Healthcare Recovery Plan

Version 2.6

August 2017

ACKNOWLEDGEMENTS

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SIGNATORIES

Signatory Party	Representative Name and Title	Signature

RECORD OF DISTRIBUTION

Agency/Organization	Date

RECORD OF CHANGES AND REVISIONS

Change/Revision	Date of Revision	Changing Entity

EXECUTIVE SUMMARY

Maryland's Department of Health (MDH) works to promote and improve Marylanders' health and safety. MDH serves Maryland and its five regions. Region III is based on the subdivision of Maryland developed and utilized by the Maryland Institute of Emergency Medical Services Systems (MIEMSS) and includes Harford, Carroll, Baltimore, Anne Arundel, and Howard counties, as well as Annapolis and Baltimore cities. In 2006, the Maryland Region III Health & Medical Coalition was created to increase regional collaboration between local and state government agencies and regional healthcare facilities in the area of emergency preparedness and response.

In 2017, the Maryland Region III Health & Medical Coalition Recovery Subcommittee began researching recovery planning for healthcare entities in our region with the goal of developing a Region III Health & Medical Coalition Recovery Plan (Recovery Plan). The Recovery Plan discusses actions that can be carried out prior to a regional disaster by all members of the Region III Health & Medical Coalition and reviews how each healthcare facility's Continuity of Operations Plan (COOP) can contribute to a successful regional recovery. This scalable Recovery Plan discusses both short-term recovery strategies as well as intermediate and long-term planning strategies. Healthcare recovery is defined by a community's ability to come together to rebuild, and perhaps even redefine, how healthcare operations can serve a devastated community. In the future, local public health planners within Region III will be tasked with writing local healthcare recovery plans that will integrate with and build upon overall local and regional recovery plans.

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INTRODUCTION

Purpose

This is an operational plan for all Region III Health & Medical Coalition members and partners to coordinate and execute a healthcare regional recovery plan.

Scope

The Healthcare Recovery Plan is intended to enhance the ability of a healthcare entity to implement preparedness, mitigation, and business continuity activities. It identifies policies, strategies, and roles and responsibilities to guide local and regional jurisdictions through short-term, intermediate, and long-term recovery phases after a disaster as well as restore healthcare facilities and their services. The Healthcare Recovery Plan can be used for any type of healthcare recovery effort within Region III. The guidance provided is all-hazards and can be scaled to any appropriate level.

Principles of Recovery Planning

- The plan must represent all stakeholders, which is achieved by their active participation.
- The plan must feature a guide to analytical problem solving in the face of various types of disasters and threats.
- The plan should be flexible enough to be used as a guide rather than a mandate.
- The plan should be clear in terms of expectations and goals.
- The plan should identify tasks, a process for resource allocation, and accountability.
- An effective plan is one that is decided before an emergency develops.
- The primary purpose of healthcare recovery is to reduce morbidity and mortality by protecting patients and staff while maintaining services, providing care to victims, and providing coordination and control with other supporting agencies.
- Healthcare system recovery involves the collaboration among public health, emergency management, and healthcare entities to develop efficient processes and advocate for the rebuilding of the local and regional healthcare infrastructure to at least a level of functioning comparable to pre-incident levels and/or improved levels where possible. The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community.

Assumptions

1. The Region III Health & Medical Coalition Recovery Subcommittee intended for the Healthcare Recovery Plan to be used in preparation for and after a disaster. The Healthcare Recovery Plan includes best practices and considerations about recovery planning and discusses scenarios where the Healthcare Recovery Plan would be utilized.
2. The Healthcare Recovery Plan designates four overlapping periods of recovery; Pre-Recovery, Short-Term Recovery, Intermediate, and Long-Term Recovery. The length of time for each period will vary depending upon the severity of the disaster and the local and regional capacity for recovery.
3. The degree of Region III Health & Medical Coalition's involvement in an incident or event will depend on the impact to public health, the relevant services needed, and the applicability of Region III Health & Medical Coalition's jurisdictional reach.
4. An incident is an unplanned situation that can occur with little to no warning that impacts public health (e.g., a natural disaster, flu pandemic, or chemical spill).
5. Damage in the region will be catastrophic in nature, and will cause disruption to daily operations of the healthcare infrastructure and the disruption of regional economic, physical, and social infrastructures.
6. Time may be of the essence.
7. Region III healthcare facilities may have a reduction in staff.
8. Region III healthcare facilities may be working with less than ideal conditions.
9. Prior to or concurrent with activation and implementation of the Healthcare Recovery Plan, the Emergency Operations Plan (EOP) and COOP will all be implemented and emergency response and continuity of essential functions will be provided to the degree possible.

PLAN MAINTENANCE

Schedule

- In the event of an exercise, workshop, training, or real world incident, lessons learned and updated information will be included in the Healthcare Recovery Plan as soon as possible.

Record of Changes

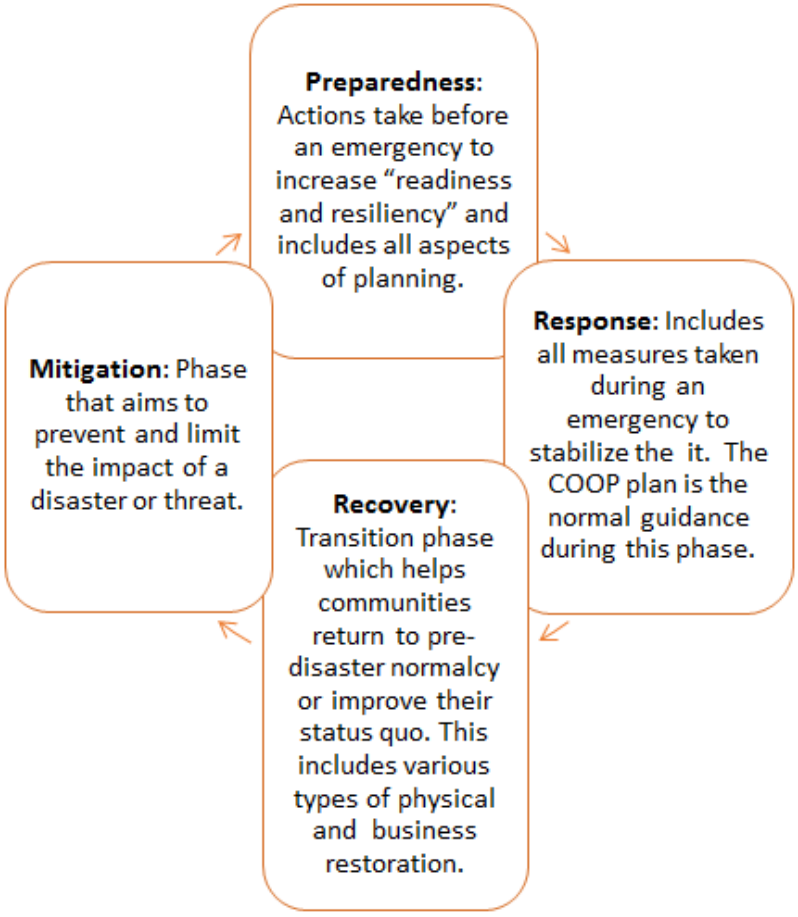
- Updated information will be documented in the Healthcare Recovery Plan in the Record of Changes and Revisions section.

PRE-RECOVERY

A partnership between local health departments and community healthcare organizations can help foster the collaborative spirit and sense of community ownership that, while not easily measured, can aid in building community health resilience. Partnering with organizations that are already linked to the community can be an essential tool for local health departments, helping them communicate with and assist difficult-to-reach populations. Non-governmental organizations often play a major role in recovery because of gaps in government-provided services.

All stakeholders with a role in recovery, and particularly elected and public officials, who lead such efforts, need to be sensitized regarding the importance not only of short-term health protection concerns but also of long-term opportunities to create healthier and more resilient and sustainable communities. Bridging the public health efforts between emergency preparedness and community health coalition efforts through cross-training, allows partners to have a better understanding of each other's roles in the recovery process and can leverage relationships within their divisions to bring the appropriate public health expertise to bear on strategic planning discussions.

Overview of Emergency Phases and Transitions (Figure 1)



Recovery Planning Process

In the context of integrating health into the disaster recovery planning process, each of the steps in the strategic planning cycle presents opportunities. These are summarized below as well as in Figure 2:

- **Visioning:** Recovery is viewed as an opportunity to advance a shared vision of a healthier and more resilient and sustainable community (e.g. town hall meetings, public workshops, surveys).

  Visioning activities may also include:

  - Identifying and engaging local health champions (from health and non health sectors) to facilitate discussions.
  - Identifying other previous efforts and experiences that are relevant.
  - Conducting health literacy efforts and educating the community on the elements of and benefits to healthy, resilient, and sustainable communities.

- **Assessment:** Community health assessments and hazard vulnerability assessments provide data that show the gaps between the community's current status and desired state and inform the development of goals, priorities, and strategies.
- **Planning:** Health considerations are incorporated into recovery decision making across all sectors. This integration is facilitated by involving the health sector in integrated planning activities and by ensuring that decision makers are sensitized to the potential health impacts of all recovery decisions.
- **Implementation:** Recovery resources are used in creative and synergistic ways so that the actions of the health sector maximize health outcomes and the actions of other sectors yield co-benefits for health. A learning process is instituted so that the impacts of recovery activities on health and well-being are continuously evaluated and used to inform iterative decision making.

  Note: Although the process is presented as sequential for purposes of exposition, in reality the order of steps may be varied, and some may be undertaken simultaneously (See Figure 1 below).

See Appendix A: A Framework for Integrating Health into Recovery Planning

Figure 2

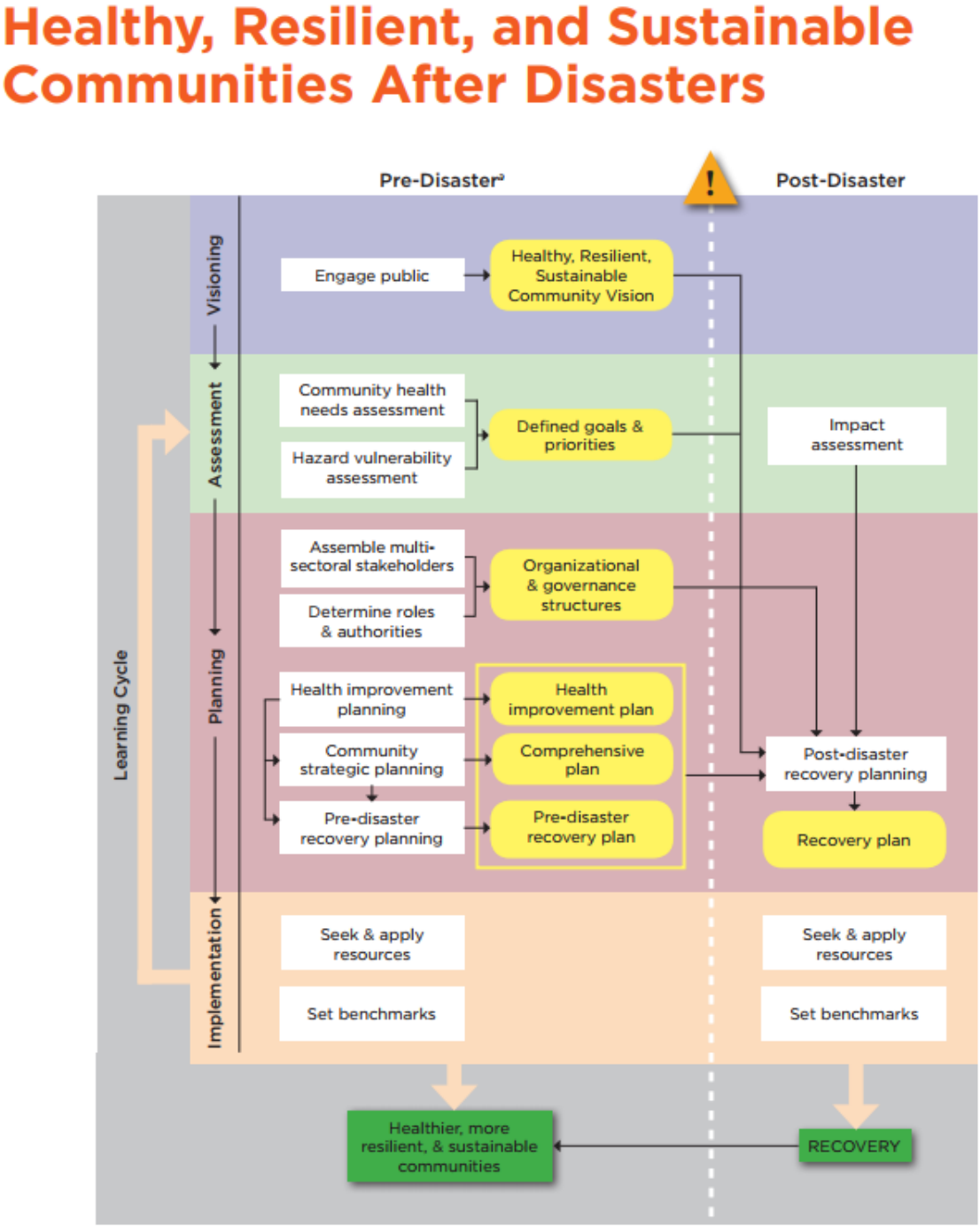


FIGURE Leveraging the products of pre-disaster planning processes supports a healthy community approach to disaster recovery.

* Although the committee strongly encourages communities to undertake these activities in the pre-disaster period to maximize the opportunities to leverage the post-event recovery process for the purpose of creating healthier, more resilient and sustainable communities, in the event that they have not been undertaken beforehand, there is still benefit to incorporating them into post-disaster recovery planning.

Committee on Post-Disaster Recovery of a Community's Public Health, Medical, and Social Services; Board on Health Sciences Policy; Institute of Medicine.Washington (DC): National Academies Press (US); 2015 Sep 10. (https://www.ncbi.nlm.nih.gov/books/NBK316527/)

Visioning

A community's comprehensive plan, health improvement plan, sustainability plan, and mitigation plan—and, in some cases, its regional development plan—can yield health-related goals and investment strategies to inform the recovery planning process. Ideally, the community health improvement plan (following from a community health assessment) will have informed the development of the comprehensive plan.

The integration of a **health-focused community vision and health improvement goals** into the community strategic planning process and the comprehensive plan itself, helps to ensure buy-in from leadership (since these plans must be formally adopted by the community's governing body) and subsequently the incorporation of these elements into recovery strategic planning.

Threat Hazard Identification and Risk Assessments

One of the first steps in the pre-recovery phase is to ensure your local and regional jurisdiction has conducted a Health Hazard Vulnerability Assessment. The purpose of a risk assessment is to identify the needs, assets, and capacities of the community; prioritize interventions; and, provide a baseline against which change and progress can be measured. The hazard vulnerability analysis provides an interface between the healthcare and emergency management sectors and should be complementary to the Threat and Hazard Identification and Risk Assessment process.

In general, a healthcare recovery plan should consider risks that are specific to the local jurisdiction. One consideration is what will the jurisdiction need in order to prepare for a threat or hazard. A second consideration is what shareable resources are required in order to be prepared for a threat or hazard. A final consideration is what actions could be employed to avoid, divert, lessen, or eliminate a threat or hazard. In Maryland, the Region III Health & Medical Coalition can assesses each risk in context, develop capability targets, and estimate the resources needed to achieve these targets for each of the core capabilities identified in the National Preparedness Goal.

A Healthier Community

The following three actions can help to ensure a community's healthcare recovery plan will contribute to an overall healthier community:

1) Engage the full range of community stakeholders in the process of pre-disaster community health improvement planning that addresses comprehensive physical and social determinants of health.

2) Adequately integrate health improvement planning into the community strategic planning process which sets forth community priorities and allocates funds.

3) Ensure health improvement planning is adequately integrated into disaster recovery planning.

4) Educate all sectors of the community on the importance of health-related threats posed by disasters and the benefits to be gained by integrating community health improvement objectives and priorities into disaster recovery plans to achieve shared goals.

See Appendix B: Healthy Resilient & Sustainable Communities after Disasters: A Discussion Toolkit

Incentives

One way to implement healthy community objectives into plans for reconstruction is to develop incentives. These incentives should be put in place prior to a disaster (i.e., policies, Transfer of Development Rights designation, incentives, specialized permitting procedures, plans for recovery assistance hub services to be located there, and temporary housing/business location, etc.).

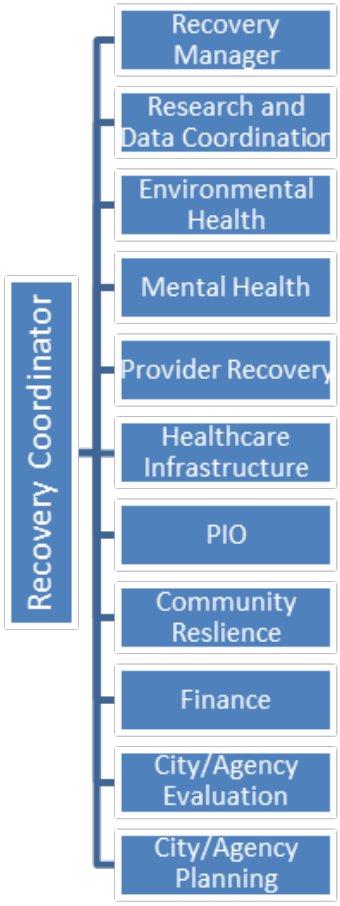
An analysis can be done prior to a disaster to determine which healthy community characteristics are most relevant and valuable to each community and develop a method to incentivize plans that incorporate these characteristics. For instance, plans with a certain percentage of walk-able streets may get first preference during the permitting process. The county can also promote healthy communities with healthy and safe environments by incentivizing green building techniques.

