to clearly understand the intent of the expenditure. For example, in describing your intention to purchase additional body bags (Mass Fatality equipment), the facility could note that “As a result of community mass fatality assessment, it was determined that our hospital should cache 50 body bags. We currently have 20, so will purchase an additional 30 to fill the gap”.
- If expenditures have already taken place (i.e. Satellite phone bills, travel to Regional meetings, etc.), ensure these are recorded in the justification and budget columns.
- Utilize the HPP Approvable Equipment List, and the information contained in Section D (pages 5-11) of the HPP Facility Grant Agreement to determine those items and activities that do not require prior approval. If an activity or equipment is not included on either of these documents, it is strongly recommended that the grantee contact HPP before committing the activity/equipment to the budget.
- All budgets will be reviewed by HPP staff, and grantee will be contacted if clarifications or additional details are needed.
- **If significant (in excess of 10% of total awarded amount) alterations to the budget are needed after original Workplan/Budget submission, please revise and resubmit to HPP.** For example, if a facility receives \$10,000 in funds, any mid-year program changes that cause changes to the Workplan/Budget in excess of \$1,000 will indicate a need to revise and resubmit budget.
- Funding distributions are based on submission of required deliverables; however the total distribution cannot exceed the total actual funds expended by the facility during the budget period. For example, if you only expend \$8,000, but your total award is up to \$10,000, you will only receive reimbursement to \$8,000. Please plan for and expend all allocated funding. Unexpended funds allocated to facilities must be returned if not utilized during the current budget period.
- Conversely, if the facility total award amount is not needed during the budget period, then prepare to be reimbursed only for the amount included in the budget. For example, if your facility only intends to spend \$7,000 of a \$9,000 award cap, and only budgets for \$7,000 in expenditures, then you will be reimbursed \$7,000. Carryover of unused funds is not available, so please plan for and fully expend your awarded amounts.
- If the grantee cannot locate the appropriate Capability and Resource Element for a planned activity and/or equipment purchase, utilize the “Other” section at the end of the worksheet.
- This document cannot cover all variations, unique situations, and individual hospital considerations, but is intended to provide general guidance for management of the allocated funds and program deliverable expectations. When in doubt, or if questions arise, please contact Kevin McCulley, HPP Manager at [kmcculley@utah.gov](mailto:kmcculley@utah.gov) or 801-273-6669.
- As this document is updated with additional information, and answers to commonly asked questions, hospitals will be notified and revisions will be posted to <http://health.utah.gov/preparedness/?formname=preparedness>

Utilize the following example to assist with completion of the workplan/budget document. The document is due 12/31/12. Note that distinct entries are created for activities and equipment that are included under the same Resource Element

Capability Resource Element - Basic overview of Resource Element within Capability	Examples of Program Activity - One or more examples of the types of program activity that will meet the Resource Element, individual facility activity may differ	Type of Program Activity (Planning, Equipment, Training, Exercises, Travel)	Required Activity Year 1 - One of the specific hospital deliverables in grant. Funding may not be required to meet the deliverable.	Example of Program Expenditure - Specific Facility Needs may differ. Refer to Approvable Equipment List and Hospital Grant language for additional information	Equipment/ Staff Time/Activity Description - For Planning Elements - briefly describe what efforts will be made to meet Element; For Equipment - Provide line items using additional lines for detail; For Training - Provide details sufficient to explain costs for training events.	Budgeted Amount
Emergency Operations Coordination					This column is where the hospital needs, plans, and proposed expenditures are entered, use or create additional lines for distinct project elements.	This column is where the budget line items are entered.
<b>Incident Management</b> - Incident information sharing, facility status reports, expected activations, communication with public, partners, emergency management	Development of processes to collect, aggregate, and share facility specific incident status information with hospital staff, patients and families, Coalition partners, and emergency management	Planning		Costs related to emergency operations plan development for hospital, to include status reporting and information sharing	We will work with Regional Coalition partners to move forward on the identification of critical healthcare incident information that would be available and helpful to share with incident management and EOC during an event.	\$0
					We will work with hospital public affairs office to develop public messaging plans for the various threats identified in our HVA. This messaging plan will be developed with the assistance of a public affairs contractor who will handle development of a social media messaging platform. Costs will be incurred to hire a contractor for this project.	\$1,200
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<b>Resource Coordination</b> - Managing and resupplying resource caches, inventory, tracking of used	Development of processes to track the use of disaster supplies that are utilized during a response	Planning		Costs related to development of inventory management plans for disaster equipment and supplies	Our disaster response equipment inventory is maintained in our normal inventory management system, with identifying tags in the system that identify the equipment as for disaster use only. This year, we will develop a protocol for staff to record the use of disaster equipment, and will develop a trigger mechanism in the system to alert	\$0

