

# Emergency Management 101 for Health Professionals

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# Objectives

- **List phases of comprehensive emerg. management**
- **Cite examples of applicable standards/regulations**
- **Describe the 9 Step Emerg. Management Program**
- **Discuss exercise, education and plan development**
- **Explain medical surge capacity/capability**
- **Define crisis standard of care**
- **Discuss resource management concepts**
- **Cite principles of mass fatality planning**
- **Identify components of alternate care facilities**
- **Cite legal/ethical principles of emerg. management**

# Four Phases of Emergency Management



# Principles of Emergency Management

- Foundation upon which emergency management is built
- Applicable to an “all-hazards” approach to disasters
- Should be a part of any healthcare emergency management plan
- Specific reference in The Joint Commission

# Cornerstones of Emergency Management



# Mitigation

- Planning
- Analysis of weaknesses and identifying gaps (HVA's)
- Testing and Practices
- Learn from mistakes and make improvements
- Institute practices and policies
- Collaboration

# Preparedness

- Exercise
- Training
- Resource management
- Planning

# Response

- Supplies
- Staff
- Procedures
- Relationship cooperation
- Unified management of disasters



# Recovery and Resiliency

- Internal effort within an organization to ensure that mission critical business and service functions are resistant to disruption
- Business Continuity/COOP
- Recovery Plans
- Insurance Coverage
- Continuity of operations
- Continuity of services

# Standards, Regulations, Guidance



# Which Ones to Know?

- Agencies that regulate healthcare emergency management procedures, capabilities, and requirements
- Organizations that establish healthcare emergency management standards
- Healthcare non-regulatory agencies that provide guidance to healthcare industry
- Standards and regulations that pertain to healthcare during disaster situations

# Accrediting Agencies

- Accreditation Association for Ambulatory Health Care
- Accreditation Association for Ambulatory Health Care Facilities
- Commission on Accreditation of Rehabilitation Facilities
- Community Health Accreditation Program (home health and hospice)
- National Association of City and County Health Officers
- American Public Health Association
- Public Health Accreditation Board
- The Joint Commission

# Joint Commission

- EM.01.01.01 Planning and strategies
- EM.02.01.01 Emergency Operations Plan
- EM.02.02.01 Communication during a disaster
- EM.02.02.03 Manage resources and assets
- EM.02.02.05 Manage security and safety
- EM.02.02.07 Management of staff
- EM.02.02.09 Manage utilities
- EM.02.02.11 Manage patients
- EM.02.02.13/15 Management of volunteers and licensure
- EM.03.01.01 Evaluates the effectiveness of its planning activities
- EM.01.01.13 Evaluates effectiveness of its EOP

# Regulatory Agencies

- Occupational Safety and Health Administration (OSHA) - 29 C.F.R. 1910
- Centers for Medicare and Medicaid Services (CMS)

# Centers for Medicare and Medicaid Services

- Long-term care—42 C.F.R.§483.75(m)
- CMS Intermediate Care Facility for the Mentally Retarded (ICF/MR)—42 C.F.R.§483.470(h)
- CMS End Stage Renal Disease (ESRD)—42 C.F.R.§405.2140(d)
- CMS Critical Access Hospitals (CAH)—42 C.F.R.§485.623(c)
- Rural Health Care Clinics – 42 C.F.R.§491.6©

# Standard-Setting Organizations

- National Institute for Occupational Safety and Health (NIOSH)
- American Society for Testing and Materials (ASTM)
- National Fire Protection Agency (NFPA)



# National Fire Protection Association

- NFPA 99-Health Facilities
- NFPA 101-Life Safety Code (LSC)
- NFPA 110-Emergency and Standby Power Systems
- NFPA 111-Standard on Stored Electrical Energy
- Emergency and Standby Power Systems
- NFPA 1600-Disaster/Emergency Management and Business Continuity Systems

# Nonregulatory Agencies

- Department of Health and Human Services (HHS) Centers for Disease Control and Prevention (CDC)
- HHS-Agency for Healthcare Research and Quality (AHRQ)
- DHS-Federal Emergency Management Agency (FEMA),
- National Integration Center (NIC), Incident Management System Division

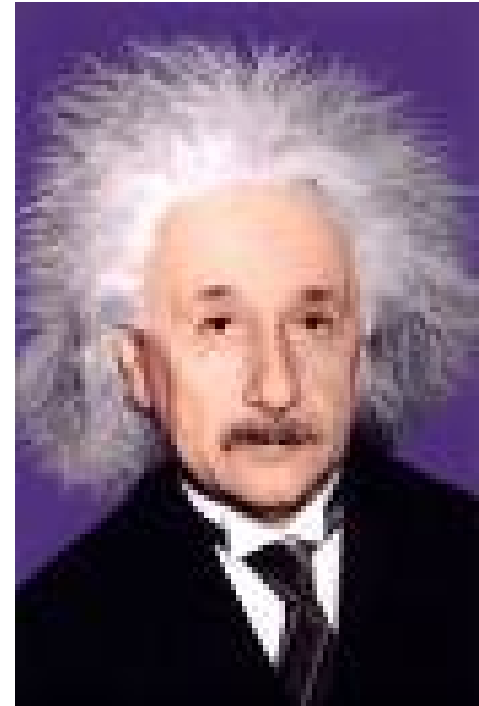
# Professional Organizations

- American Hospital Association (AHA)
- American Society of Healthcare Engineering (ASHE)
- American Nursing Association (ANA)
- American Medical Association (AMA)