Major redevelopment projects after a disaster could be fast tracked for permitting if they include green and healthy design components.

Establishing an Operational Structure

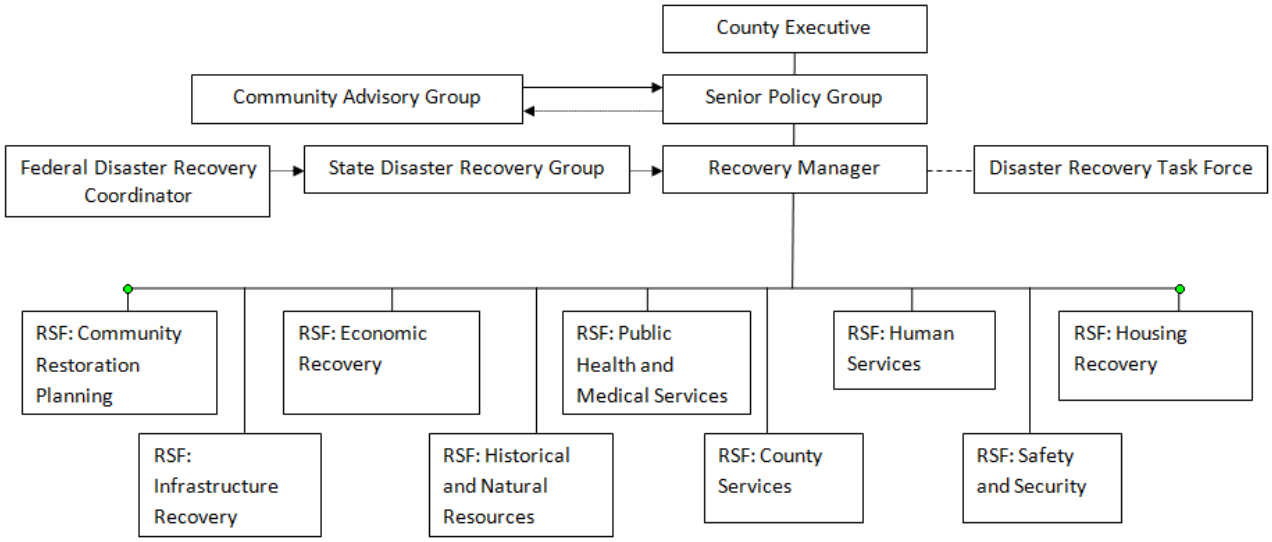
Local health department and regional health coalitions should consult with their local emergency management agencies to discuss what type of recovery framework has been established. The two structures (Figure 3 and 4) presented below are just examples of what a recovery framework might look like.

Figure 3
See Appendix C: Recovery Workgroup Flyer



NYC Health: Hurricane Sandy: Proposal for DOHMH Recovery Process v.2012-11-28.

Figure 4



Region 3 Recovery Plan

Recovery Workgroups provide essential scaffolding for decision-making processes but by themselves are not sufficient. The effectiveness of an integrated planning and recovery approach is greatly enhanced by shared information. One of the greatest challenges associated with disaster recovery is that decision makers often must take action before the information needed to support those decisions can arrive. Planning processes that may in normal times have been spaced out over a period of years must now be conducted in a timeframe of just months. Decision making is distributed during disaster recovery, creating challenges related to coordination of actions. Recovery proceeds more effectively when the myriad actors involved are aware of each other's actions. Thus, accelerating and broadening the flow of information is crucial to success.

Local health department and regional health coalitions should consult with their local emergency management agencies to discuss how each RSF (Recovery Support Function) team will communicate within the local and regional recovery framework.

Establishing an Operational Plan

It is vital for the community to draft an operational healthcare recovery plan. The planning process can be divided—before and after a disaster. Healthcare recovery planners who examine the community before a disaster can inventory health resources, track funding, and list stakeholders. Then, planners can identify priorities and educate stakeholders on them, build stakeholder relationships, define leadership roles, and lead with transparency. Healthcare recovery planners who examine the community after a disaster can:

1) Develop a basic command structure within their Public Health- Medical Service RSF.

2) Execute a healthcare communications protocol.

3) Describe how to effectively manage funds.

4) Plan for access to basic and necessary health services.

5) Work to restore healthcare infrastructure.

Stakeholders, including community members, should determine whether long-term recovery seeks to achieve a "new normal" or return to status quo.

The recovery healthcare operational plan should address the following issues:

a) Roles and responsibilities.
b) Community health assessment process: who will be making the health assessments and how often?
c) How and when a healthcare improvement plan will be written?
d) How will implementation be carried out?
e) Who will hold healthcare project managers accountable?

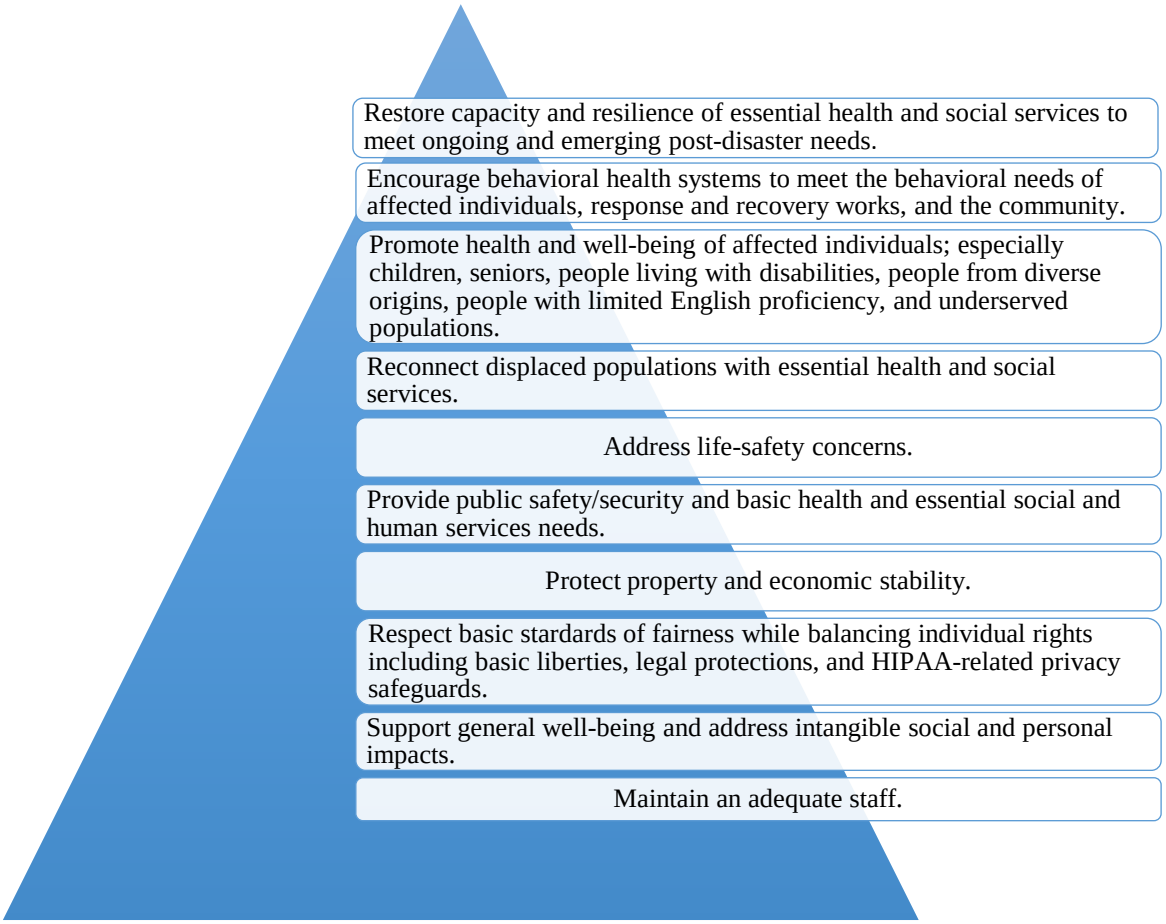
Consider the following topics when discussing healthcare recovery:

1) Food and nutrition
2) Health and human services
3) Social cohesion
4) Mental health
5) Physical activity
6) Clean air and other environmental exposures
7) Public safety

See Appendix D: Maryland Department of Health Recovery Operations Checklist

See Appendix E: Summary of Recovery Recommendations

The following is a list of possible recovery goals:
Figure 5



Pre-Disaster Critical Infrastructure Self Assessments

Communities should encourage larger healthcare facilities to perform pre-disaster critical infrastructure self-assessments to assist them in better identifying what their vulnerabilities would be should a disaster occur.

See Appendix F: Supply Chain Disaster Preparedness Manual

See assessment tool below:
Table 1

Pre-Disaster Critical Infrastructure Self-Assessment

Evacuation-Relevant Resources	Implication
• How many patients are otherwise oxygen dependent?	<10 ____ 11-25 ____ 26-50 ____ 51-100 ____ 100+ ____
• Does the medical gas system rely on electricity?	Y= more vulnerable
• If the medical gas system fails, how long can these patients be maintained using the current stock of portable/backup oxygen?	Hours = time until evacuation
Information Technology and Telecommunication	
• Are servers and other telecommunication systems on the hospital premises or offsite?	On premises = more vulnerable
• Are redundant hardware and software systems deployed offsite?	N = more vulnerable
• Are critical databases (e.g. EMRs) managed or backed up offsite?	N = more vulnerable
• Can the EMR quickly generate patient discharge summaries to accompany each evacuated patient?	N = more vulnerable
• Can manual, paper-based backup systems and procedures be rapidly reconstituted (e.g. manual order entry, manual medication dispensing), and have staff been trained to safely use these systems?	N = more vulnerable
• Does the hospital have VOIP capabilities or two-way radios that interoperate with local emergency responders?	N = more vulnerable
Security	
• Does the hospital employ its own security staff or contract with an outside security firm?	Own staff____ Contracted____
• Are sufficient security staff on site during every shift (including nights and weekends) so that two can be stationed at every entrance/exit?	N= more vulnerable
• Can sufficient additional security staff be brought in to escort/guard transport vehicles?	N= more vulnerable
• Does the hospital evacuation plan assume that municipal or State police will be available to assist?	Y= more vulnerable

Pre-Disaster Critical Infrastructure Self-Assessment

Evacuation-Relevant Resources	Implication
City Water	
• Is water used for heating the hospital?	Y= more vulnerable
• Is water used for cooling?	Y=more vulnerable
• Does the hospital have a well?	N=more vulnerable
• Is there one water line going into the hospital, or also a backup line?	Only 1=more vulnerable
• Is there a water storage tower/tank on the roof?	Y=more vulnerable to earthquakes (but good backup water source)
• If the water tower/tank collapsed, would the hospital then be without water (or sufficient pressure)?	Y=more vulnerable
• How long can the hospital maintain a safe temperature without city water in summer heat?	Hours = time until evacuation
• How long can the hospital maintain a safe temperature without city water in winter cold?	Hours = time until evacuation
Steam	
• Does the hospital receive steam for heat from a separate steam-generation plant?	Y=more vulnerable
• Is that steam plant on the hospital premises?	N=more vulnerable
• Is there one steam line into the hospital, or also a backup conduit?	Only 1=more vulnerable
• How long can the hospital maintain a safe temperature if the steam-generation plant is off line?	Hours = time until evacuation
• Is steam also used to generate electricity?	Y=more vulnerable
• If so, what % of electricity would be lost if the steam-generation plant went offline?	>50%=vulnerable
Electricity	
• Does the hospital have a central backup generator?	N= more vulnerable
• More than 1?	N= more vulnerable
• Is there a fuel storage tank on site with a direct line to the backup generator?	N= more vulnerable
• Is the fuel storage tank underground?	N= more vulnerable
• In a flood, would the intake be underwater?	Y= more vulnerable
• How long can essential power be maintained using the current fuel supply?	Hours = time until evacuation
• Does the hospital have smaller or portable generators for floors/sections of the hospital?	N=more vulnerable

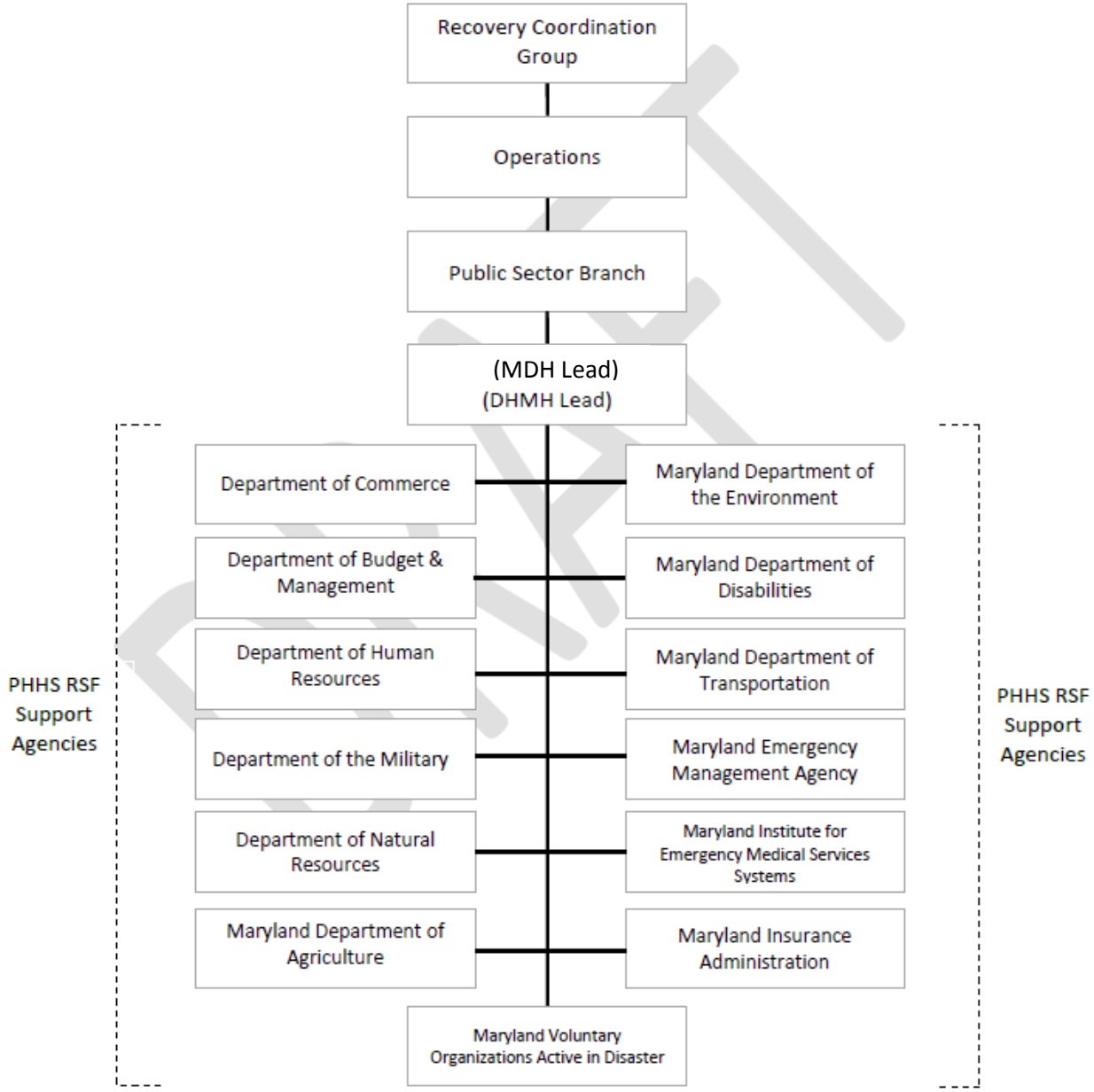
Hospital Evacuation Decision Guide: AHRQ Publication No. 10-0009 May 2010

COORDINATION

State Recovery Organization

MDH, in collaboration with and support from partner agencies, will coordinate activities to complete state recovery objectives (see Figure 6). Additionally, MDH is responsible for coordination and communication with the Public Sector Branch, which provides situational awareness to the Operation Section and ultimately the Recovery Coordination Group at the state level.

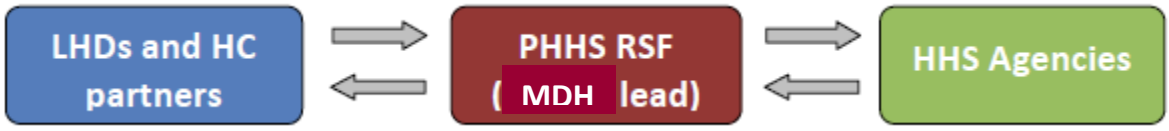
Figure 6



Coordination with Federal and Local Counterparts

To achieve the Public Health and Healthcare Services (PHHS) RSF goals and objectives listed earlier, the PHHS RSF lead and supporting agencies will collaborate with federal and local partners as demonstrated by the information sharing graphic below, see Figure 7.

