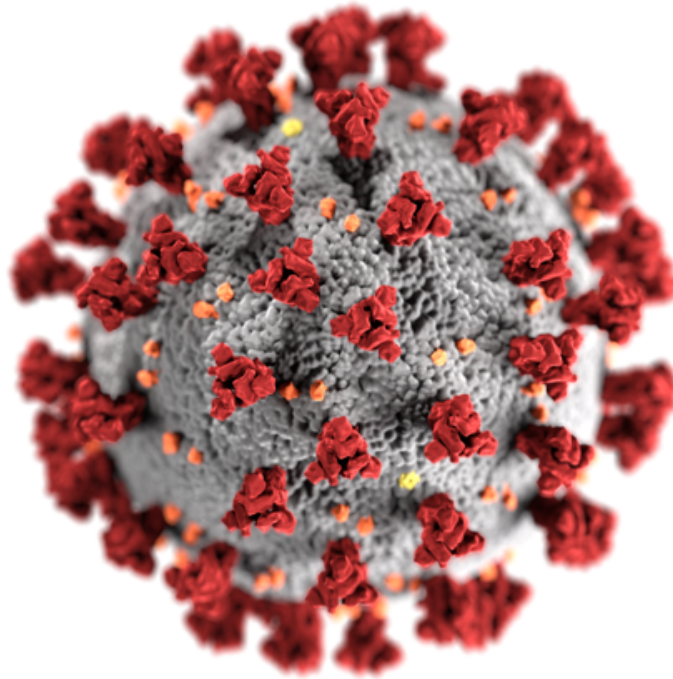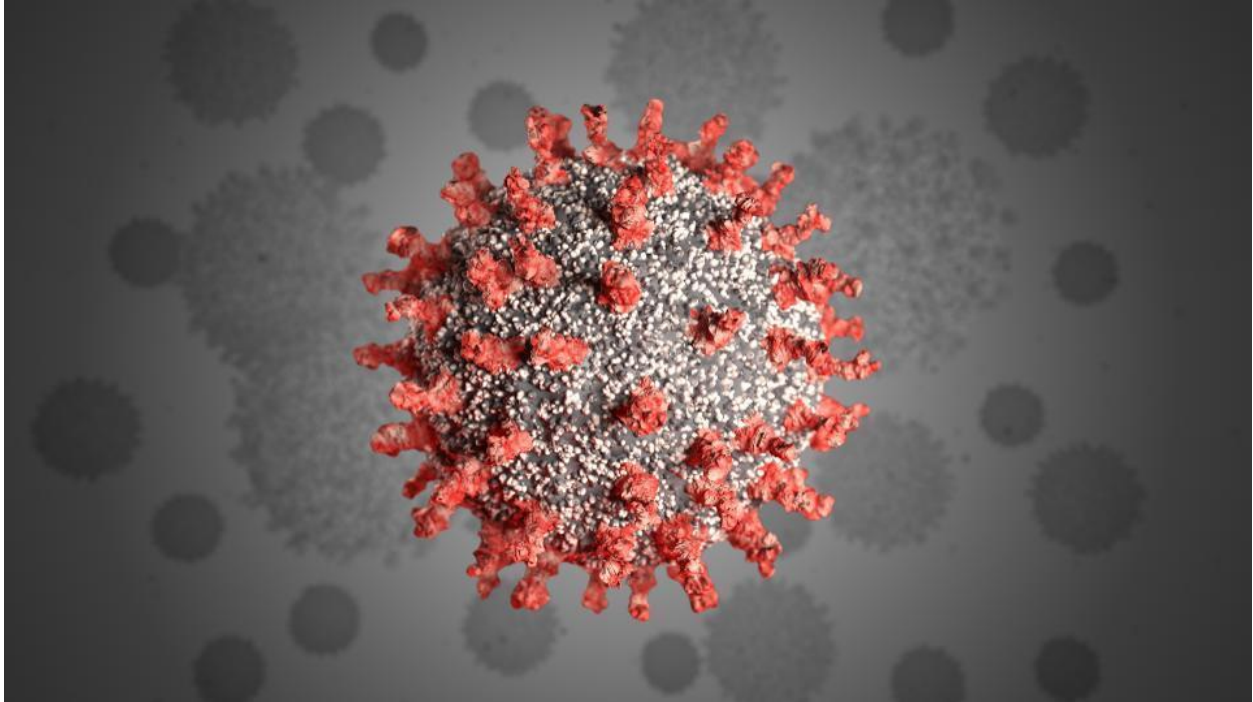# LARGE SCALE HOSPITAL
COVID-19 Emergency Response Plan

THIS COVID-19 PLAN TEMPLATE AND SELF ASSESSMENT DOCUMENT
FOR ACUTE CARE HOSPITALS WAS PREPARED AS A PUBLIC HEALTH SERVICE
BY
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In Fulfillment of their Graduate Studies Course Requirements
GU-5150: Emergency Preparedness for Healthcare Organizations
NYU School of Global Public Health, New York, NY.

July, 2020

COVID-19 Pandemic Disaster Plan for Large Scale Hospitals

<Hospital Name Here>

<Address>

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Preface

The National Institute of Allergy and Infectious Diseases defines coronaviruses as a large family of viruses that usually cause mild to moderate upper respiratory tract illnesses, such as the common cold, or serious to life threatening infections such as pneumonia or acute respiratory distress syndrome (ARDS). This type of virus can often be traced back to animal species, such as camels, cats, and bats. Although it is rare for animal coronaviruses to infect humans and then further spread through human-to-human contact, there have been well-known instances of zoonotic infections with coronaviruses in recent years, such as the SARS outbreak of 2002 and the MERS outbreak of 2012.

In mid-December, 2019, multiple cases of pneumonia of an unknown origin began to appear in Wuhan City, located within China's Hubei Province. Those who fell ill from the virus had visited a live animal market in Wuhan, China. There is controversial evidence regarding the spread of this coronavirus type from animals to humans that is believed to have originated in Wuhan, China. This new virus was later identified as a novel coronavirus. On January 30, 2020, the World Health Organization (WHO) officially declared the outbreak of this novel coronavirus a "public health emergency of international concern," which is a designation reserved for extraordinary events that threaten to spread internationally. This announcement came after tens of thousands of cases had been reported by Chinese health officials, with spread extending to several regions and further spreading within countries around the world. On February 11, 2020, the virus was named "SARS-CoV-2," while the disease it causes was named "coronavirus disease 2019" (abbreviated "COVID-19"). On January 31, 2020, Health and Human Services Secretary, Alex M. Azar, declared a public health emergency (PHE) for the United States due to SARS-CoV-2. Despite this PHE declaration, the CDC initially considered the immediate risk of COVID-19 infection low for the general American public up until early March. The first case of suspected local transmission in the United States in the state of California occurred on February 26, 2020 and the first COVID-19 fatality occurred on February 6, 2020.