# Conclusion

- Numerous regulatory and standard setting organizations
- It is important to know which standards apply to you
- As Einstein said “I don’t need to know everything, I just need to know where to look it up at”



# Emergency Management Programs



# Drivers and Influences

- **National/Federal guidelines, e.g. ASPR, CDC, DHS**
- **Presidential Directives (e.g., #'s 5, 8, 21)**
- **State/local guidelines and initiatives**
- **Regulatory / Accrediting– e.g. JC, OSHA, NFPA**
- **Real and emerging threats and events**

# Senate Bill 3678: The Pandemic and All-Hazards Preparedness Act (2006)

- Establishes Office of Preparedness and Response, headed by an Assistant Secretary (ASPR)
- More streamlined management of functions and programs and clearly delineated specific public health emergency management elements
- Titles : Title I: National Preparedness and Response, Leadership, Organization and Planning; Title II: All-Hazards Medical Surge Capacity; Title III: Public Health Security Preparedness; and Title IV: Pandemic and Biodefense Vaccine and Drug Development

**All disasters start  
as local incidents.**





# Timeline for Disaster Response



**Minutes**

**Hours/Day**

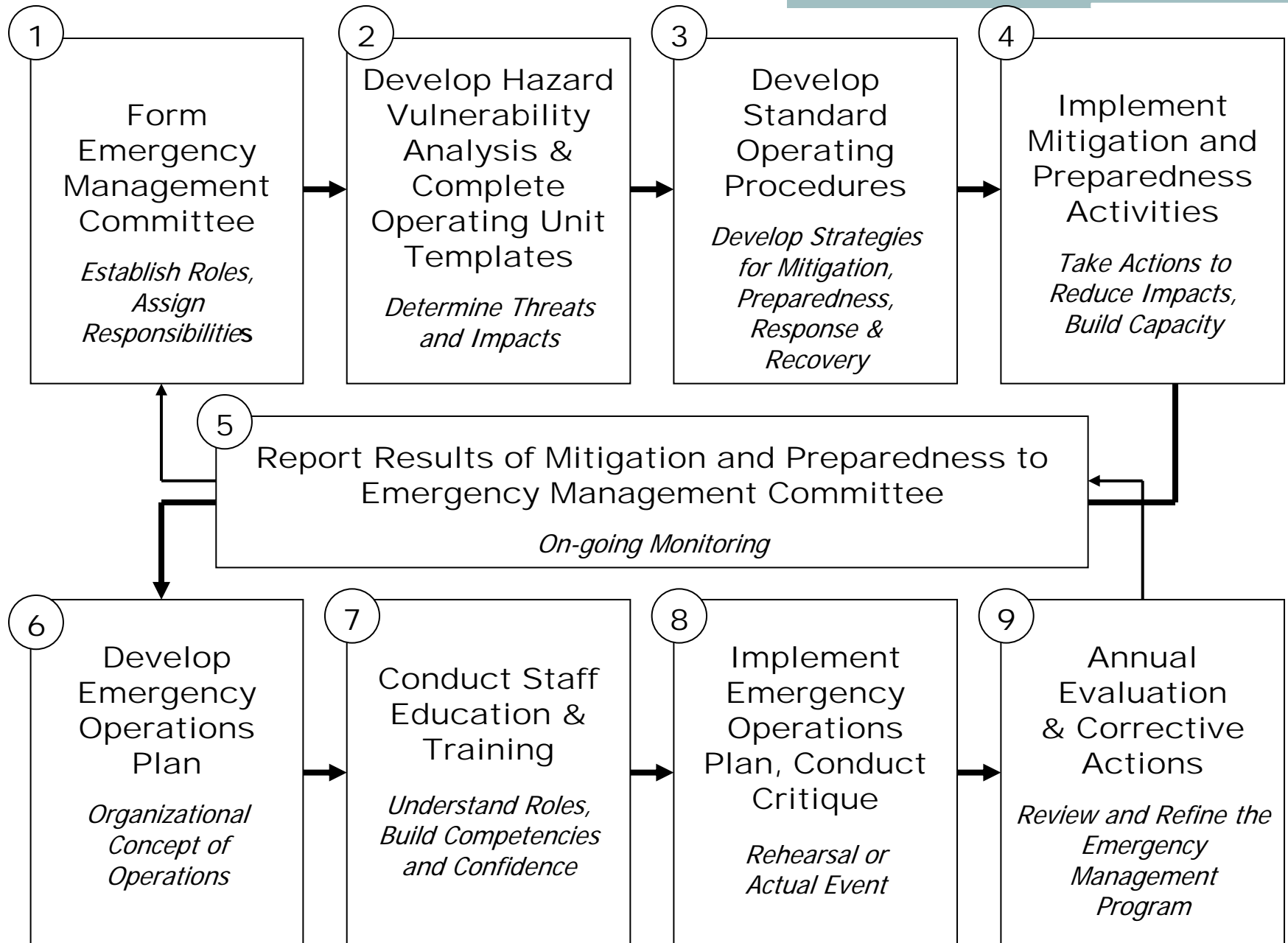
**Days**

**Federal assets in  
disasters with warning  
or high profile events.**

**Federal assets in  
disasters without warning.**

# EM Program Goals

- Continuity of care
- Safety of patients, families and staff
- Support to community (and Nation)
- Preservation of vital records / property



# Nine Step Process

## 1.) Form Emergency Management Committee

- CEO – Appoint Chair (e.g., emergency coordinator) and members representing key ICS/IMS functions.
- Establish regularly scheduled meeting times, goals, milestones and tasks.
- Record minutes to share with staff and brief to management (and board, as appropriate).
- EM Committee representative should also represent organization at external committees.

# Nine Step Process

## 2.) Conduct Hazard Vulnerability Analysis (HVA)

- 3 Categories:
  - Naturally Occurring
  - Human Related
  - Hazardous Materials

# HVA

- Assess:
  - Probability
  - Human Impact
  - Property Impact
  - Operational Impact
- Is no “required” HVA template
- Examples of widely-used template-accessed at:  
<http://www.gnyha.org/eprc/general/> (Kaiser Permanente)

# Nine Step Process

- 3.) Develop Standard Operating Procedures (SOPs)
  - SOPs based on HVA results
  - Include strategies on four CEM phases (mitigation, preparedness, response, recovery)

# SOP TEMPLATE

- Description of the event - impact on mission & critical systems