Figure 7



Maryland Public Health & Healthcare Services Disaster Recovery Support Function Annex, July 2016

Local health departments and health care partners will regularly report to MDH, who will coordinate with appropriate federal agencies. The PHHS RSF will oversee the distribution of resources, if not already located at the local level, and will coordinate federal resource requests from state and local partners through the recovery structure found in the previous section. The PHHS RSF will also share technical assistance and federal agency feedback, to include federal grant guidance, with local partners as appropriate. MDH, as the PHHS RSF lead, will ensure situational awareness among partners and may bring pertinent partners together on specific issues on an as-needed basis.

Transition from Response

The PHHS RSF is activated by any one of the following:

- The Maryland State Disaster Recovery Operations Plan (SDROP) is activated and PHHS RSF is requested;
- The Governor declares a state of emergency and assistance is requested by the appropriate authorities to assist with health services recovery efforts;
- The MDH Secretary declares a Public Health Emergency and assistance is requested by the appropriate authorities to assist with recovery efforts;
- ESF-8 or ESF-11 activates and assistance is requested by the appropriate authorities to assist with recovery efforts; or
- Recovery activities involve more than one PHHS RSF agency.

The following process will occur for PHHS RSF activation of MDH and other support agencies:

- The SDROP is activated and a State Disaster Recovery Coordinator is appointed.
- The State Disaster Recovery Coordinator will activate appropriate RSFs.
- Once the PHHS RSF is activated, MDH will select a PHHS RSF operations coordinator, who will work with ESF 8 and ESF 11 response staff to appropriately transition pertinent information to recovery operations as shown by the graphic below.

- The PHHS RSF operations coordinator will then coordinate pertinent information sharing with federal, state, and local partners to ensure recovery objectives and timelines are met.

ROLES AND RESPONSIBILITIES

The National Disaster Recovery Framework (NDRF) envisions that individuals and households need to be prepared to sustain themselves immediately after a disaster by carrying adequate insurance; holding essential supplies of medication, food, and water; and listening to public information announcements on the recovery process. Moreover, state and local emergency management is moving away from federal government led efforts and toward a "whole community approach" because each community is unique in its experiences, efforts, and needs. Community partnerships are especially important for routines and support networks. Although the primary ones will stay the same, partnerships may change depending on what stage of recovery is currently underway. Presently, the overarching goals of recovery are as follows:

1) Recovery workgroups should strive to understand and meet the actual needs of the whole community.
2) Recovery workgroups should work to engage and empower all part of the community.
3) Recovery workgroups should focus on strengthening what works well in the community on a daily basis.

Federal Government

The central role of the federal government is to facilitate the efforts of state and local governments to leverage needed resources to rebuild communities. The federal government can use the NDRF to recruit and engage available department and agency capacities to promote local and regional recovery. Federal support must be scalable and adaptable to meet community needs.

State Government and State Department of Health

The Maryland Department of Health is the primary and coordinating agency of the state Public Health and Healthcare Services Annex of the Maryland Disaster Recovery Support Plan.

See Appendix G: Maryland Public Health and Healthcare Services Disaster Recovery Support Function Annex

MDH will:

1) Conduct a public health assessment for:

- Environmental health conditions, including laboratory water and soil testing
- Food safety and food establishments
- Behavioral health interventions
- Healthcare needs that can no longer be met by community resources
- Structural, functional, and operational impacts to healthcare facilities

2) Ensure impacted residents have access to:

- Trauma services
- Acute care services
- Mental and behavioral health services
- EMS response services
- Dialysis services
- Pharmaceutical services

3) Prioritize the restoration of and begin the implementation of all other public health and medical services necessary to meet the demand of the impacted population.

4) Ensure displaced patients are transferred to appropriate permanent facilities.

Table 2 outlines how state agencies and private sector, non-profit, and/or faith-based partners will provide support:

Table 2

Agency/Organization	PHHS RSF roles/responsibilities
Department of Commerce	• Provide an estimate of the immediate economic impact of public health recovery, as requested by the Maryland Emergency Management Agency. Where possible and applicable, the Department shall provide estimated projections of long-range effects of each instance including: residents, businesses (including healthcare facilities), and local, state, and federal agencies.
Department of Budget and Management	• Assist state agencies in identifying potential additional costs associated with supporting local agencies during recovery, and accompanying strategies to request appropriation authority for such additional costs.
Department of Human Resources	• Coordinate the Disaster Food Stamp Program for public health emergency victims. • Provide USDA donated food to disaster relief agencies and emergency feeding programs, and assist with its distribution and storage through the Emergency Food Assistance Program (TEFAP). • Coordinate with county social service agencies, to meet the childcare needs of public health emergency victims unable to care for their children. • Coordinate with county social services to shelter populations in need of sheltering and/or housing after a public health emergency.
Department of the Military	• Prepare and maintain plans and procedures to support civil authorities should public health recovery exceed state and local resources (Maryland National Guard and State Defense Force).
Department of Natural Resources	• Provide personnel and equipment recovery support, such as law enforcement, traffic control, and public alerting operations, when requested by MEMA. • Coordinate with the State Police and the Department of Transportation for air operations and air transportation services.
Maryland Department of Agriculture	• Conduct surveillance of zoonotic diseases in impacted areas during recovery and submit data for public health impact assessment.
Maryland Department of the Environment	• Provide environmental monitoring in affected areas during recovery and submit data for public health impact assessment. • Support the restoration of services requiring environmental permitting. • Provide personnel to serve on an Interagency Hazard Mitigation Team/Hazard Mitigation Survey Team, following a presidential declaration of disaster or when requested.

Maryland Department of Transportation	• In coordination with neighboring States and communities, the private sector, transportation providers, and DHMH, develop transportation contingency plans that identify a range of options for different stages of recovery, including support for public health restoration strategies, maintaining State and community functions (e.g. making transportation routes passable, public transport, etc), transportation restriction options and consequences, delivery of essential goods and services, and other key regional or local issues. • Implement highway traffic management plans and procedures for the restoration of highway travel, as needed. • Coordinate air transportation and reconnaissance with the FAA, Airports, Military Department, Department of Natural Resources, State Police, and general aviation, as requested.
Maryland Emergency Management Agency	• Coordinate the overall emergency planning, preparedness, response, and recovery of all state agencies. • Maintain communication with DHMH regarding status of recovery in Maryland. Coordinate the activation of the State Disaster Recovery Plan in accordance with guidance from DHMH. • Inform the Governor, the Superintendent of the Maryland State Police, Executive Council, and the Legislature, as appropriate, of recovery efforts • Facilitate the request for a presidential disaster declaration as appropriate. • Facilitate any Emergency Management Assistance Compact (EMAC) requests • Oversee communications with the media. • Coordinate continuity of operations planning and standards for state agencies and provide recovery support.
Maryland Institute for Emergency Medical Services Systems	• Ensure impacted areas have access to EMS response services • Notify MIEMSS regional medical directors, jurisdictional and commercial EMS operational programs of status of public health recovery. • Coordinate resources for local ambulance providers including arranging for transportation and medical services for displaced patients transferring to appropriate permanent facilities who require an ambulance when requested. • Coordinate Critical Incident Stress Debriefing (CISD) support to fire and rescue personnel as needed.
Maryland Department of Disabilities	• Facilitate communication efforts regarding available public health and medical services to persons with disabilities through its existing communications network • Advise on unmet public health and medical services needs for persons with disabilities
Maryland Voluntary Organizations Active in Disaster	• Coordinate volunteer organizations to provide health-related recovery services for residents in impacted areas, such as medical and behavioral health interventions.

Local Government/ Health Departments or Regional Healthcare Coalitions

Local government is the most important because it will have the most effective, efficient, and timely response to a disaster. Local government plays a central role in planning and managing all phases of a community's recovery. When local governments are overwhelmed by their responsibilities, they seek the services of state and federal governments. Local governments also galvanize the preparation of hazard mitigation and recovery plans, raise hazard awareness, and educate the public prior to and during the recovery process. Checklist 1 is a tool for local government's healthcare recovery planning.

Checklist 1

- ✓ Establish communication with the State Health Agency Disaster Recovery Point of Contact
- ✓ Through established communication networks, educate constituents regarding applicable health interventions being recommended by public health
- ✓ In conjunction with local and regional response partners, inform the community of the availability of any disaster or community case management services being offered that provide assistance for community members impacted by the incident
- ✓ Maintain public health service delivery with an emphasis on patients with special medical needs, at-risk populations, and individuals with functional needs
- ✓ Maintain local volunteer deployment; demobilize personnel according to demobilization plan
- ✓ Work with local, regional, state, and federal partners to ensure timely reconstruction of public health related critical infrastructure
- ✓ Maintain and replenish local public health supply caches
- ✓ Activate demobilization procedures for public health transportation assets
- ✓ Work with local emergency management and service providers to ensure full restoration of public health information technology and communication networks
- ✓ Prepare After-Action Reports, Corrective Action and Improvement Plans

Non-Profit Sector and Healthcare Coalition

The non-profit sector encompasses faith-based and other volunteer community organizations, charities, foundations and philanthropies, professional associations, and academic institutions. Major roles of the non-profit sector include case management, volunteer coordination, behavioral health and psychological support, housing repair, and construction. Non-profits tend to fill the gaps when governmental services and support do not meet a community's comprehensive needs. Non-profits often conduct advocacy for community members. Checklist 2 is a tool for non-profit healthcare recovery planning.

Checklist 2

- ✓ Advocate for full heath care service delivery restoration for member facilities and organizations within coalition boundaries
- ✓ Continue to interface with volunteer groups and staffing agencies to monitor and assess the needs of member organizations to supplement their workforce during the recovery phase
- ✓ Advocate for members to receive priority critical infrastructure restoration and reconstruction
- ✓ Replenish and demobilize regional supply caches maintained by the coalition
- ✓ Activate demobilization procedures for any transportation assets maintained by the coalition
- ✓ Advocate for full restoration information technology and communication systems for coalition members
- ✓ Prepare After-Action Reports, Corrective Action and Improvement Plans

Private Sector

The private sector plays an essential role by retaining and providing employment and a stable tax base. It also owns and operates much of the country's infrastructure, including electrical power, financial, and telecommunications systems. The private sector, including utilities, banks, and insurance companies, can foster mitigation and encourage community resilience. Public–private partnerships are critical resources during recovery and facilitate the coordinated leveraging of funding from multiple sources.

COOP

It is recommended that every health system have in place a Continuity of Operations Plan (COOP). A COOP establishes policy and guidance to ensure the execution of the *mission-essential functions* for hospitals and healthcare facilities in the event that an emergency in or around Region III threatens or incapacitates operations. A COOP provides a mechanism to restore those functions where there is an obligation to continue operations, and to fulfill the Region's mission to "strengthen the health and medical preparedness and response capabilities of Maryland Region III." (https://www.mdregion3hmc.org/mission-vision-values/) To develop and provide a functional, fully-integrated COOP, Region III partners should consider the elements necessary to maintain operations during recovery as well as the specific, mission-essential healthcare functions that must be restored to fulfill its obligation to the community and Region III.

See Appendix H: COOP Development Guidance

Continuity Elements

A COOP must include essential functions in addition to six sections, which are orders or succession, delegation of authority, continuity facilities, continuity communications, essential records management, and devolution of control and direction.

First, a COOP must put forth and maintain Orders of Succession for key positions in the event leadership is incapable of performing authorized duties.

Table 3

Sample: Succession Plan

Key Position (Position Title)	**Successor 1**	**Successor 2**	**Successor 3**
[LEADERSHIP]			
[LEADERSHIP]			
[LEADERSHIP]			
[OPERATIONS]			
[PLANNING]			
[LOGISTICS]			
[FINANCE/ADMIN]			

Second, a COOP must establish Delegations of Authority to provide successors the legal authority to act on behalf of the Agency/Organization for specific purposes and to carry out specific duties.

Table 4

Sample: Delegation of Authority Plan

Authority	**Type of Authority**	**Position Holding Authority**	**Triggering Conditions**
Close Facility	Emergency Authority	Senior Leadership	When conditions make coming to or remaining in the facility unsafe
Represent Agency/ Organization when engaging Govt. Officials	Administrative authority	Senior Leadership	When the pre-identified senior leadership is not available
Activate Agency/ Organization MOU's/MAA's	Administrative Authority	Senior Leadership	When the pre-identified senior leadership is not available

Third, a COOP must identify continuity facilities to conduct business and/or provide clinical care to maintain essential functions when the original property, host facility, or contracted arrangement where the Agency/Organization conducts operations is unavailable for the duration of the continuity event.

Table 5

Sample: Facility Continuity Plan

Continuity Facility	**Type of Facility**	**Location of Facility**	**Accommodations**
ABC Hospital	Alternate Site	1234 Medical Center Drive, Niceville, USA	Hot Site, Identified meeting room with telephones internet access, ham radio access, satellite radio access, 2 desktop computers, laptop connectivity
County EOC	Alternate Site	7000 Disaster Way My Town, Gotham City	Warm Site, Possible meeting room with telephones, internet access, shared ham radio capability, shared satellite phone capability, No desktop

			computers, laptop connectivity
Home Telework	Devolution Site	Home of Record HCC Leadership	Warm Site, telephones, internet access, no ham radio, no satellite phone, desktop computers, laptop connectivity

Fourth, a COOP must outline how to maintain a robust and effective communications system to provide connectivity to internal response players, key leadership, and state and federal response and recovery partners.

Fifth, a COOP must outline access to essential records and describe how the use of essential records management systems enables the performance of essential functions and reconstitution to normal operations. A COOP must include directions for the maintenance of both electronic and hard copy records.

Sixth, a COOP must involve devolution of control and direction. Devolution is the transition of roles and responsibilities for performance of Agency/Organization essential functions through pre-authorized delegations of authority and responsibility. The authorities are delegated from Agency/Organization leadership to other representatives in order to sustain essential functions for an extended period.

Essential Functions of Healthcare Actors

See Appendix I: Healthcare Essential Functions

Sample Hospital Mission Essential Functions

1. Emergency Services (Emergency Department)
2. Surgical Services (Operating Room)
3. Laboratory Services (Lab)
4. Health Information Technology (HIT)
5. Patient Care Unit
6. Central Supply (CS)
7. Human Resources (HR)
8. Obstetrics
9. Pharmacy Services
10. Public Relations
11. Food Services
12. Security
13. Laundry

14. Health Information Management
15. Infusion Chemotherapy

Continuity of Operations Phases & Implementations

See Appendix J: ASPR Healthcare COOP and Recovery Planning

Readiness & Preparedness

1. Develop Continuity of Operations Program
2. Review COOP annually
3. Facilitate COOP drills and exercises that activate plans in coordination with regional, state and federal plans
4. Revise COOP accordingly

Activation

1. Utilizing state and regional information sharing platforms, initiate an alert and notification to all partners executing the transition from immediate emergency response to COOP activation
2. Establish appropriate liaisons between LHD/HCC/HCO and state health disaster response and recovery officials
3. Provide situational updates to response partners, state health authorities, and local/regional emergency management through information sharing platforms when applicable
4. If the event disrupts the availability of response leadership to assist response partners in activating continuity operations procedures, delegation of authority and devolution options will be instituted to ensure continuation of essential functions

Continuity Operations

1. Prioritize COOP activities to focus on rapid resumption of Mission Essential Functions and Essential Supporting Activities
2. Develop a Common Operating Picture (COP) to assess and inform key stakeholders of status
3. Communicate needs to state health authorities and local emergency management officials to establish priority resumption of critical services
4. Inform response partners of available Federal/State/Local resources and the process to access needed infrastructure, supplies, transportation, and human capital
5. Assist response partners in preparing a reconstitution strategy when transitioning from immediate response activity through continuity operations to the recovery phase of the event.