Due to its highly contagious nature, the global incidence and mortality rate of COVID-19 increased rapidly in the following weeks.[1] This alarming widespread incidence of COVID-19 resulted in a pandemic declaration on March 11, 2020, following an unprecedented spike in global infections, particularly in Italy, Spain, and the U.S. The world would immediately transform through stringent lock down policies and quarantine of individuals at risk of infection because of exposure or placed in isolation because of known infection. The world was suddenly confronted with these stay-at-home orders as well as uncertainty in all aspects of human life. The New York metropolitan area quickly became the epicenter of U.S. infections given its population density, crowded apartment buildings, proportion of those living below the poverty line, and daily use of a mass transit system with over 8M riders per day. Unsurprisingly, a disaster of this magnitude was only amplified in a major city, like New York City (NYC), as it serves as a melting pot for many individuals and is a central location for many functions. NYC

welcomes 65.2 million tourists each year, with 51.6 million being domestic travelers, and 13.5 million being international travelers. Tourists from China and other Asian countries comprise the second highest rate of visitors to NYC, at approximately 1.1 million individuals per year. As of July 12, 2020, there have been 3.3M cases and nearly 140K deaths overall in the US, with NYC accounting for 223K cases and nearly 23K deaths. More than half the states are seeing a rise in the number of cases and several have seen record numbers of cases and deaths. As the phased re-openings continue in many parts of the country, marginalized and vulnerable minority members of the community continue to be disproportionately at risk of exposure and infection, and it is believed that large numbers of these and other patients will eventually need to be hospitalized, thus requiring sustained surge capacity responses from hospitals. Those most vulnerable to severe outcomes remain the elderly and those with compromised immune systems. If COVID-19, mimics the Spanish Flu of 1918, there is increased likelihood of a second wave of this pandemic as well. Therefore, a coronavirus-related disaster plan is necessary for all hospital settings throughout NYC and wherever COVID-19 Plans are needed in the US and the world. This is even more critical and warranted in major medical centers where the population served is often of a lower socioeconomic status, historically disenfranchised, has poor access to quality nutrition, and has the highest rates of comorbidities such as asthma, obesity, diabetes mellitus, hypertension, and cardiac disease, making them more likely to succumb to complications of COVID-19. These secondary complications or infections along with management of these primary diseases leads to thousands of deaths per year and costs the U.S. healthcare system billions of dollars annually. Reducing health disparities is critical for the health and wellbeing of all citizens, and societies as a whole, and is never more so than during a pandemic event.

This plan guidance is provided to help facilities that are developing or updating COVID-19 Disaster plans.

Signature Pages

The undersigned staff concur with the jurisdictional and departmental features of the following COVID-19 disaster plan guide. By signing below, they agree to the inclusion and implementation of the COVID-19 plan as an official *<hospital name>* Emergency Operations Plan.

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Name   Date

CEO, *<hospital name>*

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Name   Date

Director of Emergency Management, *<hospital name>*

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Name   Date

Commissioner of Health, *<X State>* DOHMH

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Name   Date

Commissioner, *<X City>* DOHMH

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Name   Date

Commissioner, *<X City>* Emergency Management

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Name   Date

Senior VP & Executive Director, *<XYHA>*

Mission Statement

Here is an example Mission Statement, please add your own Hospital's Mission Statement.

From its founding in 1884 by Jewish philanthropists as a care facility for patients with chronic illnesses to its status today as one of the largest healthcare systems in the nation, *<hospital name>* has been at the forefront—translating scientific breakthroughs into diagnostics and treatments that save lives, educating the next generation of compassionate healthcare professionals, and combining our deep commitment to the community with nationally-renowned expertise. The institution has continued to expand its medical center in order to meet the needs of the community head-on, in order to honor its **core mission** which is to heal, to teach, to discover and to advance the health of the communities we serve. Our mission is exemplified in our exceptional, compassionate care and dedication to improve the well-being of those we serve.

In addition to being a multi-faceted hospital dedicated to meet the growing needs of their community residents, *<hospital name>* has partnered with the Bronx Emergency Preparedness Coalition and New York State's Division of Homeland Security and Emergency Services to do community outreach training sessions to teach citizens to have the tools and resources to prepare for any type of disaster— natural or manmade—and to respond appropriately, including developing a family emergency plan and a stock of emergency supplies. This vital partnership is also beneficial to our ambulatory clinics and in-patient facilities in assisting and ensuring appropriate disaster mitigation management, preparedness, response, and recovery programs are in place to ensure that the institution's standards of service and quality of care are met during a disaster, emergency, or potential epidemic or pandemic.

Statement of Purpose

The purpose of the present document is to establish a detailed **COVID-19 Disaster Plan** for implementation throughout *<hospital name>*'s Main Campus. Like all disaster plans, this document sets out to outline the policies and procedures upon which an organized COVID-19 emergency response can be executed, addressing elements and contingencies specific to the novel coronavirus. It will allow us to have a culture of preparedness to join the fight to eradicate this disease and prevent unnecessary loss of life, income, and business. Guidelines are defined to inform *<hospital name>*'s Team on the necessary actions to be carried out during an emergency situation involving COVID-19, including but not limited to: notification systems for staff and patients; roles and responsibilities for each department and its leaders; supply and resource needs and utilization; and hospital evacuation procedures.

Although *<hospital name>* currently has an emergency plan in place for **pandemic disasters**, one specific to COVID-19 has not been developed or implemented. The ultimate goal is for successful collaboration with local and state Offices of Emergency Management and Departments of Health, eventually leading to the of this COVID-19 Disaster Plan as an official document in *<hospital name>*'s inventory of institutional disaster plans.