supplies					hospital emergency manager when a specific supply item is nearly out.	
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<b>Inventory management System</b> - to track and record available and shared assets	Develop a system to tag and track disaster response equipment at hospital	Equipment		Purchase of an inventory management system, to be used solely for the identification, tracking, and resupply of disaster response equipment	No activity planned, will use existing system.	\$0
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<b>Command Center Training</b> - Ensure hospital staff have been trained on the operation and management of hospital command center	Provide training courses for staff who will fulfill command center roles and responsibilities	Training		Costs for staff time and other costs related to command center skills development, such as a trainer, supplies, photocopies of manuals, etc.	We have identified a need to develop disaster messaging skills within our Public Affairs office due to H1N1 after action reporting, so we will send three public affairs staff to a disaster Public Information Officer training course. There is a course available in December 2012 in Arizona.	\$1,850
					Several Command Center positions have only one staff that has been trained to fulfill the role. To increase depth of the Command Center staffing, we will bring in a Hospital Incident Command System trainer to conduct 2 training courses for Operational Team and Planning Team staff.	\$2,200
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<b>Command Center Equipment</b> - Ensure adequacy of supplies and equipment to fulfill hospital command center functions	The hospital will maintain a functioning command center that serves as the information hub and incident management location for the facility.	Equipment		HICS vests, printer, laptop, dry erase board, signage, HICS binders, monitors, storage cabinets, etc.	The Command Center laptop distributed by UDOH has reached the end of its useful life and needs to be replaced. We will replace the laptop, and install the hospital incident management system, inventory manager, and communication software on it.	\$1,800
					The Command Center does not have adequate storage for response supplies, as evidenced by an inability for staff to locate their ICS vests during a recent exercise. We will install locking storage cabinets in the Command Center, with labeled shelves for each of the Response staff positions.	\$650

					We need to route and wire the command center to provide command staff visibility on the hospital security camera system. This became evident during our response to the bus crash, when command center staff kept leaving to go to the ED because they could not maintain situational awareness of what was occurring in the ED.	\$550
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**4. Planning – Submission of facility Emergency Operations Plan Sections.** A few important elements to note:

- A plan is considered current if it has been revised or appended since 2011, or if plan revisions have been included as a result of an exercise AAR or real-life event.
- A plan is considered approved if it has been signed off on by whatever hospital team approves such plans, such as Emergency Management Committee, Risk Committee, Board of Directors, or Executive Team.
- Plans should be updated to correlate with relevant elements of Regional Medical Surge Plan as appropriate.
- If facility has no current plans matching the required submissions, please contact the HPP.
- Templates for each plan will be posted on <http://health.utah.gov/preparedness/?formname=preparedness>

**Active Shooter/Workplace Violence Plan Suggested Plan Elements –**

- Purpose
- Definitions
- Pre-incident considerations
- Overhead Code Designation
- Triggers for calling the Code
- Procedures for staff to follow to protect themselves, patients, and guests
- Hospital security procedures
- Lockdown Procedures
- How to help Police
- Calling All-Clear
- An excellent template resource can be found here - <http://www.calhospitalprepare.org/active-shooter>

**Medical Evacuation/Shelter In Place Plan**

- General Considerations – no-notice vs. advance notice events
- Criteria for Activation of plan – choosing to shelter in place vs. evacuate
- Securing Hospital Site
- Alternate Care Location/ Hospital Transfers/Evacuation Receiving Facilities
- Location and use of evacuation resources/equipment
- Maintenance of continuity of care for patients, access to patient records, durable medical equipment
- Post-evacuation, pre-transfer staging areas for patients

- Tracking of patients throughout the process
- Public Affairs and family notification
- Notification procedures for Regional Coalition, Emergency Management, and EMS agencies
- Verification of completed evacuation
- Procedures for reopening, recovery, and return of patients to facility.
- Shelter in place plans should have additional considerations including management of resources, safety and security, management of critical infrastructure, discontinuation of clinical activities, etc.
- Again an excellent resource site - <http://www.calhospitalprepare.org/evacuation>

#### **Decontamination/Hazardous Materials Plan**

- Too many items to list, refer to <http://www.calhospitalprepare.org/hazardous-materials> and <http://www.calhospitalprepare.org/decontamination> for excellent resources and templates.

As with any planning and guidance, please consider this a work in progress, and subject to change. Please notify HPP staff of any errors, inconsistencies, and suggested changes or additions to this or any HPP document.