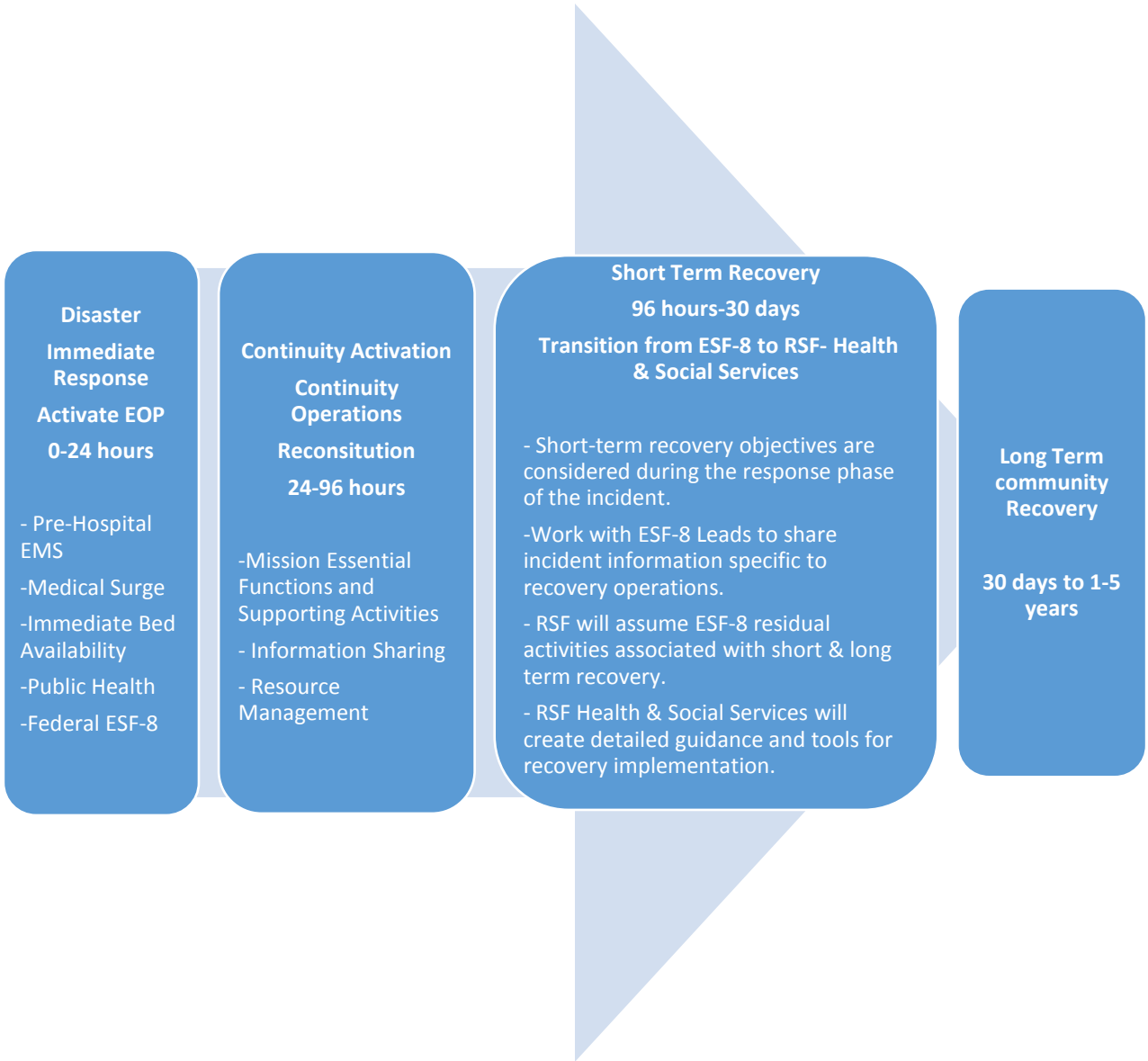
Reconstitution

1. Assist response partners in implementing reconstitution operations
2. Collect situational assessment data from response partners who are reconstituting healthcare operations and provide updates to State Health Authorities and Local/County/State Emergency Management and Recovery personnel

3. Partner through the SHA with State Emergency Management, applicable Federal ESFs, and Federal RSFs to ensure a timely and smooth transition of HCOs to:
    a. Re-Enter Healthcare Facilities
    b. Re-Open Healthcare Facilities
    c. Re-Patriation of Patients
4. Resumption of Normal Healthcare Service Delivery

See Appendix K: Essential Functions and Considerations for Hospital Recovery

Figure 8
How COOP Fits Into Recovery Operations



ASPR Healthcare COOP & Recovery Planning Jan. 2017, pg. 17.

SHORT-TERM RECOVERY

Short-Term Recovery is the demobilization of emergency efforts and the transition to routine activities after an emergency.

The objective of systems restoration is to return primary health care services to a state that provides the greatest responsiveness and effectiveness to the community. Primary care is defined as the level of services provided by the primary care provider for acute and episodic health care needs, with integrated mental health services. This includes, but is not limited to such services as medication refills, ambulatory care management of noncomplex chronic medical problems, and management of stable complex medical problems. For systems restoration to be complete and successful, the county/region should ensure the local/regional healthcare infrastructure includes:

1) A viable system of primary care physicians including internal medicine, family practice, obstetric, and pediatric providers;
2) Emergency medical services are at appropriate levels to respond to a changing health care system;
3) Continuity of operations planning and adequate support of ancillary services are taking place; and
4) Community residents are able to obtain necessary information from benefit providers' databases.

In addition to providing the necessary primary health care, an efficient plan for systems restoration should help revitalize the local economy by restoring and sustaining employment in the local area's healthcare industry. It should also mitigate the impact that a lack of or diminished health care system would have on an area's workforce and attractiveness for future development.

Incorporating Health Considerations into the Recovery Decision Making Process

Several kinds of information can be used to support the incorporation of health considerations into the recovery decision-making process to improve health outcomes after a disaster. These include:

1) Knowledge of the potential health impacts of alternative decisions;

2) Knowledge gained from past disaster experiences and in particular, effective (and ineffective) practices;

3) Knowledge of available resources; and

4) Up-to-date information on the recovery environment (i.e., status).

Reliable sources of each of these kinds of information should be identified in advance of a disaster as part of pre-event planning. Sources of such information include

- Health impact assessments;
- Guidance, training, and technical assistance; and
- Information systems, including health information systems.

Assembling Resources

The choices facing community leaders at the beginning of the recovery planning process are not about the content of the recovery plan; they are about assembling the resources (including human capital) and agendas for the work ahead. Because institutions often work in some degree of isolation, community leaders sometimes are unaware of the key stakeholders that should be integrated into the recovery planning process. The task after a disaster is to ensure that prior collaborations are added to the list of organizational assets and then to incorporate those personnel and groups into the recovery planning effort.

Objectives for Public Health

Local public health representatives should participate in the local and regional Recovery Workgroups to ensure healthcare infrastructure needs are being addressed at both a local and regional level.

1) Within 1 week following an incident, conduct a public health impact assessment for:

- Environmental health conditions, including laboratory water and soil testing.
- Food safety and food establishments.
- Behavioral health interventions.
- Healthcare needs that can no longer be met by community resources (e.g. immunizations, medical care shelters).
- Structural, functional, and operational impacts to healthcare facilities.

2) Within 1 week following an incident, ensure impacted residents have access to:

- Trauma services
- Acute care services
- Behavioral health services
- Emergency Medical Services
- Dialysis services
- Pharmaceutical services
- Vital records

3) Gather data from members of the healthcare community who have been impacted by the disaster in order to provide a complete situational assessment of the healthcare infrastructure for the purpose of requesting a Presidential Disaster Declaration within 1-4 weeks of an event.

4) Ensure 100% of displaced patients evacuated to other facilities are transferred to appropriate permanent facilities within 30 days of the transition to recovery operations.

5) Prioritize the restoration of all other public health and medical services necessary to meet the demand of the population and begin the implementation to restore these services within 1 month of the transition to recovery operations.

6) Provide impact assessment data and strategies to the state Community Planning Capacity Building team to assist with the State Recovery Support Strategy within 6 months of an event.

Tiered Plan

Health departments should be overall responders for the community because they are subject matter experts and can understand what kind of health problems can be addressed. Health departments should make themselves known in the jurisdiction and make themselves a presence. Likewise, they should be active participants in healthcare recovery planning. One point of collaboration between health departments and healthcare facilities is the tiered plan.

The tiered plan sets priorities for facilities to come back online and assists with minimizing emergency department surges at local hospitals. Please note that this section acts as a guide for healthcare facilities to define the tiers in their own recovery plan. The tiered approach serves to separate entities for recovery based on assessment of the community before and after disasters. It does not lock any entity into a plan; it simply establishes priority levels. As the facilities in each tier are reopened, the facilities in the next tier become a top priority. **For tiers 1 and 2, a situational assessment should be obtained every 2 hours.** These tiers may also overlap in some areas as facilities come back online.

Tier 1: Emergent Care Facilities

These are essential facilities whose functions must be restored immediately, ideally within 12-24 hours. These facilities deal with life threatening situations which, if not immediately re-opened, may result in casualties. These facilities include:

- Hospitals
- Dialysis Centers
- Behavioral Health Facilities
- Health Departments

Tier 2: Essential Care Facilities

These are essential facilities which are important but whose reopening can be accomplished within 24-48 hours. These include:

- Pharmacies
- Nursing/Assisted Living Facilities

- Methadone Clinics
- Urgent Care Centers
- Inpatient Facilities

Tier 3: Primary Care Facilities

These are facilities which can take as long as 72 hours to enter the recovery phase following an emergency. These facilities are unlikely to result in casualties if not immediately reopened but may be important for daily living. These facilities include:

- Stand-Alone Labs
- Private Care Doctors
- Home Health Entities

Tier 4: Secondary Care Facilities

These are facilities which can take as long as 96 hours to enter the recovery phase following an emergency. These facilities, while important, are unlikely to result in casualties if not immediately reopened. These facilities include:

- Surgery Centers
- Screening Centers
- Medical Day Care
- Rehabilitation Facilities
- Hospice
- Medical Equipment Sales/Rental Facilities
- Vital Records

Behavioral Health Care Needs of the Community

Disasters are often traumatic events. Expect that those already at risk will need additional care. Also, expect an increase in the number of people needing care. One strategy may include accumulating additional resources as well as assisting existing providers with additional resources. Another strategy may include forming a coalition of qualified providers from a variety of channels who can work toward making care more easily accessible. Local Health Departments should work with their local CORE Service Agency to ensure a local mental health all-hazard disaster plan has been written.

Consider the following:

- Do you have a plan to deal with the short and long-term mental health and behavioral needs in relation to events induced or exacerbated by the disaster?
- How will you provide emotional and psychological care to employees and their families and to patients?
- How do you determine population exposure following an incident? How are disaster mental health needs estimated and assessed?
- When is mental health counseling made available to/promoted among employees, patients, and their families?
- Have you assessed the capacity of mental health services that your facility provides/uses?
- How do you track and record mental health counseling that your facility provides?
- Does your facility promote psychological first-aid and/or psychological resiliency among staff, patients, and their family members? What routine services or outreach is available to staff, patients, and their family members?
- Who are employees instructed to turn to when they are concerned about the wellbeing of a colleague, patient, or family members?
- How does your facility request additional mental health resources from local/state/federal/non-governmental agencies?
- Following an emergency, how are mental health resources coordinated among other providers at the local level, within your facility's service area, and statewide?
- Does your facility have plans to establish and operate a family assistance center (FAC)?
- What public information is your facility prepared to disseminate informing the public how to seek mental health counseling following a disaster?
- Will you offer the option of telehealth?

See Appendix L: Mental Health Services following Disasters

Pollution and Environmental Concerns

Develop a work group to promote coordination between federal, state and local governments, and the private sector when responding to hazardous material incidents and other threats to the environment and the public health. This work group will focus on parks, environmental assets/areas, mold remediation, disaster debris removal, and containing contaminated water and soil. These might be community issues, individual issues, or a combination of both. There should be an emphasis on distributing educational materials and helping people get access to the resources they need. Damage will need to be addressed on individual level and regional level. Consider the following recommendations:

- Inventory all natural resource including key environmental areas, endangered species habitats, floodways, wetlands, aquifers and drinking-water supply watersheds.
- Identify relevant federal programs and incentives that have a role in supporting the preservation, protection, conservation, rehabilitation, recovery, and restoration of natural resources during recovery.
- In the short-term recovery phase, this work group should consistently monitor assets and resources and in the long term, coordinate for their eventual restoration or rehabilitation.

A major contributor to post-disaster health issues is mold, which can quickly grow to unhealthy levels in a home, business, or public building that has had flood damage and may not yet be obvious or thought to be a health hazard immediately. Other post-disaster health-related issues can occur from handling debris or coming into contact with contaminated water or soil.

Strategy

In the case of a major disaster, health-related pollution will most likely need to be addressed on two levels: at the household level and on a regional level. Environmental health concerns include but are not limited to the following:

1) Disaster debris
2) Disposing of household hazardous waste
3) Keeping mold under control
4) Addressing problems with private water wells

These issues can be addressed through public outreach and the distribution of educational materials. The region can utilize existing materials such as those prepared by the Environmental Protection Agency (EPA) and CDC to teach residents safe and practical ways to keep themselves and their homes safe during redevelopment.

The central recommendation for addressing all levels of environmental health concerns, both household and regional, is for the region to develop a collaborative body to deal with environmental health issues that surface within towns/cities, throughout the county, as well as among relevant state and federal entities. This body can serve as a single, comprehensive source of information related to environmental health issues and facilitate repopulation efforts by providing up-to-date information on any health issues associated with contamination, debris, or other storm-related risks. In collaboration with Public Outreach and Environmental Restoration, the organization can launch an environmental health risk communication program to provide information to the public and to local responsible government offices while establishing a long-term monitoring process to assess the impact of environmental factors on health.

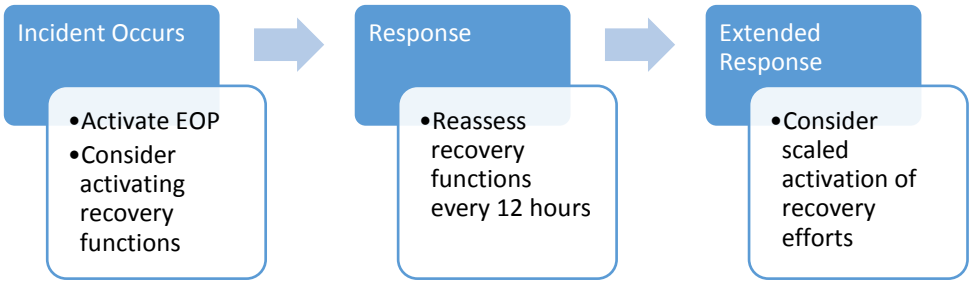
Objectives for Healthcare Facilities

Triggers for Activation and Notification

It is important for facilities to consider how and when they will activate their recovery functions relative to other areas of emergency management such as response plans and continuity of operations plans as there is overlap among all these plans. However, it is imperative that facilities develop clear and specific triggers to activate elements of their recovery functions as early as possible during an incident, see Figure 9. It is also important that facilities do not wait to look to move into active recovery after an emergency.

Figure 9

Healthcare Recovery - Triggers for the Activation of Recovery Functions
1. Facilities should consider activating their recovery functions as soon as their EOP is activated. 2. Facilities should regularly reassess the value of activating their recovery functions when involved in extended response operations (e.g. at least every shift change). 3. Facilities should consider a tiered or scaled activation of recovery functions, giving consideration to potentially conflicting response and recovery objectives.



Essential Functions & Considerations for Hospital Recovery, Sept 2013

It is also important for facilities to discuss possible threats that may require a response plan, a short-term recovery plan, and the activation of an emergency operations plan including when notification should begin. Possible threats may come from a situational assessment and may include a hurricane, a terrorist attack, or a pandemic. Additionally, there are questions to consider when creating an activation plan, such as:

1. How do you transition from response to recovery?
2. What is the process for activating recovery functions? Is it scalable?
3. What are the criteria/triggers for activating the recovery functions?
4. Who activates recovery functions during response?
5. How are recovery functions activated?
6. How to address the impact of HIPAA Security? See Appendix M: Impact of HIPAA Security

Notification

The internal notification process describes how staff should notify management/other health entities/the public following the detection or receipt of information indicating the occurrence of an unusual public health incident(s) as well as describing how any additional notifications will be made. The person who receives the threat will then alert the next person who will, in turn, assess the situation and determine if the incident command system will be used in any level of plan activation or response.

Each entity has its own staff that will be responsible for internal messaging. The jurisdiction is responsible for notifying the community at large.

Plan Considerations

1. Who determines when notification is necessary?
2. Notification levels
3. Who to notify for each level
4. How will you alert stakeholders (text, email)?
    a. Identify contacts, update.
    b. If those people cannot help, who else can you rely on? Look to people with whom you don't regularly do business.
5. Who will you contact first?
6. Will you notify the public? How?

The chart provided (Figure 10) is only to be used as a rough guide. Entities must determine what triggers/resources/levels they will utilize based on need.

Figure 10

Notification Level	Indication	Who To Notify	Status
White	Initial assessment does not warrant further notification	N/A	No action needed. Business as usual.
Yellow	Credible but unsubstantiated threat, developing situation or significant concern that does not immediately impact Region III.	• Region III Coalition	Be aware. Region III may establish an incident management team for planning or response purposes.

Orange	Potential Threat that may impact Region III.	• Region III Coalition	Be ready. Region III may establish an incident management team for planning or response purposes.
Red	Confirmed threat to Region III.	• Region III Coalition	Take action. Implement response as per All-Hazards Response and Recovery Plan. Incident management team will be activated.

Standards, Goals, and Objectives

Healthcare facilities can improve their recovery if they have standards/goals that the healthcare facility can target. The following are aspirational recovery standards/goals.

1. Restore the capacity and resilience of essential health and social services to meet ongoing and emerging post-disaster community needs.
2. Encourage behavioral health systems to meet the behavioral health needs of affected individuals, response and recovery workers, and the community.
3. Promote self-sufficiency and continuity of the health and well-being of affected individuals; particularly the needs of children, seniors, people living with disabilities whose members may have additional functional needs, people from diverse origins, people with limited English proficiency, and underserved populations.
4. Assist in the continuity of essential health and social services, including schools.
5. Reconnect displaced populations with essential health and social services.