- Responsible units and personnel
- Notification
  - Within facility, system
  - Other - (gov, external)
  - OSHA
- Training, references, etc.
  - Texts and manuals on issues/procedures
- Review date





# Nine Step Process

## 4.) Implement Mitigation and Preparedness Activities

- Mitigation activities – e.g., building repairs, utility checks, safety procedures
- Preparedness activities – e.g., training, supply inventories, agreements to build capacity

# Nine Step Process



## 5.) Report Results of Mitigation and Preparedness to Emergency Management Committee

- Committee should monitor and direct activities.
- Conduct briefings & updates to management.
- Make recommendations to improve EM Program.

# Nine Step Process

## 6.) Develop Emergency Operations Plan (EOP)

- Applies ICS/IMS concepts throughout
- EOP focus is on response / early recovery
- Includes a Base Plan, Concept of Operations (organization's mission / actions during response and recovery) and Systems Description (organization of assets during response / recovery)

# EOP Components

- EOP Base Plan – Purpose, scope, policies, situation, planning assumptions, concept of operations
- Functional Annexes – Aligned with ICS functions
- Support Annexes – e.g., EOC set-up, evacuation
- Incident–Specific Annexes – e.g., infectious disease outbreak, flood, winter storm

## EOP (cont.)

Attachments to Annexes may include checklists and brief guidance / documents.

Examples:

- Mobilization checklist
- Call-back roster
- Job Action Sheets
- Business Continuity Plans

# Nine Step Process



## 7.) Conduct Staff Education and Training

- All staff should be trained on potential roles in competency-based emergency management. (Also—All should be familiar with EOP, location of procedures, activation processes, etc.)
- Those expected to perform ICS/IMS functions should take IS 100, 200, 700 and 800. Access these and others : <http://www.fema.gov> and through local/State depts. of health and EMAs.

# Nine Step Process

## 8.) Implement EOP; Conduct Critique

- Exercise or actual event
- Successful exercise includes:
  - ✓ Assessment of need (HVA, regulatory guidance, past After-Action Reviews, external involvement, EOP review, personnel/facility changes)

# Nine Step Process

## 9.) Annual Evaluation and Corrective Actions

- Review and revise EMP
- Address exercise (or actual event) AARs, training programs, competencies, HVA, SOPs, EOPs, interface with community and external agencies, formal agreements, staff roles and facility's/system's mission and roles