Authorities

1. World Health Organization
2. CDC's COVID Response Corps
3. Centers for Medicare and Medicaid Services Emergency Preparedness Regulation
4. Joint Commission for Accredited Healthcare Organizations
5. Occupational Safety and Health Administration

Acronyms and Definitions

CDC	=	U.S. Centers for Disease Control and Prevention
COVID-19	=	Novel coronavirus disease identified in 2019
EHS	=	Emergency Health & Safety Service
EM	=	Emergency Management Team
EMC	=	Emergency Management Committee
EOC	=	Emergency Operations Center
ESF-8	=	Emergency Support Function
HAI	=	Healthcare-associated infection
HCS	=	Health Commerce System
HERDS	=	Hospital Emergency Reporting Data System
HFD	=	Healthcare Facility Directory
HICS	=	Hospital Incident Command System
HVA	=	Hazard Vulnerability Analysis tool
IAP	=	Incident Action Plan
JCAHO	=	Joint Commission
PHE	=	Public Health Emergency
PIO	=	Public Information Officer
WHO	=	The World Health Organization

Common definitions[1,2]

1. **COVID-19:** The name of the disease caused by the novel coronavirus, SARS-CoV-2, and is short for "Coronavirus Disease 2019

2. **SARS:** It is a common acronym used for Severe Acute Respiratory Syndrome which is an infectious disease with symptoms including fever and cough and in some cases progressing to pneumonia and respiratory failure

3. **Coronavirus:** A family of viruses that cause illness ranging from the common cold to more severe diseases, such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV)

4. **Case Fatality Rate:** An estimate of the risk of mortality from a contagious disease. The CFR is calculated by dividing the number of deaths caused by a disease by the number of cases of that disease in a given time period. The CFR is time and location-dependent, and many different factors can influence the CFR, such as speed of diagnosis of cases, health system capacity, age and other demographic characteristics, among others

5. **Droplet transmission/spread:** A mode of transmission for a contagious disease that involves relatively large, short-range (less than 6 feet) respiratory droplets produced by sneezing, coughing, or talking

6. **Community Spread:** Community spread refers to a process when the virus starts spreading in the general masses. Community spread is detected when a confirmed case of the virus is found without having a known origin. It happens when a person without any travel history or interaction with any infected person contracts the virus

7. **Incubation Period:** Incubation period refers to the time period required for the virus to develop symptoms in the body, i.e. time period between contracting a virus and emergence of its symptoms. The incubation period of COVID-19 is somewhere between 2-14 days

8. **Quarantine and Isolation:** Quarantine refers to separating and restricting the movement of people exposed (or potentially exposed) to a contagious disease. While isolation is Separating sick people with a contagious disease from those who are not sick to stop the spread of the virus

9. **Comorbidity:** It refers to a medical condition, in which a person has more than one disease at the same time. Cases of comorbidity have a higher risk of turning sensitive in case of COVID-19. For example, if someone has high blood pressure and is also diabetic, they have comorbidities and have a higher risk of developing complications

10. **Physical Distancing:** Measures taken to reduce person-to-person contact in a given community, with a goal to stop or slow down the spread of a contagious disease. Measures can include working from home, closing offices and schools, canceling events, and avoiding public transportation

11. **Flattening the curve:** Slowing a virus' spread to reduce the peak number of cases and related demands on hospitals and infrastructure. This allows healthcare services to better manage the same volume of patients

Facility Profile Document

Directions: Fill in the information in accordance with your specific hospital's information.

Hospital Name:	
Total Licensed Beds (Based on NDMS definition):	
Facility Information	
Address:	
Main Phone Number:	
Main Fax Number:	
Main Email:	
Affiliations	
JCAHO Accreditation	□ Yes □ No
Year of Accreditation	
Facility Affiliation	□ As part of a medical center/school □ Stand-alone or community □ Part of a regional hospital system □ Part of a national hospital chain □ Military or Government
National Disaster Medical System (NDMS) member?	□ Yes □ No
If YES - Site of Federal Coordinating Center (FCC)	
Is Facility located in a Metropolitan Medical Response System Region	□ Yes □ No □ Unsure
Important Contact Information	
Patient Condition Information	

Page Operator	
Emergency Department	

Hospital Staffing	# of FT/PT
Clinical	
Non-Clinical	
Licensed Practitioners	
Residents (if teaching hospital)	
Total Hospital Staff	

Non-Hospital or Satellite Clinics and Staffing	
Number of Clinics	
Clinic Staff	
Full-Time Staff	
Contract Staff	
Total Staff	

Helipad Access	
Facility has on-site heliport or helipad?	□ Yes □ No
If YES	
Capacity of helipad	Weight:
	Number of Pads:
Lighted	□ Yes □ No
Access?	
Support?	

How is it coordinated?	
Temporary helipad available?	□ Yes □ No
Landing zone maintained by?	
Crash Response provided by:	
Hospital Response Team (unit)	□ Yes _____ □ No □ Unsure
Local Fire Department (location)	□ Yes _____ □ No □ Unsure

Communications Plan

<mark>*<Hospital name>*</mark> utilizes the Hospital Incident Command System (HICS) to coordinate services and assign responsibilities during emergencies. The system is integrated with local, state, and federal incident command system processes. HICS allows the center to activate a command structure to respond to the specific needs of an event. All positions of the HICS organization chart are covered at all times to ensure emergency management capabilities 24-hours, 7 day/week. At the recommendation of the Director of Infection Control, the Hospital Administrator will activate the Hospital Incident Command System (HICS) and convene the Coronavirus Planning and Response Team

Internal Communication

1. Center-wide Notification of HICS Activation

    The Incident Commander guides the Public Information Officer or designee for notifying the Center for HICS Activation. Overhead announcements will be made for immediate life safety threats. Staff and LIPs may be notified using methods like Center-wide email, intranet announcement, and messaging to personal communication devices (e.g., pagers, walkie-talkies, and cellular telephones). For mass notification, EzNotify will also be used. As an alternate communication method, the staff may be notified through radio or television by the Public Information Officer, if indicated.

2. Staff Communications during Emergencies

    The staff is strictly advised to limit phone communications for only disaster-related issues, and communications related to critical and life safety. The operator should not be

contacted by call for information related to the incident. RED disaster phones will be used during the failure of regular phone systems. The Emergency Management website contains the Red Phone directory of numbers, and all the departments are recommended to keep a paper copy ready for reference

External Communication

1. Notifying & Communicating with External Authorities

All appropriate external authorities will be notified to facilitate effective response, continue operations, and recovery from an emergency that disrupts the normal patient care and/or business operations of the organization. On the activation of the disaster plan, the appropriate external authorities and community partners will be notified as required.