While the aforementioned standards/goals improve accountability, they are not concrete, specific objectives. Facilities should set simple, measurable, achievable, realistic, and task-oriented (S.M.A.R.T.) objectives during recovery just as they do during response. Facilities can consider their operations and organizational priorities in order to set S.M.A.R.T. objectives during recovery. Facilities should consider response actions and decisions that will automatically generate recovery objectives, see Figure 11. Anytime a service or normal business operation is altered, reduced, or shut off during response, there may be actions the entities need to take during recovery to return to normal operations or to prepare for the next emergency.

Figure 11

Facility Recovery - Setting Recovery Objectives

1. Develop Standing Recovery Objectives
    a. Ensure the safety of staff and patients throughout all recovery efforts
    b. Prioritize facility functions as they relate to the facility's mission
    c. Stabilize complex medical problems
    d. Provide basic healthcare
2. Prepare Pre-Written Recovery Objectives that are Triggered by Response Actions
    a. Examine response actions that require attention during the recovery phase to help the entity resume normal operations

- Ex. 1 (power outage): Service and refuel emergency generators within 24 hours of power restoration
- Ex. 2 (power outage): Reschedule cancelled elective procedures within 72 hours following restoration of power/surgical services
- Ex. 3 (MCI/surge): Offer staff critical incident stress debriefings before they are sent home following any mass casualty incident

3. Prepare to Establish Incident Specific Objective(s)
    a. Prioritize short-term and long-term department, unit, service, and/or utility recovery objectives based upon facility-wide damage assessment, facility needs, and community needs
4. Prepare to Establish Incident Specific Objective(s)
    a. Conduct Public Health Assessment Within 1 Week

Essential Functions & Considerations for Hospital Recovery, Sept 2013

Resource Requests and Funneling Resources to Existing Facilities

See Appendix N: Region III Procedures for Deployment of Assets & Resource Request Form

It is important to know your partners and what they can supply. The Region III Resource Management Plan summarizes the operational elements of each regional resource to allow for rapid requests and deployment during emergency responses and identify the triggers that will initiate regional resource availability. Furthermore, it highlights the existing regional capabilities while delineating the appropriate vertical and horizontal communication pathways for equipment mobilization.

If regional partners cannot reopen existing healthcare facilities, it may be necessary to activate alternate care sites or send resources to healthcare facilities that can accommodate overflow. Alternate care sites may be used during an emergency but their eventual closure may cause gaps in service. To prevent this, consider funneling resources to existing providers who can improve their facilities and accommodate the overflow. This will be less disruptive to the community. The preference is to resume operations at previously established places or send resources to healthcare facilities that can accommodate overflow rather than create a new normal in a facility that will be difficult to close.

Medical Personnel Retention and Recruitment

Even during normal operations, retaining quality healthcare professionals can be a challenge. For the jurisdiction to be able to build a viable and responsive health and medical system, it will need a solid and permanent base of providers, which may not be overtly available immediately after a disaster Maryland Responds, the State of Maryland Medical Reserve Corps, will be utilized for recruiting medical staff and as a way to organize sources/staffing/mental health resources post-disaster including, but not limited to, providers, nursing, mental health, laboratory, radiology, pharmacy, administrative, financial, facility, as well as any other specialized or general occupations. It is critical to consider the immediate needs of medical staff such as housing, child care and daily essential needs.

> ***Uniform Emergency Volunteer Health Practitioner Act (UEVHPA)***
> *(A national movement that has not yet been adopted in Maryland)*
> *UEVHPA establishes a system whereby healthcare facilities and disaster relief organizations in affected states (working in cooperation with local emergency response agencies) can use registered professionals (health professionals in Maryland would register with Maryland Responds) to confirm registrants are appropriately licensed and in good-standing. Properly registered professionals would have their licenses recognized in affected states for the duration of emergency declarations, subject to any limitations or restrictions that host states determine may be necessary.*

Maryland Responds Medical Reserve Corps (MDRMRC) Network

The mission of the MDRMRC Network is to enhance Maryland's emergency preparedness and response capabilities by augmenting county, regional and state level public health and medical services with a source of pre-identified, credentialed, and trained volunteers.

The MDRMRC State Program is responsible for the development of a statewide system of MDRMRC Units to facilitate a coordinated approach to volunteer management. Based on the CDC's *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, volunteer management is the ability to:

1. Coordinate volunteers
2. Notify volunteers
3. Organize, assemble, and dispatch volunteers
4. Demobilize volunteers

Housed within the Maryland MDH, OP&R, the MDRMRC State Program aims to support MDRMRC Units in each of these functional areas by providing resources, guidance, and technical assistance, to meet local needs, build capacity, and strengthen response capabilities.

MDRMRC volunteers include medical and public health professionals, such as physicians, nurses, physician assistants, pharmacists, dentists, veterinarians, and epidemiologists. Many other nonmedical community members also support the MDRMRC, such as interpreters, chaplains, office workers, and legal advisors.

All volunteers, regardless of professional background, should* meet the following requirements for membership and to become eligible for deployment:

Membership Requirements:

1. Must beat least 18 years of age
2. Must complete the online application through the Registry

Deployment Eligibility Criteria:

1. Complete the MDRMRC required training courses.
2. Must keep their volunteer profile 100% complete ensuring their contact and license information is up-to-date at all times
3. Must agree to abide by and sign the "MDRMRC Liability Policy"
4. Must agree to abide by and sign the "MDRMRC Confidentiality Policy"
5. Follow procedures to obtain MDRMRC ID badge and Polo shirt
6. Must remain free of felony and serious misdemeanor convictions

**Exceptions may be made based on situational need during emergency response activations.*

Automatic license verification is built into the Registry for some healthcare occupations regulated by State Licensing Boards. Credential verification for the healthcare licenses that are not automatically verified by the Registry are conducted manually by the MDRMRC State Administrators when issuing ID badges.

In addition, certain healthcare occupations and facilities regulated by MDH require background checks as part of the professional or facility license. This information will be considered when determining whether an additional background check through the Registry will be needed. The following is a list* of healthcare professions, regulated by the Maryland Professional Licensing Boards that require a criminal history background check:

- Psychologist
- Registered Nurse
- Chiropractor
- Pharmacist

*This list is not all inclusive and will be updated when additional information is available.

See Appendix O: Maryland Responds Paper Registration Form and Volunteer Request Form

INTERMEDIATE RECOVERY

Goals

1) Provide impact assessment data and strategies to the state Community Planning Capacity Building Recovery Support team to contribute to the development of the State Recovery Support Strategy (SRSS).

- Collate impact assessment data and provide to the Community Planning Capacity Building Recovery Support Function.
- Provide strategy recommendations for the State Recovery Support Strategy (SRSS), which will include long-term recovery needs and transition strategy to appropriate partners.
- Provide on-going subject matter expertise and comments regarding the SRSS.

2) Collaborate with the Long-Term Recovery Committee to establish and accomplish milestones.

- Continue to participate in the Committee and give the state Public Health and Healthcare Services team related updates for relevant milestones.
- Continue to provide subject matter expertise, technical assistance, and recommendations necessary to achieve milestones.

Ongoing Disaster Impact Assessments

In the aftermath of a disaster, a disaster impact assessment can help determine what damage the disaster has caused, providing public officials and emergency management with information about the needs of an affected community. The assessment includes not just damage to infrastructure but all of the needs of the community. As part of this assessment, interview teams comprising staff and volunteers from state, local, and regional health departments conduct community-specific surveys. Officials can then use this information to identify what resources are needed and to target specific warnings to affected residents.

The disaster impact assessment helps identify unmet health needs. It is important that such assessments be conducted periodically throughout the response and recovery process following a disaster. Such reassessment provides real-time information about the status of various health-related factors such as housing, mental health, and utilities services. As response and recovery activities progress, the health needs of a community may change, especially if migration of families takes place into or out of an affected community. Conducting a disaster impact assessment immediately after a disaster and then reassessing throughout the recovery process enables continuous monitoring of how a disaster has impacted and continues to impact the health of a community.

Displaced Assisted Living and Nursing Home Patients

Special attention should be given to nursing home residents during long-term redevelopment as evacuated residents return to their home facilities. There is likely to be a shortage of qualified staffing and suitable facilities. The return of these residents must be closely coordinated with emergency management personnel, and financial assistance or mutual aid agreements may be needed.

Note: According to Global Action on Aging, medical clinicians in Louisiana reported after Hurricane Katrina that the health status of patients returning to their care had declined significantly.

Facilities should take into consideration the length of time it takes to improve the health status of many returning nursing home evacuees who may be experiencing functional and mental decline. This will affect the amount and expertise level of staff that facilities need to have on hand throughout redevelopment.

Establish a community based working group of representatives from local nursing homes, senior advocacy groups, the Health Department, and the Health and Social Services Department to assess the level of preparedness of facilities to meet the needs of their residents in a disaster event and ensure that they can provide appropriate services. The coalition can also look into expanding medical recruitment and retention programs to include qualified staff for nursing homes that will be in high demand throughout redevelopment. Training programs can be developed to quickly train staff for issues and circumstances unique to evacuation and reentry situations.

LONG-TERM RECOVERY

Community Plan

Each community must determine, based on its own unique circumstances, what a successful disaster healthcare recovery looks like. Some communities will want to rebuild every healthcare component as it was before the disaster. Others will plan for growth or use the opportunity to consolidate or restructure healthcare projects and services. Some communities, particularly those experiencing widespread devastation, choose to re-invent themselves from the ground up.

The following four gaps impede the development of plans to "build back better," and specifically in ways that contribute to an overall healthier community:

- Inadequate pre-disaster community health improvement planning (not being done at all, or not using a process that engages the full range of community stakeholders in addressing the comprehensive physical and social determinants of health);
- Inadequate integration of health improvement planning and the community comprehensive (strategic) planning process use to set priorities and allocate funds;
- Lack of integration of health improvement planning and disaster recovery planning;
- Insufficient awareness across all sectors of the health-related threats and opportunities posed by disasters and of the benefits to be gained from integrating community health improvement objectives and priorities into comprehensive and disaster recovery plans to achieve shared goals.

Once the recovery plan is agreed upon, then a community can integrate its plan. Progress is continually measured as predetermined. Even if it is not possible to tackle each priority area initially, a prioritized list makes it possible to evaluate future opportunities to determine how they can be leveraged to achieve the vision. Thus, the process of implementation feeds into a continuous cycle of assessment, planning, and implementation.

Goals

Long-term healthcare recovery is a lengthy process, and keeping track of goals is an effective tool for progress. Some suggested goals are as follows:

1) Aim to sustain efforts and keep people engaged.

2) Continue to conduct healthcare damage assessments and accept resource requests. Depending on the type of incident, healthcare facilities should be checked for structural damage and reported to the proper authorities. If the facility wants a declaration from FEMA, a government entity will do a community assessment, and the facility will do an internal one. Procurement for general clean up and repair should be initiated. Some areas may need to be decontaminated.

3) Continue to focus on restoration. The facility should conduct an inventory of all supplies, equipment, medicines, and resources then reorder as necessary.

4) Continue to provide psychosocial support and personnel recognition. Both facility staff as well as patients may need psychosocial support. Organizations should consider overtime compensation, furloughs, and/or special child-care support needs for facility staff. Staff who also received medical treatment may need additional support. A point person should be selected to monitor staff for undetected issues.

Community Engagement

Successful recovery and the post-disaster rebuilding of healthier and more sustainable and resilient communities require the coordinated efforts of an extremely broad, multidisciplinary group of stakeholders (i.e., a whole-community approach). Yet many of these stakeholders are not accustomed to working in the emergency management context and are not familiar with planning processes, terminology, or resources. Therefore, it is integral that community partners and residents-at-large are involved even though they may not be familiar with emergency planning. A community that is working across all sectors to achieve improved population health during normal/ daily operations is inherently better suited to recovering from a disaster.

In order to engage the community in an efficient manner, the community should be an active participant in every aspect of the healthcare recovery process. The community should be included in the development and implementation of plans. Local government must balance two competing priorities- speed and deliberation. Balancing speed and deliberation will prevent stakeholders from nostalgic feelings of restoring the community to the status quo when long-term planning could lead to better and more improvements.

1) Participation is critical to ensuring that healthcare recovery decisions align with the community's vision and that community values are respected in decisions about contested issues. Such conversations may center on short-term issues such as setting priorities and goals to ensure access to scarce health resources as well as controversial long-term decisions such as buyouts through eminent domain.

2) An inclusive process leverages existing community organizations and social networks, which builds trust, ensures that local needs will be met, and creates a sense of ownership, thereby increasing the likelihood of success.

3) The active engagement of the community in the healthcare recovery planning process also promotes healing and strengthens resilience. When the community gathers together to plan and implement a recovery strategy, ties among residents are strengthened, thereby building social networks and empowering residents.

It may be helpful to communicate to the community that this process has been successfully implemented in many jurisdictions. Leadership might decide to provide a document that outlines federal, state, and local resources and how they work together after a disaster. The document probably states who is accountable at each level and what their functions are. Organizational structures for recovery planning must enable bidirectional communication between the community and decision makers. For example, there may be partnerships between local government and community organizations, or there may be official advisory bodies that represent different sectors of the population and act as a link between the community and decision makers. These bodies represent the voices and needs of the affected population.

Advisory Bodies

Some jurisdictions have opted to create official bodies to engage with the community and obtain input on the recovery process. These bodies act as a link between the community and decision makers, and they should represent the full geographic, cultural, and economic diversity of the community to ensure that the voices and needs of all the affected population are heard. After severe weather caused major flooding in Iowa in 2008, for example, the governor established the Rebuild Iowa Advisory Commission (RIAC), a 15-member independent advisory body made up of a cross-section of Iowans. The RIAC traveled to affected areas of the state, holding town meetings and talking to residents to gain insight into their immediate- and long-term needs, and then developed recommendations for recovery and provided strategic direction to recovery decision makers. The RIAC proved to be an invaluable tool for focusing the recovery effort on the needs of residents and giving Iowans a channel for their feedback on the recovery process.

There may already be community advisory boards established in some local jurisdictions. Local health departments should attempt to educate those associated with the management of these advisory boards on the topic of healthcare recovery and the importance of pre-recovery planning and how the advisory boards could provide critical feedback on the healthcare needs of the community.

Leadership

The effective governance of healthcare recovery from a disaster requires strong leadership that harnesses the actions of a broad array of agencies from multiple levels of government, along with the nonprofit and private sectors, to address highly complex and interrelated challenges using an integrated multidisciplinary approach. Several emerging approaches to leadership have particular relevance to the healthcare disaster recovery context:

- **Meta-leadership** is an approach to leadership focused specifically on breaking down organizational silos and fostering a spirit of cooperation that motivates people to work together. Core to the concept of meta-leadership is the ability to lead by influence, since engaging organizations outside of one's silo necessarily means reaching beyond lines of authority. This ability is particularly crucial during recovery, which has been characterized as “nearly the opposite of command and control.”
- **Distributive leadership** is based on the premise that diffusion of responsibility and authority is needed in situations where a centralized command and control approach cannot

adequately meet complex decision-making needs. After a disaster, distributive leadership enables rapid response to changing conditions on the ground through locally informed decisions. “With distributive leadership, there is a shift from reliance on systems and procedures to an increased capacity to adapt, to change, learn, and innovate.”

Learning System

Leaders must be prepared to act using the best information available and to change course as new information emerges. Consequently, decision-making frameworks need to be built on a learning system approach whereby new knowledge is captured as strategies are implemented and is fed back into the decision-making process to support continuous improvement.

Communities are complex adaptive systems, and an adaptive management approach to disaster healthcare recovery is therefore warranted. Adaptive management is an approach that allows community leaders and members to explore alternative ways of achieving disaster healthcare recovery objectives, identify potential health outcomes, implement one or more methods, and monitor their impacts on the healthcare recovery process so that course corrections can be made in the process of iterative decision making. Continuous evaluation of progress toward healthcare recovery goals is thus an integral part of the process that needs to be incorporated into the overall healthcare recovery process. Evaluation can occur at multiple levels, including the individual organization, sector, and community levels (e.g., through a composite recovery indicator). This learning-based approach to decision making links learning with policy and implementation over time, providing a framework that enables healthcare policy planners to make good decisions in the face of uncertainty.

Healthcare Recovery Workgroup

It is recommended to appoint a healthcare recovery manager to oversee long-term efforts. The healthcare recovery manager should be chosen from the workgroup. Additionally, each healthcare facility should appoint a recovery manager.

Healthcare recovery managers oversee health impact assessments, which are used after an incident to determine what healthcare services are required to address the current health needs of the community in terms of resources and possible health needs that may occur in the future. Assessments are utilized to evaluate infrastructure as well as patient and staff needs. As response and recovery activities progress, the health needs of a community may change, especially if migration of families takes place into or out of an affected community. Conducting a disaster impact assessment immediately after a disaster and then reassessing throughout the recovery process enables continuous monitoring of how a disaster has impacted and continues to impact the health of a community. Such reassessment provides real-time information about the status of various health-related factors such as housing, mental health, and utilities services.