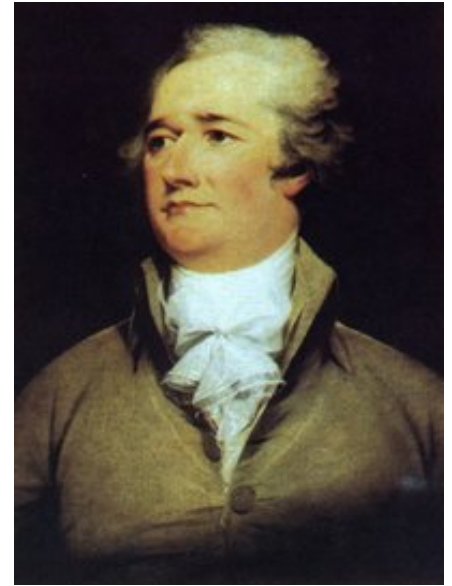


# EMP Should Be:

- All-hazards
- Comprehensive Emergency Management
- Dynamic and continuously updated
- Compatible with standard EM concepts, yet unique to the particular facility
- Include involvement with community / external
- Fully supported by management

**“Men often oppose a thing merely because they have had no agency in planning it, or because it may have been planned by those whom they dislike.”**

**Alexander Hamilton**



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***...How do we motivate others to support Emergency Management Programs?***

# Exercising, Educating, and Maintaining your Plans



# Why Do We Exercise?

- Regulatory requirements (JCAHO, OSHA, FEMA, NFPA)
- Past history and worldwide politics
- To evaluate our level of preparedness for a real disaster
- To improve our organizations capacity to execute its response plan
- People react they way they are trained



# Regulatory Requirements

- FEMA – requires exercise of functions, multi agency, EOC activated
- TJC - JC EM01.01.13
- OSHA – multi organizational drills
- NFPA – Standard 1600, 5.13.1.2.3
- State and local requirements

# Exercises

- How do I know what needs to be exercised?
  - Regulatory Requirements
  - HVA
  - Previous exercises
  - New staff, policies, facilities, equipment
- How do I know what kind of exercise?
  - Scope
  - Resources
  - Finances
  - Time
  - Liability and Safety Issues



# Homeland Security Exercise and Evaluation Program (HSEEP)

- HSEEP purpose:
  - The HSEEP is a capabilities and performance-based exercise program which provides a standardized policy, methodology, and terminology for exercise design, development, conduct, evaluation, and improvement planning
- HSEEP volumes can be adapted to a variety of scenarios and events (e.g., natural disasters, terrorism, technological calamities)
- Conforming to Best Practices
  - Adherence to the policy and guidance presented in the HSEEP Volumes ensures that exercise programs conform to established best practices and helps provide unity and consistency of effort for exercises at all levels of government

# HSEEP Requirements

- Conduct annual training and exercise plan workshops and maintain a multi year training and exercise plan
- Plan and conduct exercises that are consistent with entities multi year training and exercise plan
- Exercises are based on capabilities and their associated critical tasks (contained in EEGs)
- Develop and submit a properly formatted AAR/IP (HSEEP Volume III)
- Track and implement corrective actions identified in the AAR/IP



# HSEEP

## Discussion Based:

- Workshops
- Tabletop Exercises
- Games/Models
- Simulations

## Operations Based:

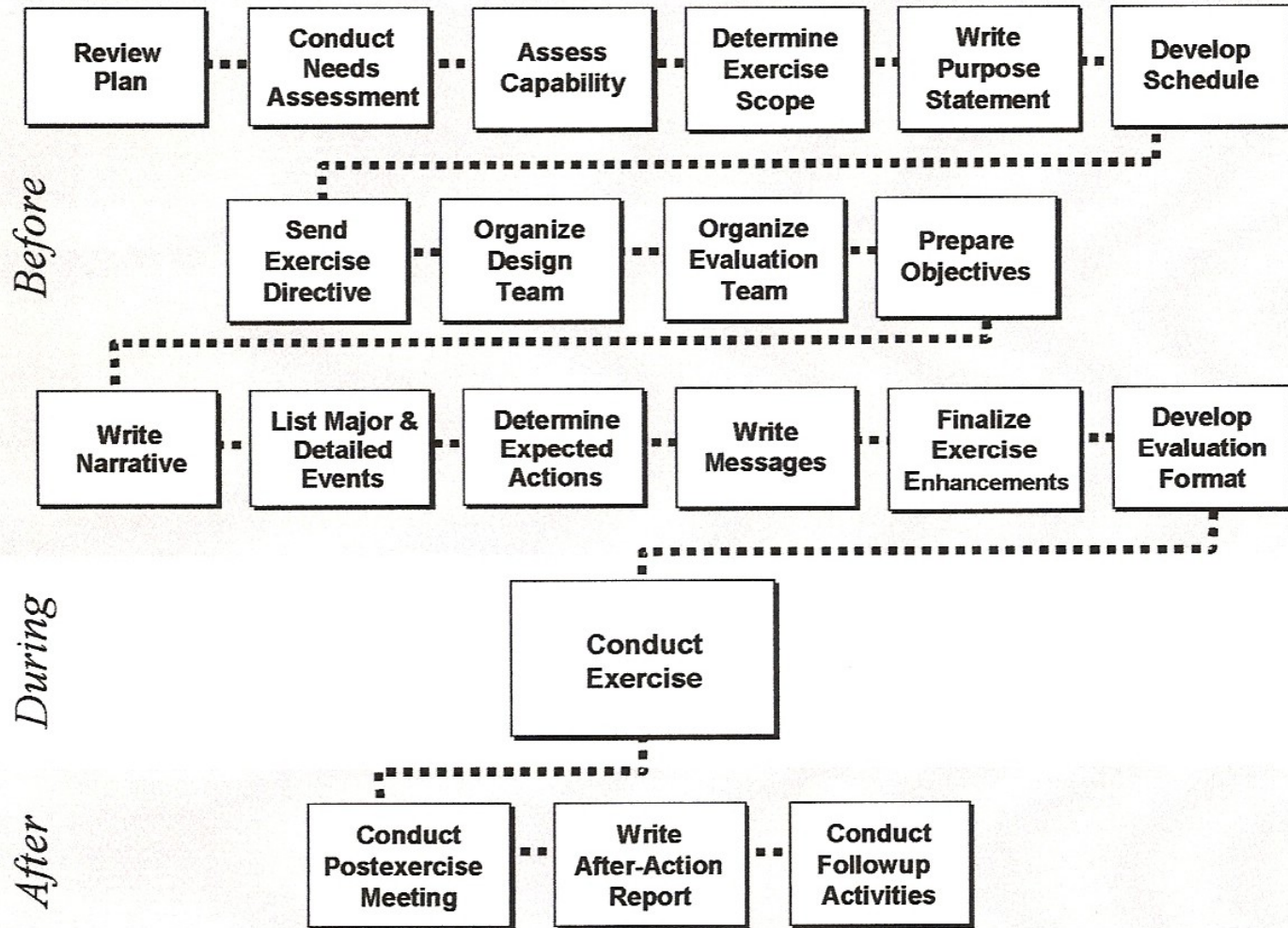
- Drills
- Functional Exercises
- Full Scale Exercises