2. Coordinating with Healthcare Organizations and Public Safety Agencies

For minor incidents, *<X City>* Emergency Management (*<X City>*EM) will activate its Situation Room. For major incidents, *<X City>* Emergency Management (*<X City>*EM) will activate the full Emergency Operations Center (EOC) which is a central location for emergency management. Senior officials from City, State, and Federal agencies and appropriate private entities can meet at EOC and discuss coordinating response efforts, making decisions, and obtaining and providing information. Member agencies and organizations of Emergency Support Function (ESF-8/Health and Medical) are requested to participate in the process if an incident is expected to involve and/or affect the health care sector. ESF-8 will share information, coordinate resource requests, and address public health and medical needs. Representatives from different associations or agencies who represent various components of the sector form the City's ESF-8. *<X City>*EM's 24-hour emergency phone number is *<#phone number>*. A number of the entities have dedicated phone numbers at the EOC

3. Communicating with Healthcare Organizations and Public Safety Agencies

Emergency Contact Directory is maintained, updated and disseminated quarterly by *<XYHA>* which contains contact information for key roles at each member hospital, as well as for local, State, and Federal response agencies. *<Hospital name>* keeps its electronic and hard copy in HCC. The Center and other Healthcare organizations within the geographical area of the facility have a direct Mutual Aid Agreement (*<X City>*PH) through which they communicate and work together. They also participate through planning and exercises collaboration and sharing resources and critical information. (One *<Hospital name>* covers contact information for city wide and neighboring hospitals)

<Hospital name> informs jurisdictional authorities for patient occupancy and evacuation needs (including number of patients), and other related needs. The information is provided to the DOH using HERDS surveys sent to health care facilities through HCS,

and also through communication with regional offices. Municipally authorized private disaster relief agencies will be communicated via coordination with the City's EOC (ESF 8 desk or HEC), and it will be managed through Planning and/or Operations Section of *<Hospital name>* Hospital Incident Management System depending on the specific purposes.

The *<X State>*DOH will activate the HealthCare Evacuation Center (HEC) when multiple health care facilities need to evacuate patients. Occupancy levels and resource needs in these facilities will be monitored by HEC staff. Necessary information will be shared with the HEC via a web-based survey tool. A request for assistance can also be made by *<Hospital name>* in real time by contacting the appropriate representative at ESF-8 Health and Medical within the EOC, or through the Hospital Emergency Radio Program

4. Communicating Patient Information

Patient evacuation may be necessary during an emergency affecting life safety, possibly in case of fire, flooding or other infrastructure failure which can impact and disrupt the operations necessary for clinical care and a safe environment. *<Hospital name>* has an electronic and, a manual paper process (in case of IT failure), to transfer patient information.

*<Hospital name>*updates inter-facility transfer forms and patient face sheets that are used for day-to-day transfers for their effective use during a large-scale patient evacuation to ensure that they have critical demographic and clinical information throughout the transport and relocation process for evacuating patients *<Hospital name>* also has policies and procedures regarding the release of patient information following HIPAA privacy rule and applicable State privacy laws

5. Communicating with Patients & Family Members

Establishment of a family support center will be done that will facilitate communication with the family members of patients. The center will coordinate with patients' family members for their needs, for providing information on the location of patients, and for providing critical incident stress debriefings. The provision of information and human services for family members of patients will be coordinated by the Patient Information Officer and the Human Services Unit Leader. For tracking patients, the Patient Tracking Unit Leader will coordinate with the family support center. In case the emergency contact family member is not with the patient, the recent location of the patient will be provided to them once they are moved or evacuated. The protocols will be followed for Translation Request service if translation is required during the emergency event.

6. Communicating with the Media & the Public

The Public Information Officer (PIO) is responsible for public information and communicating with media during any event related to or involving the Center. The PIO already has working relations with the local media and public health agencies. The PIO/Joint Information Group will share the information as a unified message to the area. In case the Center is the only one who is involved during an event, the communication with the community or local media will be made by the PIO in the Center's Command Center

7. Communicating with Supply Chain Vendors

A list of purveyors is maintained by the Center. This list of vendors, contractors, and consultants that can provide necessary services before, during, and after an emergency event, and the Procurement, Director of Patient Support Services and the Director of Emergency Management maintain them. For facilitating the services during a community event, there is a Memoranda of Understandings (MOUs) to help, when necessary.

8. Redundant Communication Capabilities

Along with the Red Phone capability, the Center's Telecommunications Department also keeps alternate communication systems and devices which are tested regularly. The systems include cell phones, radios and Vocera devices. These devices can be moved to clinical floors and given to team members of HICS. *<Hospital name>* has a mass communications tool for on and off duty staff called EzNotify which can communicate with multiple devices at the same time. A Communications Plan that describes all communications capabilities is maintained by *<Hospital name>*

9. Alternate Patient Care Areas (ACS) Communications

An alternate care site is established during the event. The Center's Command Center (HCC) will communicate with the Alternate Care Site (ACS). Assessment of ACS will be done by the HICS IS Chief and Telecommunications Unit Leader, and they will also direct the establishment of IT and tele-communication capabilities

Mutual Aid Agreements

<Hospital name> participates in community-wide emergency planning with the *<partner organization name>* and other public health and municipal emergency response agencies

<Hospital name> will protect and care for its patients and assist its mutual aid partners, *<name of partner 1>* and *<name of partner 2>*

Logistics and Facilities and Back-up Plan

Communication Abilities	a. Number of backup walkie talkies _____
	  i. Common Walkie Talkie Lingo
	    1. 10-9 = Repeat message
	    2. 10-10 = Transmission completed, standing by
	    3. 10-11 = Talking too rapidly
	    4. 10-12 = Visitors present
	    5. 10-20 = My location is _____
	    6. 10-91 = Talk closer to the microphone
	    7. 10-93 = Check my frequency on this channel
	    8. 10-94 = Please give me a long count (1-10)
	    9. 10-99 = Mission completed, all units secure
	    10. 10-200 = Police needed at _____
	  ii. Common Color Code
	    1. Code Red- Fire
	    2. Code Blue-Medical Emergency(adult)
	    3. Code White-Medical Emergency (pediatric)
	    4. Code Pink -Infant Abduction
	    5. Code Yellow- Bomb Threat
	    6. Code Orange- Hazardous Spill
	b. Emergency contact list can be located in _____