Vulnerable Populations

Populations who are particularly vulnerable to health problems due to age, disability status, race/ethnicity, socioeconomic status, geography, or gender may need additional assistance during

recovery. Some identified barriers may include transportation, education, information, economic factors, language, or cultural barriers amongst others.

Homeless populations are also vulnerable populations. It is recommended that the community build partnerships and alliances among organizations representing this population. Organizations may include food banks and soup kitchens, transitional services, and various types of shelters.

Seeking and Applying Recovery Resources

Developing a comprehensive financial strategy is an important component of the recovery planning process. This strategy should consider a community's needs, known sources of recovery resources, and any potential gaps in funding. The process of distributing and applying recovery resources is complex, and it requires that a community best match the available resources to its needs. Furthermore, to obtain and implement these resources effectively requires a thorough understanding of the varied sources of funding available, along with the requirements and restrictions associated with each.

In the case of a major disaster, funding may be available for short-term behavioral health support and for the repair of critical health care infrastructure. In addition, a supplemental appropriation can potentially generate funds for specific social service needs. Largely, though, recovery resources are allocated predominantly to other sectors and services. However, the activities of other sectors can be leveraged in ways that have a positive effect on health outcomes. It is here that health sector stakeholders need to have pre-established relationships with other agencies to ensure integration and coordination of resource allocation to support long-term health, resilience, and sustainability. The use of recovery resources by all sectors represents an opportunity to consider health impacts and to develop complementary strategies whereby these funds can be used to achieve multiple goals, one of which is improved health.

Section 1135 Waivers for Certain Medicare/Medicaid Providers

Section 1135 of the Social Security Act provides the U.S. Secretary of the Department of Health and Human Services (HHS) with authority to temporarily waive or modify application of certain regulatory requirements for healthcare facilities, including some provisions of Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), HIPAA, and the Emergency Medical Treatment and Labor Act (EMTALA).

To issue a Section 1135 waiver:

- The President of the United States must declare an emergency or disaster pursuant to either the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and
- The Secretary of HHS must declare a public health emergency under Section 319 of the Public Health Service Act.

It is important to note that **a Section 1135 waiver affects only those provisions of law or regulations named in the waiver; any provisions or regulations not contained in the waiver remain unchanged**.

For example, during a declared public health emergency, the Secretary of HHS may issue a Section 1135 waiver that modifies limitations on payments for certain items and services furnished

to patients through Medicare; however, unless explicitly stated, this particular waiver would not affect any provisions of HIPAA or EMTALA, and sanctions for violations of those laws would continue to apply.

Examples of some of the provisions or requirements that **may** be temporarily waived or modified through a Section 1135 waiver include, but are not limited to:

- Certification requirements, program participation requirements, and pre-approval requirements for healthcare providers participating in Medicare;
- Limitations on payments for certain healthcare items and services furnished to individuals enrolled in a Medicare + Choice plan by healthcare providers (both individuals and facilities) not included in such a plan;
- Requirements that healthcare providers be licensed in the state in which they provide services;
- Sanctions for transfers of patients that would otherwise violate EMTALA;
- Sanctions regarding federal physician self-referral prohibitions; and
- Conditions of participation from noncompliance with regulations pertaining to HIPAA and the HIPAA Privacy Rule.

A Section 1135 waiver may be made retroactive to the beginning of a declared emergency period or any subsequent date specified by the Secretary of HHS. These waivers terminate upon either the termination of the related disaster or emergency, or 60 days after the waiver is published, unless the Secretary of HHS wishes to extend the waiver pursuant to law.

Section 1135 waivers are designed mainly to ensure that:

- "Sufficient healthcare items and services are available to meet the needs of individuals in area[s]" affected by a declared disaster or emergency who are enrolled in Medicare, Medicaid, or SCHIP; and
- Healthcare providers who provide goods or services in good faith may "be reimbursed for such items and services and exempted from sanctions" if they are unable to comply with program requirements during a declared emergency or disaster, "absent any determination of fraud or abuse."

While the above list includes a number of provisions that may be waived, response personnel should always assume that all laws and regulations not listed in the Section 1135 waiver are still in full effect and should make every effort to comply with the requirements of the current legal framework.

After Action Reporting/Debriefing/Maintenance and Monitoring

Consider drafting a formal After-Action Report which discusses strengths and weaknesses in how the emergency was handled. The information that is collected can be used for future rounds of planning. This creates the opportunity for further improvement.

All levels of personnel within the Healthcare Recovery Support Function and other healthcare organizations impacted by the disaster should be required to participate. This will increase engagement and accountability. Consider setting milestones and goals with a defined period then have an after-action conference after each is met. This allows continuous assessment. Even without an emergency, the plan should be tested, assessed, and readjusted annually.

APPENDICES

Appendix A: Framework for Integrating Health into Recovery Planning

Collaborative Roles of Sector and Community Stakeholders in the Integration of Strategic Planning Processes[a] to Achieve Healthier and More Resilient and Sustainable Post-Disaster Communities

	Visioning	Assessment	Planning	Implementation
Task	Educate community on elements of healthy, resilient, and sustainable communities	Conduct community health assessments, ensuring that Internal Revenue Service (IRS)-required hospital Community Health Needs Assessments (CHNA) are integrated	Develop health improvement plan based on health assessment	Exercise pre-disaster recovery plan by practicing organizational arrangements suited to hypothetical disasters
Lead(s)	Public health, emergency management, urban and regional planning	Public health, health care	Public health	Emergency management
Partners	All sectors, all stakeholders, community members	Social services, behavioral health	All sectors	All sectors
When[b]	❶ ❸	❶ ❸	❶ ❸	❶
Task	Conduct community visioning process	Assess vulnerability of critical infrastructure	Develop comprehensive plan, ensuring inclusion of all relevant plans (e.g., hazard mitigation, health improvement, economic, redevelopment)	Adopt regulations, incentives, programs, budgets, and community outreach to achieve community vision and goals
Lead(s)	Urban and regional planning, public health	Public health, public works, emergency management, facility management, planning	Urban and regional planning	Chief executive, community managers, elected governing body
Partners	All other sectors	Management, finance, budget	Public health, emergency management, other local agencies	All implementing agencies and organizations
When[b]	❶ ❸	❶ ❷ ❸	❶ ❸	❶ ❷ ❸
Task	Incorporate community vision into comprehensive planning process	Identify areas with large socially vulnerable populations	Plan organizational structures for post-disaster coordination of activities	Seek methods for making optimum use of technology and information systems for both public outreach and pre-disaster policy analysis
Lead(s)	Urban and regional planning, public health, environmental health, social services	Public health, urban and regional planning, emergency management, social services	Emergency management	Emergency management, public health, urban and regional planning

	Visioning	Assessment	Planning	Implementation
Partners	All sectors, plus management, finance, budget offices	Research organizations, community groups, neighborhood associations, health and medical system partners	All sectors	All sectors
When[b]	❶ ❸	❶ ❸	❶	❶ ❸
Task	Ensure that pre-disaster recovery plan incorporates community-developed vision of healthy, resilient, sustainable community	Periodically assess effectiveness of institutional arrangements that promote cross-sector collaborations and joint mitigation activities	Develop pre-disaster recovery plan	Establish joint communications center; facilitate information exchange on community recovery needs
Lead(s)	Emergency management, urban and regional planning	Emergency management, urban and regional planning, public health	Urban and regional planning, economic development agency, emergency management	Emergency management, public officials
Partners	Public health and other agencies	Education system, health and medical system partners, business representatives	All sectors	Public health, health care, behavioral health, social services
When[b]	❶	❶ ❸	❶ ❸	❷
Task	Periodically revisit community vision statements for relevance in light of changing conditions and altered vulnerabilities	Assess unmet social needs, pre- and post-disaster	Conduct health impact assessments to inform recovery planning	Develop recovery finance strategy, determine funding eligibility, apply for funds, administer grants
Lead(s)	Urban and regional planning, public health, emergency management	Social services	Public health	Designated recovery manager
Partners	All sectors, plus management, finance, budget offices	Public health, behavioral health, emergency management	All sectors	All sectors
When[b]	❶	❶ ❸	❸	❸
Task	Monitor economic development and community development initiatives that may strengthen the community, add resilience, create sustainability	Conduct post-disaster assessment of disaster impact on infrastructure and systems	Develop post-disaster recovery plan	Carry out recovery projects and programs; arrange project and program management

	Visioning	Assessment	Planning	Implementation
Lead(s)	Urban and regional planning, public health, emergency management	Emergency management	Emergency management, urban and regional planning	All sectors
Partners	All sectors, plus management, finance, budget offices	Urban and regional planning, public works, public health, management	All sectors	Management departments such as budget, finance, legal services
When[b]	❶	❸	❸	❸

a The processes to be integrated include community comprehensive planning, health improvement planning, mitigation/ resilience planning, and disaster recovery planning.
b 1 = pre-disaster; 2 = response and short-term recovery; 3 = long-term post-disaster recovery. Coloring of the symbols indicates urgency: red = priority; black = possibility.

Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery

Committee on Post-Disaster Recovery of a Community's Public Health, Medical, and Social Services; Board on Health Sciences Policy; Institute of Medicine

National Academies Press (US); 2015 Sep 10.

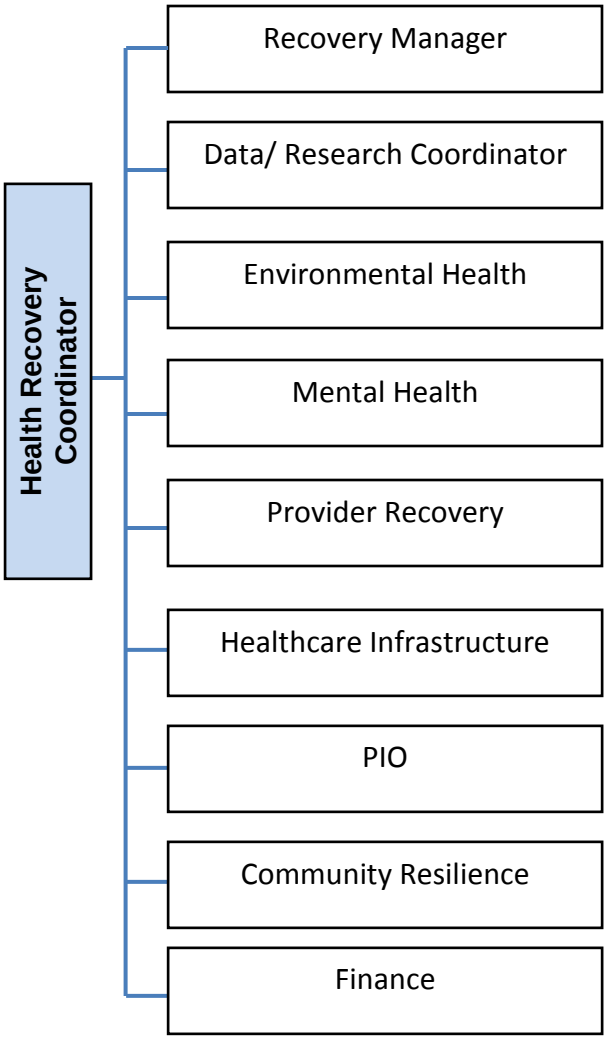
Appendix B: Healthy Resilient & Sustainable Communities after Disasters: A Discussion Toolkit

Healthy Resilient and Sustainable Communi

Appendix C:

Recovery Workgroup Flyer

Proposed Recovery Workgroup: The group will meet weekly at first, then biweekly for one year at which time the group will reassess its meeting schedule. The Recovery Manger will produce a biweekly progress spreadsheet. The proposed tasks are based on previous recovery efforts documented in peer-reviewed journals or reference works.



Recovery Manager
Directly manage the schedule/progress/information flow of the recovery process.

Data/ Research Coordination
Compile and formulate data for Recovery Manager.

Environmental Health
Coordinate response to mold, carbon monoxide, hypothermia, bleach poisoning, vectors, land use, sanitation/hygiene, disaster inspections, etc.

Mental Health
Monitor and manage mental and behavioral health concerns. Advise on service delivery in impacted areas.

Provider Recovery
Advise on health impacts and healthcare service provision for impacted areas. Consider a public health impact task force.

Healthcare Infrastructure
Coordinate public health input into infrastructure recommendations for healthcare systems.

Public Information Officer
Coordinate, create and distribute community messages and ongoing educational/community campaigns.

Community Resilience
Coordinate involvement in long-term recovery committees; act as liaison with community organizations and vulnerable population groups.

Finance
Coordinate financial recovery and reimbursement processing.

Appendix D: Maryland Department of Health Recovery Operations Checklist

Stabilized Response/Short-term Recovery (Impact through first week)		
Activity	**Responsibility**	**Date/Time Completed**
Select a Public Health and Healthcare Services (PHHS) Recovery Coordinator (OP&R Director or designee)	OP&R Director	
Set up Recovery Operations: • ICS structure • Situation Report schedule • Operational Tempo	OP&R Director/ PHHS RSF Recovery Coordinator	
Attend all MEMA Recovery Support Function Leadership Group conference calls and provide updates as available. Notes from this meeting should be sent to Recovery Operations team.	PHHS RSF Recovery Coordinator	
Conference calls with all impacted PHHS ESF (ESF-8)/RSF partners - discuss issues/outstanding needs for: • COOP planning • Public Health Impact Assessment: Environmental health conditions, including laboratory water and soil testing Food safety and food establishments Behavioral health interventions Healthcare needs that can no longer be met by community resources Structural, functional, and operational impacts to healthcare facilities	OP&R Director/ PHHS RSF Recovery Coordinator	
Investigate and report on deaths due to the incident. Daily reports are submitted for inclusion into the Situation Report	OCME	
Maintain surveillance on event related illnesses via ESSENCE. Daily reports are	OP&R Epidemiology	

submitted for inclusion into the Situation Report		
Continue to schedule, deploy, and staff shelters as needed (Maryland Responds and/or other MDH staff as needed)	Professional Volunteer Coordinator/ OP&R Director/ PHHS RSF Recovery Coordinator	
Submit a list of impacted healthcare facilities to OP&R for inclusion in the Situation Report	OHCQ	
Provide technical assistance for Public Health Impact Assessments (to be conducted by local health departments) - consult MDH Recovery matrix for MDH roles/responsibilities. Assessments should be completed within first week. Environmental health conditions, including laboratory water and soil testing Food safety and food establishments Behavioral health interventions Healthcare needs that can no longer be met by community resources Structural, functional, and operational impacts to healthcare facilities	PHHS RSF Recovery Coordinator with support from MDH Offices/ Administrations as necessary	
Ensure impacted residents have access to - should be completed within first week: Trauma services Acute care services Behavioral health services EMS response services Dialysis services • *Pharmaceutical services* • *Vital Records* *Some of these services may provided through a Disaster Assistance Center - ensure health staffing of this center	PHHS RSF Recovery Coordinator with support from MDH Offices/ Administrations/LHDs and MIEMSS as necessary	
Send MDH sanitarians to flooded areas (when deemed safe) to inspect: • Wells • Packing houses • Seafood industry	Food Control	

• Restaurants		
Sanitarians: • Verify available staff and status of Baltimore and Hagerstown Offices. • Double staff cars to inspect seafood operations around Bay and collect water samples for testing from wells once floods have receded. • Handout disinfection methodology to operations with flooded wells. • Inspect facilities flooded by storm or with extensive power outages. • Support industry by witnessing food write-offs for insurance claims. • Support disposal of major quantities of adulterated foods. • Support LHDs with resource issues either with available State staff, re-deployed sanitarians from less impacted counties or Federal staff via Baltimore FDA office or FDA Regional office in Philadelphia. • Support food related requests from MEMA as necessary. • Check potable water availability, particularly south of Cambridge. • Issue stock press releases as necessary on: ▪ Power Outages – refrigerators/freezers/food disposal. ▪ Recovering from floods – cleaning/food disposal/kitchen equipment. ▪ Icemaker cleaning, etc. – from flooded water systems/wells.	Food Control	
Provide infection control immunizations support to local public health	IDEORB	
Public information in the affected areas to include information as needed on: • Boil water/safe water practices • Safe food information • Behavioral health information • Mold and mildew eradication • Lead/Asbestos • Infectious disease/immunization updates • Other public information warning/recovery messaging as appropriate (including sharing information from other partners)	MDH PIO	
If already occurred during response, request Maryland Insurance Administration issue bulletins requiring pharmacies to waive time restrictions for prescription	OP&R Director/ PHHS RSF Recovery Coordinator	

medication refills and replacements for durable medical equipment, eyeglasses, and dentures for residents living in affected areas		
If already occurred during response, request Maryland Insurance Administration issue bulletins encouraging insurers to provide reasonable accommodations to life/health insurance policyholders in affected areas, including, but not limited to a grace period for premium payment.	OP&R Director/ PHHS RSF Recovery Coordinator	
Coordinate/communicate with HHS Region III and federal partners as needed	OP&R Director/ PHHS RSF Recovery Coordinator	
Intermediate Recovery (weeks to months)		
Activity	**Responsibility**	**Date/Time Completed**
Prioritize the restoration of all other public health and medical services necessary to meet the demand of the population and begin the implementation to restore these services within 1 month of the transition to recovery operations.	PHHS RSF Recovery Coordinator with support from MDH Offices/ Administrations/LHDs and MIEMSS as necessary	
Ensure 100% of displaced patients evacuated to other facilities are transferred to appropriate permanent facilities within 1 month of the transition to recovery operations.	PHHS RSF Recovery Coordinator with support from MDH Offices/ Administrations and MIEMSS as necessary	
Provide data to inform the request for a Presidential Disaster Declaration within 1-4 weeks of an event.	PHHS RSF Recovery Coordinator	
Continue to support local public health participation in Disaster Assistance Centers as needed	PHHS RSF Recovery Coordinator	