# Developing an Exercise

- Decide size, scope, purpose and type of exercise
- Determine who needs to participate in exercise
- Gather Design Team
- Develop objectives for exercise
- Develop scenario and activities to test those objectives (exercise flow)
- Evaluation should match objectives

## Sequence of Tasks for a Successful Exercise



# Evaluation and The Improvement Plan

- Evaluation process is critical
- After Action Reports
- The Improvement Plan
  - Set review periods
  - Named responsibility
  - Should include “lessons learned”
  - Use Improvement Plan to help develop next exercise

# Exercise Tips

- Partner with others to obtain grants, share costs
- Look for consultants and training programs that “Train the Trainer”
- Command (management) needs to “buy in”
- If you don’t make improvements from “lessons learned”, don’t bother



**BREAK**

# Medical Surge



# Medical Surge

A sizable increase in demand for services compared to a baseline demand

Dimensions:

- Influx (volume rate)
- Event (type, scale and duration)
- Resource demand (consumption and degradation)





# Medical Surge Capacity

The ability to evaluate and care for a markedly increased volume of patients – one that challenges or exceeds normal operating capacity

- ✓ Refers to more than “just” beds, personnel, pharmaceuticals, supplies and equipment
- ✓ Is primarily about the systems and processes that influence specific asset quantity

# Medical Surge Capability

The ability to manage patients requiring unusual or very specialized medical evaluation and care

- ✓ Spans the range of specialized services (expertise, equipment, procedures, personnel)
- ✓ Not normally available at location where needed
- ✓ Patient problems that require special intervention to protect staff, patients and facility
- ✓ Includes functional needs and at-risk populations

# Type of Incident...

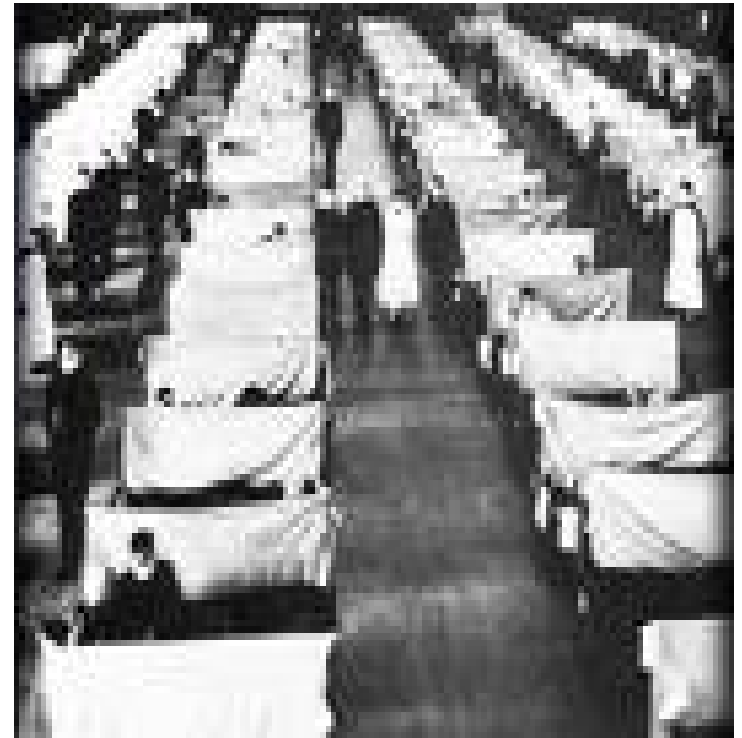
will impact medical surge capacity and capability requirements, resources and management

Implications of:

- Disaster with or without warning?
- Terrorist incident?
- Contamination?
- Infectious agent?
- Short or prolonged response/recovery?