Incident Response Team	a. Incident commander \<name and contact #\> b. Finance Coordinator \<name and contact #\> c. Administration Coordinator \<name and contact #\> d. Information Technology Coordinator \<name and contact #\> e. Human Resources Coordinator \<name and contact #\> f. Public Relations and communications Coordinator \<name and contact #\> g. Programs and Grants Coordinator \<name and contact #\>
Emergency Power	a. Emergency power duration is hours.
	b. Emergency power generation capability is:
	c. Emergency power generator is located: (physical location) At grade Above grade Below grade

	d. Emergency power generator was last tested:
	e. How often is it tested?
	d. Do you have: None Partial Load of Operations Full Load of Operations
	e. How long can it be run without refueling?
	f. Does it power only Life Safety? Yes No
	g Does it power Life Safety and full facility? Yes No
	h. Does it power elevators? Yes No
	i. Does it power the critical branches? Yes No
	j. Load shed?
	k. Preservation of food?
Supplies and Resource	a. Spill- clean up kits can be located in _____ b. Gloves located in _____ c. Emergency stock of N-95, KN95 masks (___ ct) located in _____ d. Emergency stock surgical masks located in _____ e. Level A/B hazmat suits located in _____ f. Have the suppliers been notified yes no
Water Supply	a. Source of facility water is: community facility
	b. Secondary source of water if primary source is cut off: Yes No Capacity:
	c. Can you attach non-potable water to your facility? Yes No

Fuel	
	a. Facility has _____ days of fuel on-hand.
	b. How does the facility get additional fuel?
	c. How long can boilers run?
	d. What is the amount of time (in hours) that boilers can operate w/o refueling?

Patient Care Capacity

	LICENSED BED CAPACITY	AVERAGE STAFFED BEDS (Average beds actually in use and staffed in last 6 months)	BEDS WITH NEGATIVE AIR FLOW (For use in respiratory isolation)	MONITORED BEDS (Beds equipped with cardiac and vital signs monitors)	VENTILATORS (Number of ventilators in each unit) Owned or rented	SURGE CAPACITY (Number of additional beds that can be staffed & equipped w/in 12 hours)	Negative Pressure Beds/ Isolation
Skilled Nursing Facility Care							
Ambulatory							
Behavioral Health							
Burn							
Emergency Department							
Intensive Care, Medical							
Intensive Care, Neonatal							
Intensive Care, Pediatric							
Intensive Care, Stepdown							
Intensive Care, Surgical							
Medical-Surgical							
Nursery							

Obstetric (Ante/post-partum, labor, delivery)							
Operating Room							
Psychiatric							
Pediatrics							
Geriatric							
Post Anesthesia Care							
Oncology/Immunocompromised							

Other Hospital Capacities

Laboratory	Lab Biosafety Level: b 1 2 3 4
Trauma level designation	I II III IV V (Tick one) Certified by ACS OR State
Ambulance/ EMS	Does the hospital lease or own an ambulance? Ground OR air
Morgue	Capacity:
Transportation	List types and number of vehicles facility owns /operates for patient transport (not including EMS rigs)
Portable cardiac monitors	
Portable X-ray	
Portable sonograms	
Portable ventilators	
Inclusive of disposable	

Automatic resuscitation devices	
Total number of ventilators	
Average % of ventilators in use within last 6 months	
Number of isolation beds for COVID-19 patients	
No. of portable and dedicated dialysis machine	_____ portable _____ dedicated
No. of PPE in stock	

Facility Readiness

Respiratory Protection Equipment Status	a. Percent of Clinical staff with Medical Clearance to be Fit tested: b. Percent of total clinical staff with fit-testing for N95 or N99 respirators annually: c. Percent of non-clinical staff with fit-testing for N95 or N99 respirators annually: d. Quantity of surgical masks for daily use: e. Quantity of powered air purifying respirators:
Education and Training	a. Percent of total staff who have completed disaster response/preparedness training: b. Percent of medical staff who have completed disaster response/preparedness training: c. Percent of nursing staff who have completed disaster response/preparedness training: d. Percent of total staff who have trained with facility's own disaster plan: e. Percent of medical staff who have trained with facility's own disaster plan: f. Percent of nursing staff who have trained with facility's own disaster plan:
Healthcare Services/ Surge Capacity	a. Surge capacity plans include strategies to help increase hospital bed capacity. b. Surge capacity plans include strategies for maximizing number of staff available for direct patient care

	c. A procedure has been developed for communicating changes in hospital status to health authorities and the public. d. STAFFING: A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential. e. POSTMORTEM CARE: A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased patients. f. Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.

Continuity of Business Operations

The plan could be activated in response to a wide range of events or situations – from a fire in the building; to a natural disaster; to the threat or occurrence of a terrorist attack. Any event that makes it impossible for employees to work in their regular facility could result in the activation of the Continuity plan.

a. Facility has a continuity of operations plan (COOP). ☐ Yes ☐ No	
b. Has COOP been exercised in the last 6 months? ☐ Yes ☐ No	
c. If no, when was the last time it was exercised?	
d. Facility has a business continuity plan ☐ Yes ☐ No	
e. What are the 3 priority functions restored first?	
f. There is a mechanism to track the use of financial resources? ☐ Yes ☐ No	
Cost Analysis Assessment: 1. What are the potential costs of downtime or a total business failure/hospital loss? Do you have up to date business insurance?	Please list amount here.
2. What is the cost of downtime per hour for each department?	Please list amount here.
3. What is the cost of downtime versus the cost of specific recovery solutions?	Please list amount here.
4. What are the findings of all annual assessments to the (insert each unit/position title?	Please report your findings here.