Send MDH sanitarians to flooded areas (when deemed safe) to inspect: • Wells • Packing houses • Seafood industry • Restaurants	Food Control	
Assist food wholesale/retail facilities with expedited plan reviews and inspections in response to repair activities.	Food Control	
Support local health departments with their PHHS RSF planning and operations, to include technical assistance and other resources as available	PHHS RSF Recovery Coordinator	
Coordinate/communicate with HHS Region III and federal partners as needed	OP&R Director/ PHHS RSF Recovery Coordinator	
Assist facilities with expedited plan reviews and inspections in response to repair activities.	OHCQ	
Continue to monitor facilities with drowned wells for re-occurrence of contamination (Isabel – UV treatment – testing over 6 months).	MDE	
Collect expenditure reports for potential reimbursement	OP&R Director/ PHHS RSF Recovery Coordinator	
Provide impact assessment data and strategies to the Community Planning Capacity Building RSF to inform the development of the State Recovery Support Strategy (SRSS) within 6 months of an event.	PHHS RSF Recovery Coordinator	
Long-term Recovery (months to years)		
Collaborate with the Long-Term Recovery Committee to establish and accomplish applicable milestones.	PHHS RSF Recovery Coordinator	
Support local health departments with their PHHS RSF planning and operations, to include technical assistance and other resources as available	PHHS RSF Recovery Coordinator	

Appendix E: SUMMARY OF RECOVERY RECOMMENDATIONS

This is a list of recommendations and guidance on actions that could be taken by all sectors to improve health outcomes after disasters. This means not just restoring systems to pre-disaster levels of functioning but building back better and in ways that contribute to an overall healthier community. This goal is best accomplished through pre-disaster planning informed by a community's shared vision and a locally driven assessment of community health needs, assets, and risk. Those assessments are an essential component of a health improvement plan. Thus, incorporating health goals from a formal health improvement planning process into disaster recovery planning is a critical mechanism for ensuring improved individual and community health and resilience after a disaster. However, the committee recognizes that health improvement plans are underdeveloped or nonexistent in many communities, and when they do exist, they may be outdated and may not be familiar to or supported by current local leadership. Health goals from a health improvement plan need to be integrated into the community's strategic planning process, which is used to set priorities and allocate funds, so that decision making before and after a disaster is guided by a vision of a healthier community. A community that has already integrated health considerations into its strategic planning process and comprehensive plan is better equipped to rebuild infrastructure and systems in ways that promote health, resilience, and sustainability because it is more likely to have leadership buy-in and collaborative structures that include health components. However, it is important to note that even if a healthy, resilient, sustainable community vision and associated goals have not been integrated into a community's pre-disaster community strategic planning processes, this health perspective can still be included in post-disaster recovery planning.

Recommendation 1: ***Develop a Healthy Community Vision for Disaster Recovery*****.**

The committee recommends that state and local elected and public officials incorporate a vision for a healthy community into community strategic planning and disaster recovery planning.

Implementation of this recommendation will require action at the state and local as well as federal levels. Specifically, at the state and local levels, the following actions should be taken:

- Public health leaders should enhance health improvement planning through engagement with a comprehensive group of community stakeholders and ensure that plans are based on communities' needs and assets.
- Elected and public officials, including emergency managers and local disaster recovery managers, should together lead relevant stakeholders in risk-based disaster recovery planning that develops the procedures, processes, and administrative arrangements to be used for integrated, coordinated recovery.
- Elected and public officials, including emergency managers and local disaster recovery managers, should integrate public health officials and health improvement plans into community strategic planning and disaster recovery planning before and after a disaster. To

facilitate that integration, the community's needs and plans for health improvement should be reflected in disaster recovery priorities.

At the federal level, a coordinated, interagency effort is needed to support state and local stakeholders in the development of recovery plans that ensure that communities build back stronger. To this end, the committee believes that aligned grant guidance and technical assistance are essential motivators. Alignment is key to promoting synergy and ensuring that opportunities are not missed. Federal agencies should use existing grant programs to enhance the capacity of state and local stakeholders to plan for and implement a healthy community perspective in disaster recovery. Specifically, federal agencies should take the following actions:

- HHS, HUD, DOT, EPA, and other federal agencies should use aligned grant guidance and technical assistance for existing and future grant programs to incentivize preparedness, community health, and community development grantees to collaborate on the integration of local health improvement goals into comprehensive plans and disaster recovery plans.
- The CDC and the Office of the Assistant Secretary for Preparedness and Response should revise preparedness grant guidance related to the recovery capability to include greater focus on long-term recovery and opportunities for using recovery to advance healthier and more resilient and sustainable communities.
- FEMA should incentivize emergency management preparedness program grantees to incorporate health considerations into recovery planning by providing grant guidance and technical assistance aligned with HHS guidance.

Every policy decision made regarding a community's recovery should be seen as an opportunity to improve the health and well-being of the population. Although testimony to the committee from federal agencies representing various RSFs demonstrated progress toward cooperation and even collaboration, the committee did not find evidence that this vision or level of health integration (i.e., Health in All Policies) has been achieved during operationalization of the NDRF at the federal level.

Disasters create and exacerbate unmet human needs that, if not addressed, have significant impacts on long-term health outcomes in a community. Because these unmet needs closely resemble those with which many communities struggle during normal times (i.e., the vulnerable populations before a disaster are also the vulnerable populations after the event), the municipal structures already established for dealing with these challenges represent an important resource that can be tapped to enable integrated, coordinated recovery planning and to facilitate Health in All Policies. In such cases, critical relationships have already been built and barriers to inter sectoral collaboration overcome. In developing operational and governance structures under the framework of the NDRF, state and local decision makers should ensure that these collaborative arrangements operating prior to a disaster are added to the list of organizational assets and incorporated into the recovery planning effort.

Recommendation 2: *Integrate Health Considerations into Recovery Decision Making Through the National Disaster Recovery Framework*.

The committee recommends that the Federal Emergency Management Agency (FEMA) and the five other federal agencies that represent coordinating agencies for the Recovery Support Functions take steps to further develop and promote the National Disaster Recovery Framework (NDRF) as the basis for a locally defined organizing structure for disaster recovery at the state and local levels to promote information sharing and alignment of funding streams. Further, to ensure that health considerations are integrated into all recovery operations, FEMA, in consultation with the U.S. Department of Health and Human Services (HHS), should update the NDRF to explicitly include health implications for the activities of all Recovery Support Functions.

State and local elected and public officials should establish a steering committee to guide the development of an operational structure that incorporates the organizing principles of the NDRF—including a disaster recovery coordinator and the Recovery Support Functions—and builds on existing collaborative municipal and civic structures, authorities, and initiatives.

Successful recovery will require a systems approach with integration across the full range of community stakeholder groups, both horizontally and vertically, so that capabilities and resources, both public and private, are leveraged in a coordinated manner to achieve the best outcomes for the community as a whole. Many key stakeholders (including those from the public health, health care, behavioral health, and social services sectors) are not accustomed to working in the emergency management context and are not familiar with the relevant processes, terminology, or resources. Through this report, the committee hopes to facilitate the engagement and support of those stakeholders from both the health and the non-health sector whose involvement in recovery planning and implementation is essential to the building of healthier and more resilient and sustainable communities after disasters. This involvement will require (1) access to easy-to-use guidance materials describing the recovery process, including an overview of critical resources that are mobilized and accountable parties; and (2) a clear understanding of mechanisms for stakeholder engagement in the recovery planning process.

Recommendation 3: *Facilitate the Engagement of the Whole Community in Disaster Recovery Through Simplified and Accessible Information and Training*.

To facilitate the engagement of the whole community in building healthier communities after disasters, FEMA should lead an interagency effort centered on increasing the accessibility and coherence of information related to disaster recovery and the provision of relevant training.

Priorities should include

- the development of educational materials, including a single overarching federal document that serves as a primer on the recovery process and is easily accessible on the Web regardless of the pathway by which a stakeholder seeks to enter the recovery planning process;

- the development of companion guidance documents for state, local, and nongovernmental stakeholders for each of the Recovery Support Functions, providing more detailed descriptions that facilitate stakeholder understanding of available resources, best practices, and the pathways by which they can engage in the pre- and post-disaster recovery planning processes; and
- the development of coordinated training programs for stakeholders and their professional societies that raise awareness of threats and opportunities related to health and promote broad stakeholder participation in recovery planning under the NDRF.

Training programs should

- sensitize stakeholders to the importance of short-term health protection concerns and long-term opportunities to build healthier communities during recovery, highlighting the critical role of each sector in advancing community health, resilience, and sustainability;
- strengthen connections among emergency management, public health, community development, community planning, human services, and other stakeholder organizations to better prepare them to work together within the structure of the NDRF to increase the chances that recovery resources will be used for creating healthier communities; and
- raise awareness of steady-state community planning processes and administrative structures (partnerships and municipal and civic structures) and mechanisms for leveraging these existing processes and structures by identifying key partnerships and professional resources/sources of technical assistance.

When appropriate, existing federal and professional disaster preparedness training programs, such as those for public health emergency preparedness coordinators and the FEMA Emergency Management Institute's classroom and independent study courses for emergency managers (including those for federal disaster recovery coordinators), should be leveraged. However, new training courses may be needed to meet the priorities listed above.

The participation of community members (including representatives from vulnerable populations) in all stages of the recovery process is essential to ensuring that recovery decisions align with the community's shared vision. Achieving this participation will require robust community organizing and extensive outreach. After disasters, community planning initiatives that utilize equitable processes and increase interaction among residents can also build social capital—the social ties that are an integral feature of a community—promoting healing, restoring the social fabric of the community, and strengthening resilience. By partnering with schools, neighborhood associations, community groups, and private businesses, local governments can help foster the collaborative potential and sense of community ownership that are critical to optimal community health improvement and recovery planning. Ideally, these social networks should be developed in advance of a disaster as part of resilience-building efforts.

Recommendation 4: *Enhance and Leverage Social Networks in Community Health Improvement and Recovery Planning*.

Local elected and public officials should develop and support programs designed to strengthen social networks and deepen trust among community members before and after

disasters, thereby increasing resilience. Strategies for enhancing and preserving social networks should be specifically included in community health improvement and disaster recovery plans. Before and after a disaster, existing social networks, such as neighborhood associations, should be leveraged to enhance mechanisms for integrating the community into recovery planning.

To support implementation of this recommendation, the committee offers the following suggestions for building social capital in advance of a disaster, preserving it during a disaster, and leveraging it thereafter:

- **Building social capital prior to a disaster—**Examples of successful programs that have enhanced social cohesion include community currency and time-banking programs (as discussed earlier in this chapter) (Richey, 2007); social marketing campaigns; and administrative and financial support for local initiatives and institutions such as faith-based organizations, sport and social clubs, and civil society organizations. An example of a social marketing campaign created as part of preparedness efforts is SF72, a program created by the San Francisco Department of Emergency Management in coordination with city residents that helps San Franciscans expand their social networks. The success of these programs can be measured through surveys of levels of social cohesion and civic and neighborhood participation.
- **Preserving social networks during a crisis—**During a disaster, local disaster managers, nongovernmental organizations such as the Red Cross, and federal agencies such as FEMA should ensure that disaster management policies support existing social networks. Following Hurricane Katrina, for example, the random placement of survivors in temporary housing across the country crippled social networks by separating kin and friends. Despite time pressures, decision makers should do their best to ensure the continuation of social networks after a disaster, even during evacuation and temporary sheltering. Further, once survivors have been placed in shelters (ideally in groups that continue pre-disaster relationships), organizers should ensure that they have access to technologies that connect them with their networks.
- **Leveraging social capital during recovery—**Following a disaster, disaster managers should ensure that recovery plans and neighborhood rebuilding schemes develop through bottom-up and equitable neighborhood processes whereby local citizens, not outsiders, drive visions of the future. This can be achieved by encouraging or even requiring the solicitation of input from neighborhood-level organizations (e.g., homeowners associations) in a community requiring significant redevelopment, and outcomes can be measured through surveys that probe the depth of resident involvement in and satisfaction with planning activities.

The consideration of potential health impacts of recovery decisions in a systematic way necessitates a ready source of health information. Health impact assessments support a Health in All Policies approach and are increasingly being used to inform a wide range of policy decisions. While not yet widely applied to recovery decision making, this technique holds great potential. As operational structures for recovery are being developed and exercised, pathways for sharing information, including health information, should simultaneously be evaluated and delineated. To this end, a pre-disaster investment in infrastructure and, in some cases, data-sharing agreements are required. Continuous evaluation of health and recovery indicators through a learning system

approach enables decision makers to evaluate progress toward a healthy, resilient, and sustainable community vision and adapt recovery management strategies as need. This learning process also supports efforts to identify best practices and expand the evidence base for guidance and training (Recommendation 3).

Recommendation 5: *Establish Pathways by Which Health Information Can Inform Recovery Decision Making*.

State and local elected and public officials should ensure that clear pathways for integration and dissemination of health information are established, including mechanisms that enable concerns and priorities of community members to be transmitted to disaster recovery decision makers. Additionally, a continual feedback process should be established to allow for updating to reflect changes in conditions and measured progress toward recovery. Thus, indicators for measuring progress and success should be (1) developed, (2) incorporated into pre-disaster recovery plans, and (3) updated after a disaster based on its health impact.

Committee on Post-Disaster Recovery of a Community's Public Health, Medical, and Social Services; Board on Health Sciences Policy; Institute of Medicine. Healthy, Resilient, and Sustainable Communities After Disasters: Strategies, Opportunities, and Planning for Recovery. Washington (DC): National Academies Press (US); 2015 Sep 10.

Appendix F: Supply Chain Disaster Preparedness Manual

Supply Chain
Disaster Preparednes

Appendix G: Maryland Public Health and Healthcare Services Disaster Recovery Support Function Annex

Maryland Public
Health and Healthcar

Appendix H: COOP Development Guidance

Purpose of COOP

1. To ensure the continued operations of a facility and their essential functions.
2. To ensure the rapid response to any emergency situation requiring COOP plan implementation.

What are Essential Functions?

Essential functions are those functions that MUST be performed to achieve a facility's mission. Each facility will need to determine which functions they perform that must be continued in all circumstances. This is accomplished by prioritizing their essential functions, establishing staffing along with resource requirements, and identifying mission critical data and systems. All other functions will be deferred until normal operations can be restored

Essential Functions

Shelter, food, medical care, and transportation are essential functions for health care facilities under COMAR. For instance, operations for deliveries, preparation, and distribution of food will need to be included in a COOP to sustain food services. Reasonable efforts to continue care are required by COMAR and may or may not require transportation to provide adequate care. Transportation will be utilized during an evacuation. Therefore, a memorandum of agreement must be established. A memorandum of agreement will be discussed on a later slide during this presentation. Facility heads authorize these essential functions to be performed during an emergency or situation to continue critical operations, which may require delegating authority in the event a facility head is unable to perform his or her duties.

Delegation of Authority: Who will act on behalf of the facilities' head and key positions?

A COOP needs to identify someone as the delegating authority in order to successfully benefit a facility during an emergency. Therefore, all programs and administrative authorities need be identified for effective operations. It also needs to be determined under which circumstances the authority would be exercised and terminated. **It is key that employees are properly trained and aware of the rules and procedures** to ease into the change of authority by order of succession.

Order of Succession

Orders of succession are provisions to perform essential functions in the event those facility heads are unable to perform their essential duties. It is extremely important to have an order of succession in place for your facility, you need to determine who will "step in" if the facility head is unable to perform his or her job function. Organizations must develop and maintain orders of succession to key positions. The following actions should be taken by an organization when developing a COOP:

1. Establish an order of succession to the position of facility head.
2. Establish orders of succession for all other key positions.
3. Identify limits on delegations of authority.

Vital Records

Vital records play a critical role in a facility's daily operations. Therefore, records need to be accessed during an emergency or situation regardless of the threat. Examples of vital records include; patient and staff records, and payroll. A vital record can be identified by how it disrupts and/or inconveniences operations or the expense it takes to replace and/or recreate a record or document. Two types of vital records to consider are emergency operating records and legal and financial records. All vital records should be safeguarded to prevent disruption, inconvenience, or recreation.

To safeguard vital records have electronic and hard copies ready by using thumb drives, CDs, paper copies, and internal or external email systems. Also, store these copies in alternative locations that are accessible to the necessary employees. When planning to safeguard vital records, maintenance and accessing information need to be considered. A vital records packet should be created to include current personnel contact information, vital records inventory, keys and/or access codes, and alternative locations. These packets should be distributed to authorized personnel.