# Other Issues Re: Surge

- Diversion
  - When to implement?
  - Who decides?
  - Plans/agreements
- Tracking
  - Patients
  - Resources



# 3 – S Medical Surge Concept ...

- Staff
- Stuff
- Structure
  - Infrastructure, facility
  - Command and management

# Resource Management



# Concepts and Principles of Resource Management

- Uniform methods of identifying, acquiring, allocating and tracking resources.
- Pre-arranged agreements and relevant sources.
- Credentialing of personnel resources.

# Resource Typing

- Classification of resources whether human or otherwise. In ICS, “type” refers to a designated resource’s capability. Type 1 is considered to be more capable than Types 2, 3, or 4, because of size; power; capacity; or, in the case of incident management teams, experience and qualifications.
- Resource typing also involves categorizing the resource by its kind (e.g., what the resource is, snow plow, strike team, etc.). Therefore, resource typing may involve “kind” and “type.”



# Mutual Aid

- An agreement between organizations that they will assist each other in an emergency
  - Resources provided following formal request
  - Terms can be in-kind or reimbursement
  - Organization providing personnel retains responsibility for pay, insurance, etc. though under operational control of requestor
- \* Are also MOUs, MAAs...usually “smaller” scale...(facility to facility), not necessarily legal document

# Personnel

- Certification – Competence through testing or evaluation –through discipline’s certifying entity (In ICS, can also apply to equipment.)
- Credentialing – Verification of minimum required training, experience, currency, fitness
- Privileging – Credentials and qualifications “match” specific incident’s needs – May be unique to specific incident or location

# Trends in Health Care

- Inpatient to ambulatory care
- Shorter stays
- Reduction in staffing
- Supplies ordered daily
- ??

# Ramifications for Disasters

- Reduction in capacities useful in large disasters
- More patients at home - depend on utility services
- “Just in time” delivery of supplies
- No “reserve” healthcare staff for disaster demands: e.g., medical surge, shelters

# Resources - Support of Medical Surge

- Beds
- Isolation Capacity
- Healthcare personnel
- Pharmaceutical caches
- Personal protective equipment
- Decontamination
- Behavioral health
- Trauma and burn care

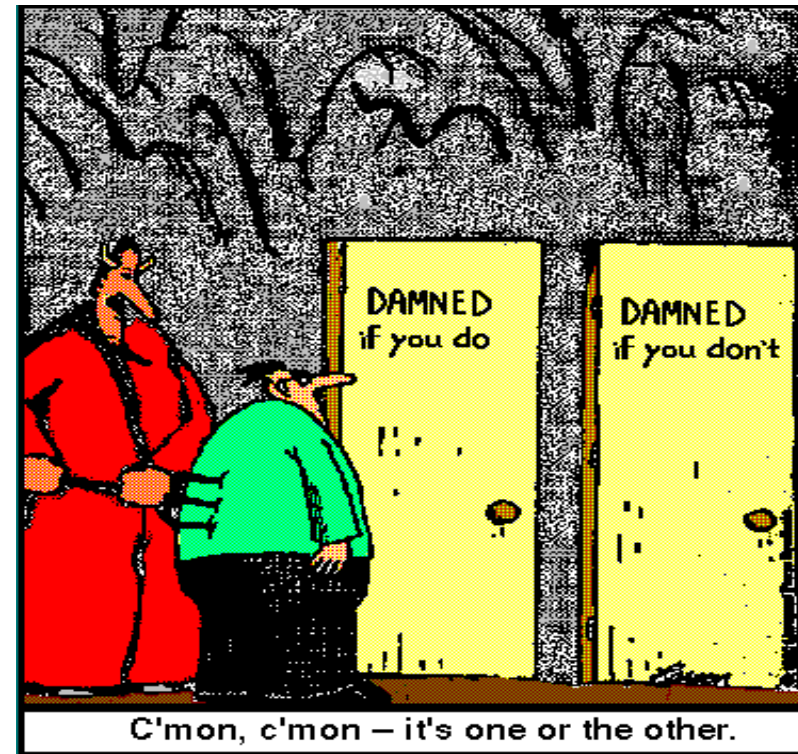
# Managerial Strategies to Achieve Surge

- Maintaining quality / increasing capacity
  - Re-distribution of authority and responsibility throughout the organization, as needed
- Plan for / apply Crisis Standards
- Stand-by resources, e.g., SNS, CHEMPAK, vendor, volunteer response personnel



# Problems with Efforts to Provide Medical Surge

- Problems with these focused approaches:
  - Cost
  - Shelf-life
  - Exclusive use
  - Difficulty in determining resources that may be needed



# The Need for a Management System

- The National Incident Management System (NIMS), if applied to all agencies and organizations that respond to disasters, will significantly improve medical surge capacity and capability and resource management through:
  - Enhanced internal coordination
  - More efficient use of standby resources
  - Optimal integration of “outside” resources.