COVID-19 Pandemic Disaster Plan

5. Conduct successor training for all hospital organizational 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. (Tests & Training)	Please report cost of this task.
6. Train on the identification, protection, and ready availability of electronic, and hardcopy 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 Essential Records program?/Incident Command system? (Tests and Training)	Please report cost of this task.
Essential Functions: The critical activities performed by organizations, after a disruption of normal activities, which include missional essential function (MEF), primary mission essential function (PMEF), & National Essential Function (NEF)	Please list those activities.
Orders of Succession: What are the provisions for the assumption of senior agency offices during an emergency in the event that those in these offices or the office itself is unable to carry out its normal duties?	Please list those provisions.
Delegation of Authority: Has an individual (s) been assigned to authorize policy determinations and decisions for the medical facility, clinics, and other outpatient/ambulatory locations?	What are the name (s) of those individuals and up to date contact information (address, cell phone number, and email address)
Continuity Facilities: Besides the main medical facility, are there other locations that will be designated or assigned to carry out essential functions, particularly in a continuity event? **Continuity/Alternate Facilities are not representative of only offsite locations, but also the non-traditional medical functions of the organization, i.e-visiting nurse services, telemedicine, etc.	Please list those locations.
Continuity Communications-Are there alternate communication methods in place that will have the capability to perform essential functions, in conjunction with other agencies, under **all** conditions?	Please list those communication methods.
Vital Records Management: For identification, protection and ready availability of electronic and hard copy documents, references, records, information systems, data management software and equipment needed to support essential functions during a continuity situation. Are there enough paper charts available? Is there an alternate plan for patients to communicate with their provider and see their results? Is the main provider still able to communicate with sub-specialties to continue optimal multi-disciplinary care?	If yes, please list what those measures are. If no, please list why not and plan in place to meet the requirement.
Human Capital: Are there emergency employees and other special categories of employees who are activated by an agency to perform assigned response duties? Do you have an effective, sustainable, and feasible deployment plan?	Please list plan here.

Devolution of Control and Direction- Is there an alternate 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?	Please list plan here.
Reconstitution: What is the process by which surviving and/or replacement agency personnel resume normal agency operations from the original or replacement primary operating facility?	Please list those agencies or organization partnerships here.
Suppliers/Vendors/Contractors: Identify key suppliers, vendors, contractors, banks and any other businesses you must interact with on a daily basis. If there are any that serve a critical role, consider developing a professional relationship with more than one company in case they are compromised and cannot service your needs. Do you have an alternate food/drink distributor? Alternate medical supplier for respirators, IV supplies, bedding, emergency code supplies?	Please list the name of the suppliers, what they will supply and contact information here.
Quarantine: If any of your employees are identified as having even casual contact with anyone known to have Coronavirus, your facility may be involuntarily shut down. Plan what you will do if your building, plant or office is not accessible. Define crisis management procedures and individual responsibilities in advance. Talk with your staff or co-workers and frequently review and practice what you intend to do during and after an emergency. Do you have enough testing supplies, available staff to cover those who must quarantine for at least 14 days? Can the current staff of employee health handle the demand of the hospital's employees?	Please list that information here.

Designation of Incident Commander and Succession

1. An Incident Command System (ICS) or Hospital Incident Command System (HICS) is in place. ☐ Yes ☐ No	
a. ICS is exercised at least twice annually. ☐ Yes ☐ No Last exercised:	
b. ICS is coordinated by a Unified Command Structure coordinated when appropriate with law enforcement, fire, EMS. ☐ Yes ☐ No	
c. 1. Incident Commander is known by all staff. ☐ Yes ☐ No 2. Incident commander succession plan is in place. ☐ Yes ☐ No	
d. There is a procedure to designate an Incident Commander. ☐ Yes ☐ No	
e. Staff assigned to ICS leadership roles are oriented to their responsibilities. ☐Yes ☐ No	
f. Staff assigned to key roles wear identifying gear during an event. ☐ Yes ☐ No	
g. All staff know where to report when the ICS is activated. ☐ Yes ☐ No	
h. Staff understands the flexibility of their positions in the ICS if leadership is unavailable. ☐ Yes ☐ No	
i. ICS or HICS is NIMS compliant? ☐Yes ☐No	
j. After action reports are completed after all exercises? ☐ Yes ☐ No	

Emergency Management Committee Document

a. Committee is multidisciplinary. ☐ Yes ☐ No	
b. Open meetings are held regularly ☐ Yes ☐ No How often?	
c. Committee regularly meets with CDC and WHO/ UNICEF to discuss latest updates/ best practices to follow during COVID-19 ☐ Yes ☐ No	

d. Committee closely works with organizations to track and monitor COVID-19 cases ☐ Yes ☐ No	
e. Committee meeting minutes/ action plan are available for review. ☐ Yes ☐ No	
f. Committee forwards critiques of all drills to appropriate services in a timely manner ☐ Yes ☐ No	
g. Committee is knowledgeable of hospital "system" plans that could override local plans. ☐ Yes ☐ No	
h. Committee communicates with and/or cooperates with other hospitals in the community ☐ Yes ☐ No	
i. Facility representative attends at least 75% of the Local/ Community Emergency Planning Committee meetings. ☐ Yes ☐ No	
j. Facility representative reports to governance of the hospital on community planning, exercises and after-action reports. ☐ Yes ☐ No	
k. Facility participates in joint training exercises. ☐ Yes ☐ No	

TRAINING, DRILLS AND EXERCISE	
All staff receive orientation to the Emergency Management Plan (EMP).	Yes No
Hospital staff complete annual training/education in CBRNE.	Yes No
Emergency Department staff receive at least twice-annual training in response to Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) events.	Yes No
All other clinicians receive annual CBRNE training.	Yes No

All non-clinicians receive annual CBRNE/emergency preparedness training.	Yes No
All clinicians receive annual blood-borne pathogens training.	Yes No
All clinicians maintain current Basic Life Support (BLS) registration.	
Percentage of total staff who have taken a NIMS course and/or are NIMS certified.	

Facility exercises an Emergency Management Plan (EMP) at least twice per year.	Yes No
Exercises are conducted at least 4 months apart and no more than 8 months apart	Yes No
Date of last exercise:	
Facilities that offer emergency services include an influx of simulated patients in one exercise.	Yes No
Facility participates in at least one community-wide exercise per year	Yes No
Drills/exercises take place on all shifts, on all units and include all facility departments.	Yes No
Contract staff is included in drills/exercises.	Yes No

Facility has conducted an exercise with casualties: Exposed to a hazardous material Agent requiring decontamination Responded to an actual event within the last 12 months.	Yes　No Yes　No Yes　No
All ED personnel participate in at least twice-annual mass casualty exercises.	Yes　No
At least one exercise in the last year was unannounced.	Yes　No
Facility has drilled evacuation of staff and patients in the last 12 months.	Yes　No
Exercise includes horizontal evacuation (to other units).	Yes　No
Exercise includes vertical evacuation (to other floors).	Yes　No