# A little about Volunteer Management

- Why needed?

- Standards
- Safety
- Security



- Issues:

- Identification
- Credentials, specializations & training
- Liability
- Who screens, assigns and manages?

# Volunteer Management

- ESAR - VHP
  - ASPR directed
  - State Depts. of Health managed
  - Know your State's program
- Other potential volunteer sources
  - MRC, CERT (and specialty, e.g., CISD)
  - NDMS and ESF #8 (and 6 and 9)
  - Local / State initiatives
  - Other – e.g., faith-based

“There are usually enough resources...The problem is the *absence of appropriate management* of resources.”



*Katrina*  
*2005*

# Alternate Care Facilities



# Potential Uses of an ACF

- Primary triage
- Primary care of victims
- Care of patients discharged “early” from hospitals
- Temporary nursing home care
- Functional needs care
- Ambulatory chronic care
- Shelter care
- Quarantine
- Palliative care
- Mass prophylaxis/vaccine distribution center

# Selecting an ACF

- Buildings of opportunity
  - Advantage of pre-existing infrastructure support
  - Schools, hotels, convention centers, surgery centers, community health centers
- Portable or temporary shelters
  - Flexible, but could be costly
- Identify/arrange site in advance

# Selecting an ACF

- Basic environmental support
  - HVAC, lights/power, plumbing, comms, etc.
- Space – patient care, families, pharmacy, food prep, storage
- Identify/arrange site in advance
- Security – establish and maintain
- Parking and access –patients, supplies, EMS

# Managing an ACF

- Command, control, communication - ownership”
- Decision process to open/activate ACF
- Staffing, supplies, equipment.
- Documentation of care
- Rules/policies
- Exit/demobilization
- Training and exercises





# **"Prepare and Prevent or Repair and Repent" Snowshoe Thompson 1894**



# Crisis Standards of Care for Use in Disaster Situations



# Crisis Standards of Care

- “Crisis standards of care” is defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster.

*Institute of Medicine - Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, 2009*

# Conventional to Crisis Care

Incident demand/resource imbalance increases →  
 Risk of morbidity/mortality to patient increases →  
 ← Recovery

	Conventional	Contingency	Crisis
<b>Space</b>	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
<b>Staff</b>	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.)	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
<b>Supplies</b>	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional reuse of select supplies	Critical supplies lacking, possible reallocation of life-sustaining resources
<b>Standard of care</b>	Usual care	Functionally equivalent care	Crisis standards of care <sup>a</sup>

Usual operating conditions

Indicator: potential for crisis standards<sup>b</sup>

Austere operating conditions

Trigger: crisis standards of care<sup>c</sup>





# EXPANDING CARE STRATEGIES

- Early discharge and elective procedure cancellations
- Medical Surge Plans
- Patient to staff ratios
- Cohorting patients/Doubling rooms
- Use of staff in different roles
- Mutual Aid Agreements (MAA)
- Home based care in cooperation with Public Health
- Expanding medical/non-medical agreements

# Acceptable Exceptions

- Granting of extraordinary powers (MSEPA)
- National Declaration (Incident of National Significance)
- EMTALA/HIPAA deviation
- Ability to extend healthcare facilities
- Waiver of licensure restrictions via EMAC's/ESAR-VHP
- Cohorting patients
- Reduced technology sophistication (O2 Sat monitor vs. telemetry)
- Expanding staff capacity
- Scope of Practice - Just in Time Training

# Grey Areas

- Infection control standards (reusing needles and disposable items)
- Working outside the scope of practice
- Alternative care means
- Safety and health standards (universal precautions)
- “Expectant” casualties



# Prioritizing Care

- Field triage in MCI's is based on most survivable, not most critical (greatest good vs. quality of life)
- AMA's model – likelihood and duration of benefit, change in quality of life, urgency of need, amount of resources required
- AHRQ – patient need, potential to return to baseline state, overall resources needed by patient, age and functional assessment, underlying health, prognosis

# Prioritizing Care in Disasters

## AMA's model

- change in quality of life
- likelihood and duration of benefit
- urgency of need
- amount of resources required

## AHRQ

- patient need
- potential to return to baseline state
- overall resources needed by patient
- age and functional assessment
- underlying health
- prognosis

VS.

## At Risk Populations

- least likely to benefit
- benefit duration the shortest
- require most resources
- least likely to return to baseline
- poorest functional assessment
- poorest underlying health
- rank lowest in functional assessment
- age will be mostly elderly
- poorest prognosis

# Palliative Care

- To provide the greatest comfort and minimize suffering to those whose lives will be shortened
- Palliative care is **not** abandonment, euthanasia, or hastening of death

Palliative care patients might be:

- Those expected to die (too sick/injured to live)
- Already existing palliative care population
- Vulnerable population who become palliative care due to lack of resources during or after event

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# Legal and Ethical Issues



# Ethics?

- A system of moral principles or values
- The rules or standards governing the conduct of the members of a profession
- The study of the general nature of morals and of the specific moral choices made by the individual in his relationship with others
- Morals vs. ethics

# Ethical vs. Legal

- Can a thing be legal and not ethical?
- What are examples of law and ethics not coinciding?
- What happens when the law and ethics clash?
- When has this occurred in medicine? In disasters?

# Formulating Legal Principles

- Employ the least restrictive means
- Equitable, necessary and relevant
- Provide reasonable measures for compliance (second languages)
- Establish mechanisms to review decisions and allow for due process
- Transparency



# Individuals Rights vs. Public Good

- Refusal to cooperate with evacuations, quarantine, immunizations
- Civil and constitutional liberties – right to assemble, freedom of speech, travel
- Respect for cultures and customs (recovery of dead after Katrina)
- Confidentiality issues (HIPAA) in disasters
- Fairness to All? (VIP's)

# Duty To Provide Care

- Do healthcare providers have a social contract, assumption of risk?
- Involuntary immunization
- Worker's Compensation and liability
- Labor laws, unions, subcontractors

## AMA Code of Ethics

1847 - 1977

"... in regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is [physicians'] duty to face the danger . . . even at the jeopardy of their own lives."

# Hospitals Duty to Provide Reciprocal Care

- Consider staff safety and well being
- Provide for family concerns
- Provide liability and other protection for healthcare workers and volunteers
- Discuss issues with staff before the disaster. EDUCATE STAFF



# Other Countries

- Family involvement in care
- Public relies less on government support
- Standard of care differs
- Customs, cultural, and religious beliefs
- Civil liberties viewed differently – state vs. individual rights



# Be Proactive

- Understand your legal environment - regulatory requirements
- Understand your emergency management plans
- Clarify the process for leadership. Identify decision makers and lines of authority
- Discuss potential ethical and legal issues that could arise before they happen

# Work Together

- Build and maintain relationships (MOUs, MAAs)
- Establish clear channels of communication to link the public health community
- Establish state, regional and local multi-agency coordination
- Devise, model and exercise response plans as a community
- Involve media in planning process
- Involve the legal and ethical experts



# Work With the Public

- Educate public
- Understand your special needs populations
- Give public tools to cope in a disaster
- Keep the public informed during a disaster



# Mass Fatality Planning





# Mass Fatality

- Situation where more deaths occur than can be handled by local medical examiner/coroner resources, and may overwhelm state's mutual aid system and requires extraordinary support from state, federal, and private resources
- Medical examiners and coroners make up medico-legal death investigation system and are lead agency in mass fatality management
- Ultimate purpose is to recover, identify, and effect final disposition of deceased in a timely, safe, and respectful manner
- Covered under ESF #8 of NRF
- Mandated for ASPR funding under the Hospital Preparedness Program (objective #3)

# Healthcare Role in Mass Fatalities

- Hospitals may have to hold bodies until medical examiners can take them
- Infection control and security issues
- Need to understand forensics principles (chain of custody, preservation of evidence)
- Public Health will be involved in investigation (epidemiology) if a public health crisis



# Unique to Mass Fatality

- Emotional toll on bereaved and loved ones
- Need to respect cultural and religious beliefs
- Media attention
- Staff stress
- Politics
- Resources



# Setting Up a Mass Fatality Plan

- Involve all potential stakeholders – identify relationships of jurisdictions
- Plan must be scalable
- Build on cooperative relationships and MOUs
- Train people on the plan and exercise your plan
- Identify expectations of plan (be realistic)
- Determine scope – large scale may need DMORT teams

# Template of Mass Fatality Plan

- Identify responsible agencies and parties
- Specific command, control structure, and authorities
- Define criteria for activation
- Identify decedent operational areas
- Formulate guidelines for decedent operational areas
- Provide logistics' system for supplies, staffing, and facilities
- Provide guidelines for safety, infection control, and other health threats
- Describe how plan will be maintained, updated and exercised

# Hot Topics

- Presidential Policy Directive # 8
- Healthcare Emergency Management Competencies
- Whole Community Concept – Diverse Populations
- Functional Needs Support Services
- At-Risk Populations
- Healthcare Coalitions
- Focus on Resilience
- Other ??

# QUESTIONS?

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