MUTUAL AID AGREEMENTS (Response Partners)	
Facility has current mutual aid Memorandum of Understanding (MOUs) in place.	____Yes _____No

Memorandum of Understanding (MOUs) are in place with: Law enforcement Fire Emergency medical services (EMS) Public Safety Military installations Other local and regional health care facilities Burn center Red Cross MMRS CERT Other	____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No
Memorandum of Understanding (MOUs) are in place for: Portable MRI Portable CT Portable Dialysis Generators	____Yes _____No ____Yes _____No ____Yes _____No ____Yes _____No
Payment, reimbursement, and allocation of costs	
Notification procedures	
Roles and responsibilities of individual parties	
Protocols for interoperable communications	
Recognition of licensures and certifications	
Sharing agreements	
Workers' compensation	

Liability and immunity	
Provisions to update the agreement	
Provision to terminate the agreement	
Operational plan and procedures requirements	
Insurance	
Termination	
Deployment notification	
Implementation schedule, training, and excercises	
Mutual Aid/inventory resources	
Mobilizing Resources	
Performance Criteria and Metrics	
Management and Coordination	
Engagement Rules	

Credentialing	
Health & Safety Protocols/Plans	
Documentation & Reporting	
Demobilizing Resources	

For this mutual aid agreement each facility or facilities must fill in their institution's name and have it dated and notarized. Any warranted changes will require repeat review and notary.

MUTUAL AID INTRASTATE AGREEMENT BETWEEN [PARTY #1] AND [PARTY#2]

[DATE]

PARTIES

This Mutual Aid Agreement (hereinafter "Agreement") is entered into between [PARTY NAME] _____, hereinafter "_____ [Party#1]," whose address is _____ [street/P.O. Box, city, state, zip], and [PARTY NAME] _____, hereinafter "_____ [PARTY #2], " whose address is _____ [street/P.O. Box, city, state, zip].

The purpose of this agreement is to establish the terms and conditions by which either party may request aid and assistance from the other party in responding to an emergency or disaster that exceeds the resources available in the requesting party's territorial jurisdiction [*or instead of above language, state the parties' agreed upon purpose by describing the scope and limitations on the services agreed by the Agreement].* [Party #1] 's geographical boundaries covered by this agreement are described as follows:

_____

_____

GENERAL PROVISIONS

TERM OF AGREEMENT. This agreement is effective upon the day and date of the last signature affixed hereto. This agreement shall remain in full force and effect until terminated by the parties. The agreement may be terminated, without cause, by either party upon thirty (30)

30

days written notice, which shall be delivered to the other party by hand or by certified mail sent to the address listed herein.

EXECUTION OF AGREEMENT. This Agreement shall be authorized and approved by the governing body of each party to the agreement [if applicable, that is not an agency of the United States government]. Each party shall be responsible for the timely submission, filing, or recording of the agreement–and any subsequent amendment or termination thereof–with local governmental or regulatory offices, in the proper form and format as required by law. Therefore, this agreement shall be executed ____ [*number*] times such that [Party#1] will have ____ [*number*] executed copies with original seals and signatures and [Party#2] will have _____ [*number*] executed copies with original seals and signatures.

[Optional: The parties agree that the number of copies for [Party #1 or #2] includes those required for [Party #1 or #2] to also submit a final, executed copy of the Agreement to the following agencies:_____ .list of agencies such as the NYS Secretary of State, NYS Attorney General, NYS Office of Homeland Security, etc.]

MUTUAL AID INTERSTATE AGREEMENT BETWEEN [PARTY #1] AND [PARTY#2]

The following provisions–AUTHORITY and REAL OR PERSONAL PROPERTY–must be included in the Agreement ONLY if one party (Party #1 or Party #2; Recipient or Provider) is located outside the State of NY.

AUTHORITY. [Required pursuant to NY.STAT.ANN. §19-13-203(c)]Any fire protection service, homeland security program, emergency response agency or emergency medical care provider deployed by Provider under the terms of this Agreement shall have authority to operate in Recipient's jurisdiction as if the fire protection service, homeland security program, emergency response agency or emergency medical care provider were organized and operated under the laws of the Recipient's state
REAL OR PERSONAL PROPERTY. [Required pursuant to NY] Real or personal property shall be handled as follows:
_____ [If the parties contemplate that real or personal property will be acquired as part of the assistance Recipient receives from Provider under the terms of the Agreement, or if the purpose of this Agreement is to form an ongoing, working mutual aid partnership, describe the "manner of acquiring, holding and disposing of real and personal property" and the method "for disposing of property upon partial or complete termination" of the Agreement.]

The following provisions–FINANCING and CHAIN OF COMMAND–must be included in the Agreement ONLY if the following conditions are met: the mutual aid arrangement is such that the Recipient will always be, or will primarily be, the same party AND one party (Party#1 or Party #2; Recipient or Provider) is located outside of NY.]

FINANCING. [Required pursuant to NY] [Recipient Party Name], as the primary Recipient under this Agreement, certifies it has budgeted funds sufficient to finance the reimbursement of [Provider Party Name] for reimbursable costs it incurs under the terms of this Agreement and as the primary provider under this Agreement. Funds in the amount of [amount of money, written out as "zero thousand zero hundred zero dollars and zero cents ($0,000.00)" where the word

"and" indicates a decimal point] have been set aside for costs incurred under the terms of this agreement from_____ to _____ [designation of Recipient's normal fiscal budget year, such as, July 1, 2012, to June 30, 2014] and such funds are budgeted and designated specifically for costs under this Agreement and not for any other purpose, agreement, or activity.

[Optional, can be used in any agreement or in conjunction with the Financing language above: Recipient agrees that it will clearly inform Provider when requesting assistance if funding is or may not be available to sufficiently reimburse costs within the requisite timeframes set forth in this Agreement. If Provider is notified of Recipient's current shortage of funds and agrees to provide assistance, Provider agrees this waives the time period required under the Reimbursement section of this Agreement. However, all other terms of the Agreement shall continue to govern assistance received by Recipient and Recipient shall remain responsible for reimbursing the cost of Provider's assistance unless otherwise waived by Provider pursuant to the terms herein.

CHAIN OF COMMAND. [Required pursuant to NY] The chain of command under this Agreement shall specifically be as follows:

_____

_____

.[Describe the exact chain of command or delegation of authority to be followed by the personnel deployed to provide services or assistance in Recipient's territorial jurisdiction but who are regularly employed by Provider or its local emergency response agencies. Information about the laws, policies and procedures to be followed should be included in these will differ from those Provider's personnel normally operate under. For example, law enforcement policies often vary from one jurisdiction to the next as to the proper use of force, pursuit of a suspect, detainment or arrest of a suspect, transportation of a citizen victim, etc.]

SIGNATURES. [This section should allow for all signatures to appear on a single page.]In witness whereof, the parties to this Agreement through their duly authorized officials of representatives, hereby execute this Agreement on the dates set out below, and in doing so certify that each has read, understood, and agreed to the terms and conditions of this Agreement as set forth herein and has the authority to enter into this legally binding contractual agreement. The effective date of this Agreement is the date of the signature and seal last affixed to this page.

[**PARTY#1**]_____

_____   _____

Signature   Date

_____
Printed Name and Title

Attested by: _____   _____
                        Clerk/Notary   Date

Affix Office Seal:

PARTY#2 _____

_____   _____
Signature   Date

_____
Printed Name and Title

Attested by: _____   _____
               Clerk/Notary   Date

Affix Office Seal:

[**Attorney General Approval] [For interstate agreements ONLY]**

_____   _____
Signature   Date

_____
Printed Name & Title of AG Representative

References

1. Centers for Disease Control and Prevention. Coronavirus Disease 2019 (COVID-2019): https://www.cdc.gov/coronavirus/2019-ncov/php/index.html
2. World Health Organization Q&A on coronaviruses (COVID-19): https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-coronaviruses
3. FEMA Coop Brochure : https://www.fema.gov/pdf/about/org/ncp/coop_brochure.pdf
4. https://emilms.fema.gov/IS706/assets/WyomingTemplate.pdf
5. https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Authority-and-Immunity-Toolkit/Mutual-Aid-and-Assistance-Agreements-Fact-Sheet/
6. https://www.fema.gov/media-library-data/1510231079545-1fabc7af0e06d89d8c79c7b619e55a03/NIMS_Mutual_Aid_Guideline_20171105_508_compliant.pdf

Annex 1: Self-assessment tool for COVID-19 Readiness

This checklist is adapted from the US Assistant Secretary for Preparedness and Response (ASPR) and from a variety of HHS Pandemic Influenza Pandemic Planning resources and is available at:

> https://www.phe.gov/Preparedness/COVID19/Documents/COVID-19%20Healthcare%20Planning%20Checklist.pdf

1. Safety / Infection Control Activities

Completed	In Progress	Not Started	Activities
○	○	○	1.1 Develop a pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.2 Develop an agency/facility pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.3 Provide staff education about COVID-19 infection control and update polices as required.
○	○	○	1.4 Support N95 respirator fit-testing for all agency/facility employees and just-in-time education on recommended infection control precautions including fit checking, applying simple mask to patients with cough, and hand hygiene.
○	○	○	1.5 Monitor availability of N95 respirators/powered air purifying respirators (PAPRs) and other supplies including alcohol-based hand disinfectants, gloves, etc., and watch and alert coalition members to supply shortages. Make recommendations on possible alternatives.
○	○	○	1.6 Prepare guidelines for conservative and re-use of N95 respirators/PAPRs if severe shortages are imminent (ideally regionally and in conjunction with local public health, occupational safety, and infection prevention providers and agencies - for example, consider use by only the highest-risk staff, re-use in selected situations, continued use while working on cohorted units, etc.).
○	○	○	1.7 Plan contingencies if appropriate levels of respiratory protection are unavailable.
○	○	○	1.8 Develop guidance for staff monitoring for signs of illness (including self-reporting, self-quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
○	○	○	1.9 Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
○	○	○	1.10 Encourage HCFs to plan for staff access to medical care for themselves and their families; determine whether illness will be handled as workers' compensation or personal insurance

Annex 2: Mental Health and Psychosocial Support (MHPSS) Needs

Take the following steps to cope with a disaster and make this information available to employees, residents, and their family members:

1. Take care of your body
    a. Try to eat healthy well-balanced meals,
    b. Exercise regularly
    c. Try to get a good night's rest
    d. Avoid alcohol, tobacco, and other drugs.
2. Connect with others
    a. Share your concerns and how you are feeling with a friend or family member.
    b. Maintain healthy relationships and build a strong support system.
3. Take breaks
    a. Make time to unwind and remind yourself that strong feelings will fade.
    b. Try taking in deep breaths.
    c. Try to do activities you usually enjoy.
4. Stay informed
    a. Watch, listen to, or read the news for updates from officials.
    b. Be aware that there may be rumors during a crisis, especially on social media.
    c. Always check your sources and turn to reliable sources of information like your local government authorities.
5. Avoid too much exposure to news
    a. Take breaks from watching, reading, or listening to news stories. It can be upsetting to hear about the crisis and see images repeatedly.
6. Seek professional psychological support if needed
    a. If an employee is experiencing a difficult time at work, your SNF site should provide you access to a professional psychologist or counselor
    b. If a resident is exhibiting signs of stress or loneliness, your SNF site should connect them with a psychologist or counselor and try to incorporate technology to allow them to interact with friends and family
    c. In the event that a resident or staff passes away from COVID-19, it is important to acknowledge grief. Allow for virtual access to connect with your SNF community to allow time to grieve and heal.

Stress during an infectious disease outbreak can sometimes cause the following:

1. Fear and worry about your own health and the health of your loved ones, your financial situation or job, or loss of support services you rely on.
2. Changes in sleep or eating patterns.
3. Difficulty sleeping or concentrating.
4. Worsening of chronic health problems.
5. Worsening of mental health conditions.
6. Increased use of tobacco, and/or alcohol and other substances.

Get immediate help in a crisis, facilities should be sure to post these resources for all employees and residents to see:

- Call 911
- Disaster Distress Helpline 1-800-985-5990 (press 2 for Spanish), or text TalkWithUs for English or Hablanos for Spanish to 66746. Spanish speakers from Puerto Rico can text Hablanos to 1-787-339-2663.
- National Suicide Prevention Lifeline 1-800-273-TALK (8255) for English, 1-888-628-9454 for Spanish
- National Domestic Violence Hotline 1-800-799-7233 or text LOVEIS to 22522
- National Child Abuse Hotline 1-800-4AChild (1-800-422-4453) or text 1-800-422-4453
- The Eldercare Locator 1-800-677-1116
- Crisis Chat text: 8388255