**Information is always changing requiring records to be updated and backed up frequently.

Alternative Sites

In the event a facility needs to be evacuated alternative sites need to be identified prior to the emergency. Each alternative site should support operations in a threat-free environment, have adequate space, equipment to sustain the relocation, and interoperable communications.

Three types of Alternate sites:

1. Hot Site: already has in place the necessary equipment, staff, food, and other supplies to conduct normal operations (this might be a sister-facility)-click the switch and go!
2. Warm Site: equipped with essential equipment, staff, food, and other supplies to conduct essential operations (other assisted living or nursing homes).
3. Cold Site: able to bring equipment, staff, food, and other supplies to conduct essential operations (lodging facilities).

Interoperable Communications

Interoperable communications are communications that provide the capability to perform essential functions, until normal operations can be resumed. Interoperable communications are needed to perform essential functions until normal operations can be resumed. A phone tree should be created and exercised to keep the lines of communications open between a facilities' staff, resources, and patients' family members.

Different types of communications include:

- Cell Phones
- Land Lines
- Radios
- Laptops

MOAs, MOUs, & Contracts

- Memorandum of understanding (MOU)
  - Form of legal document
  - Not fully binding
- Memorandum of Agreement (MOA)
  - Similar to MOU
  - Spells out terms and conditions
- Contract
  - A promise
  - Exchange of value

MOUs are agreements between two parties in the form of a legal document. It is not fully binding in the way that a contract is, but it is stronger and more formal than a traditional gentleman's agreement.

An MOA is similar to an MOU, in that the document is used to spell out the terms and conditions that will apply to all participants in a joint project. However, the MOAs tends to go into more detail, outlining processes and procedures in addition to addressing the general perimeters of the working arrangement. A contract is an agreement between two or more organizations to do, or to refrain from doing, a particular thing in exchange for something of value.

Contracts generally can be written, using formal or informal terms, or entirely verbal. If one side fails to live up to his/her/its part of the bargain, there's a "breach" and certain remedies for solving the differences are available. The terms of the contract - the who, what, where, when, and how of the agreement - define the binding promises of each party to the contract. It is a facilities choice which type of agreement to use when establishing agreements with vendors, facilities, and other types of services.

Additional Training & Information

- FEMA: **http://www.fema.gov/government/coop/index.shtm#2**
- MEMA: **http://www.mema.state.md.us/MEMA/content_page.jsp?TOPICID=eandt#**

APPENDIX I: Healthcare Primary Mission Essential Function (PMEF) & Mission Essential Functions (MEF's)

Health Care Service Delivery (PMEF)

State Health Authority *Essential Supporting Activities*
• Collect situational assessment data from Local/Regional Health Departments (L/RHD), Healthcare Coalitions (HCC), and HCOs on their ability to provide patient care
• Collect L/RHD, HCC, and HCO data to generate regional and statewide health care service delivery situation report
• Disseminate health care service delivery situation reports to Federal ESF-8
• Prepare Action Request Forms (ARF) to request assistance from ESF-8 lead

Local/Regional Health Department *Essential Supporting Activities*
• Collect situational assessment data on the impact of the disruption of public health service delivery in the local and regional area
• Partner with local emergency management and social services to determine public health priorities associated with services needed to recover from physical or mental/behavioral injury, illness, or exposure sustained as a result of the incident
• Work with U.S. Dept. of Health & Human Services (DHHS) Incident Response Coordination Team (IRCT) to assess requirements to return to normal public health care service delivery
• Disseminate health care service delivery data to state health authorities and ESF-8 partners

Healthcare Coalition *Essential Supporting Activities*
• Collect situational assessment data from member HCOs on their ability to provide patient care
• Collect individual facility data to generate coalition health care service delivery situational report
• Disseminate health care service delivery data to state health authorities
• Assist coalition members in returning to full operational status

Healthcare Organization *Essential Supporting Activities*
• Determine the extent of disruption to health care service delivery
• Determine if event has caused a complete or partial disruption of health care service delivery
• Determine if relocation of health care service delivery to alternate care sites is an option for short-term continuation of service
• Work with local emergency management and regional HCC(s) to obtain assistance in returning to normal health care delivery operations

Access to Health Workforce (MEF) -*The ability to deploy a credentialed health workforce to provide patient care to support healthcare service delivery in all environments.*

State Health Authority *Essential Supporting Activities* include**:**
• Conduct statewide assessment of health workforce shortage
• Assist LHDs, HCCs, HCOs, and Public Health in activating volunteer registries
• In coordination with community partners, assist HCCs and HCOs with the deployment management of volunteers during response and continuity operations
• Prepare Action Request Forms (ARF) to request assistance from ESF-8 lead

Local/Regional Health Departments *Essential Supporting Activities* include**:**
• Conduct Local/Regional assessment of health workforce shortage
• Coordinate the assignment of public health agency volunteers to public health, medical, mental/behavioral health, and non-specialized tasks as directed by the incident
• Refer spontaneous volunteers not needed for public health response to other organizations in need of volunteers to close gaps in the healthcare workforce during continuity operations
• Disseminate volunteer management situation reports to state health authorities

Healthcare Coalition *Essential Supporting Activities* include**:**
• Conduct healthcare workforce shortage assessment within coalition boundaries
• Coordinate with volunteer groups to supplement medical & non-medical personnel
• Disseminate reports of regional staffing shortages to local & state health authorities

Healthcare Organization *Essential Supporting Activities* include**:**
• Identify medical and nonmedical staffing shortages during response and continuity operations
• Recall additional staff incrementally to assist in disaster continuity operations
• Coordinate with contracted staffing agencies to increase availability of critical medical staff
• Integrate credentialed, licensed, independent practitioners into continuity medical operations
• Coordinate with volunteer groups to supplement medical & non-medical personnel
• Disseminate reports of HCO staffing shortages to local incident management & state health authorities

Community/Facility Critical Infrastructure (MEF) - *Fully operational critical community/facility infrastructure including power, water, and sanitation etc.., to support patient care environments*

State Health Authority *Essential Supporting Activities* include:
• Identify and assess situational reports on critical infrastructure disruption affecting healthcare sector
• Work to ensure healthcare sector, especially hospitals, are included on the priority restoration plan
• Coordinate with ESF-8 to request assistance from ESF-3 for Public Works and Engineering support

Local/Regional Health Department *Essential Supporting Activities* include**:**
• Determine local/regional disruption of critical infrastructure that affects public health sector
• Collect reports on critical infrastructure disruption
• Disseminate reports to state health authorities
• Advocate for priority service resumption for public health facilities through continuity operations and recovery phase

Healthcare Coalition *Essential Supporting Activities* include**:**
• Determine local/regional disruption of critical infrastructure that affects public health sector
• Collect reports on critical infrastructure disruption
• Disseminate reports to state health authorities
• Advocate for priority service resumption for public health facilities through continuity operations and recovery phase

Healthcare Organization *Essential Supporting Activities* include**:**
• Determine extent of disruption/loss/damage of facility critical infrastructure
o Electrical System
o Water System
o Ventilation
o Fire Protection System
o Fuel Sources
o Medical Gas & Vacuum Systems
o Communication Infrastructure
• Prioritize restoration efforts to meet the operational goals of health care service delivery
• Disseminate reports of HCO critical infrastructure disruption/loss/damage to local emergency management and to state health authorities
• Advocate for priority service resumption directly to local incident management

Access to Healthcare Supply Chain (MEF) - *Full access to the healthcare supply chain including medical & non-medical supplies, pharmaceuticals, blood products, industrial fuels, and medical gases etc.*

State Health Authority *Essential Supporting Activities* include:
• Determine statewide disruption of healthcare supply chain
• Determine priority medical and non-medical supply items needed by public health and HCOs
• Activate and distribute equipment and pharmaceutical cache contents to public health departments and HCOs
• Coordinate with ESF-8 to request assistance from ESF-7 Logistics Management and Resource Support

Local/Regional Health Departments *Essential Supporting Activities* include:
• Determine local/regional disruption of healthcare supply chain
• Determine priority medical and non-medical supply items needed by public health departments
• Allocate and distribute medical countermeasures and pharmaceutical cache contents to identified recipients
• Coordinate with SHA for supply requests
• Disseminate healthcare supply chain disruption Situation Reports (Sitreps) to SHA

Healthcare Coalition *Essential Supporting Activities* include:
• Determine regional disruption of healthcare supply chain
• Determine specific medical and non-medical supply needs of members
• Coordinate with local/regional state health departments to distribute cache contents to HCOs
• Coordinate with private sector vendors on distribution and resumption of normal supply delivery
• Disseminate healthcare supply chain disruption SitReps to SHA

Healthcare Organization *Essential Supporting Activities* include:
• Determine estimated shortfalls identified during the continuity event of needed supplies for the HCO
• Prioritize medical and non-medical supply items needed by HCO through medical/surgical supply formularies
• Redirect supplies already within the hospitals supply chain to areas first impacted
• Activate pre-event supply orders with vendors
• Coordinate with SHA for supply requests
• Disseminate HCO supply chain disruption Sitreps to SHA

Access to Medical/Non-Medical Transportation System (MEF) - *Fully functional medical & non-medical transportation system that can meet the operational needs of the healthcare sector during the response & continuity phases of an event*

State Health Authority *Essential Supporting Activities* include:
• Determine statewide medical transportation needs during response and continuity operations
• Prioritize state medical transportation assets to service highly impacted areas first
• Prepare and disseminate Action Request Forms to request assistance with medical transportation from ESF-8
• Coordinate with HHS/ESF8 to activate National Federal Ambulance Contracts

Local/Regional Health Departments *Essential Supporting Activities* include:
• Determine local/regional medical transportation needs for public health
• Prioritize local/regional health department medical transportation assets to service highly impacted areas first
• Coordinate with SHA to request medical transportation assets

Healthcare Coalition *Essential Supporting Activities* include:
• Determine regional medical transportation needs during response and continuity operations
• Determine specific needs of member HCOs
• Coordinate with regional EMS/Air Ambulance Providers to close gaps in system transportation needs
• Advocate for coalition members for medical transportation assistance

Healthcare Organization *Essential Supporting Activities* include:
• Determine additional medical/non-medical transportation needs to support response and continuity operations
• Identify an EMS Coordinator and a Transportation Coordinator to manage patient transport
• Coordinate with regional EMS/Air Ambulance Providers to close gaps in system transportation needs
• Provide transportation assistance to staff that may need transportation to facility
• Disseminate requests for transportation assistance to local emergency management and SHA

Healthcare Information Systems (MEF) - *Fully functional information technology and communications infrastructure that support high availability of the healthcare sector's data management and information sharing capability.*

State Health Authority *Essential Supporting Activities* include:
• Determine statewide disruption of communication/information technology capabilities
• Activate redundant communication capabilities if necessary
• Coordinate with service providers to restore communication/information technology capabilities
• Coordinate with local/regional health departments, HCCs, and HCOs to disseminate critical response and recovery information to the public
• Coordinate with ESF-2 through ESF-8 for restoration or repair of telecommunications infrastructure

Local/Regional Health Departments *Essential Supporting Activities* include:
• Determine local/regional disruption of public health communication/information technology capabilities
• Activate redundant communication capabilities if necessary
• Coordinate with local emergency management to secure priority service restoration to communication/information technology capabilities
• Coordinate with state health authorities to disseminate critical response and continuity operations information

Healthcare Coalition *Essential Supporting Activities* include:
• Determine extent of disruption of communication/information technology capabilities within coalition boundaries
• Activate redundant communication capabilities if necessary
• Coordinate with local/state emergency management to secure priority service restoration to communication/information technology capabilities
• Coordinate with state health authorities to disseminate critical response and continuity operations information

Healthcare Organization *Essential Supporting Activities* include:
• Determine extent of disruption of communication/information technology capabilities at facilities
• Activate redundant communication capabilities if necessary
• Coordinate with local/state emergency management to secure priority service restoration to communication/information technology capabilities
• Coordinate with state health authorities to disseminate critical response and continuity operations information

Healthcare Administration/Finance (MEF) - *Fully operational administrative and financial capability including maintaining & updating patient records, adapting to disaster recovery program requirements, payroll continuity, supply chain financing, claims submission, and losses covered by insurance and legal issues.*

State Health Authority *Essential Supporting Activities* include:
• Collect disaster response data to be used in After-Action Reports
• Monitor statewide patient movement and update patient records
• Modify state health program requirements as dictated by authorizing entities
• Keep track of disaster related expenditures
• Request disaster assistance from federal agencies
• Provide disaster assistance to regions and localities
• Monitor employee/contractor payroll systems

Local/Regional Health Departments *Essential Supporting Activities* include:
• Collect disaster response data to be used in After-Action Reports
• Monitor patient movement and update patient records
• Keep up with changing health program requirements and make modifications when directed by authorizing entity
• Monitor costs relating to supply chain management and acquisition
• Keep track of overall disaster related expenditures
• Monitor employee/contractor payroll systems

Healthcare Coalition *Essential Supporting Activities* include:
• Collect disaster response data to be used in After-Action Reports
• Keep coalition members informed on changing program requirements
• Keep coalition members informed about any available disaster assistance from federal, state and local authorities

Healthcare Organization *Essential Supporting Activities* include:
• Collect disaster response data to be used in After-Action Reports
• Modify and maintain healthcare information management practices according to changing program requirements directed by authorizing entities
• Coordinate the use of paper systems to track patients, health issues and other critical data in the event electronic systems are compromised
• Explore possible sources of disaster assistance that may be available to an organization; request assistance when appropriate
• Monitor employee/contractor payment systems; implement alternative payment systems if available
• Activate disaster recovery contracts
• Initiate “disaster orders” to increase supply chain availability
• Monitor and adjust claims submission conditions according to changing federal & state requirements
• Monitor, document, and address legal issues
• Monitor document losses for the preparation of insurance claims

Appendix J: ASPR Healthcare COOP and Recovery Planning

Healthcare COOP &
Recovery Planning.pd

Appendix K: Essential Functions and Considerations for Hospital Recovery

Essential
Functions-Hospital-Re

Appendix L

Mental Health Services following Disasters

SAMHSA **Disaster Distress Helpline** (1-800-985-5990)

Deaf/Hard of Hearing: Text "TalkWithUs" to 66746 (use your preferred relay service to call the Helpline at 1-800-985-5990).

The Disaster Distress Helpline is a national hotline dedicated to providing year-round immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster. This toll-free, multilingual, and confidential crisis support service is available to all residents in the United States and its territories. Stress, anxiety, and other depression-like symptoms are common reactions after a disaster.

Call **1-800-985-5990** or text **TalkWithUs to 66746** to connect with a trained crisis counselor.

Spanish Speakers

- Call 1-800-985-5990 and press "2"
- From the U.S., **text Hablanos to 66746**
- From Puerto Rico or the U.S. Virgin Islands, **text Hablanos to 1-212-461-4635**
- From American Samoa, Guam, Palau, Marshall Islands, Northern Mariana Islands, and the Federated States of Micronesia, **text Hablanos to 1-206-430-1097**

Appendix M: Impact of HIPAA Security

Impact of HIPAA Security.pdf

Appendix N: Regional Assets Procedures for Deployment

Requesting Facility:

A. Only the Emergency Incident Commander/designee at each Requesting Facility has the authority to initiate the transfer or receipt of resources.

B. The onsite Incident Commander must first:

1) Identify the funding stream under which an asset was purchased (UASI or HPP)

2) Determine the location of the asset (Maintaining Facility/Organization) by consulting the Unified Resource Listing (Section V.a) and/or the Resource Information Sheets (Section V.b).

C. The Requesting Facility should then notify their local health department and EOC (if activated) of any external requests for assets through either the HPP or UASI processes.

Local health department:

A. Communicate the resource request to the local EOC (if activated) as well as inform MDH of the resource request.

B. Assist with ensuring the validation process is carried through to the Request Authorizing Agency (RAA) which varies according to the resource.

Requesting Authorizing Agency:

Prior to deployment and utilization, requests must be approved by the appropriate Request Authorizing Agency (RAA). The RAA varies by circumstance:

1) MDH shall serve as the RAA for HPP-purchased resources. The MDH- Region III Coordinator will serve as a subject matter expert regarding the HPP resource(s) being requested.

2) The Baltimore Regional UASI coordinator or his/her representative shall serve as the RAA for UASI purchased resources.

In-house HPP assets only:

The Maintaining Facility/Organization may utilize their assets without receiving MDH approval. However, the assets continue to be reserved for emergency use only. Following use of in-house HPP assets, the facility is required to:

1) Notify MDH within 24 hours of asset utilization. Notify MDH via email at MDHPP.DOH@Mayland.gov or call 410- 767-8826; and

2) Submit an incident After Accident Report within 60 days of asset utilization.

HPP assets not located in-house:

The initial request for transfer may be verbal to allow the Maintaining Facility/Organization appropriate time to ensure access to equipment. However, a verbal request must be followed-up with a formal Regional Resource Request Form (R3 Form ± Appendix A-1) submitted prior to final transfer of the assets from the Maintaining Facility/Organization to the Requesting Facility.

Region III Resource Request Form

Region III Resource Request Form.pdf

Appendix O: Maryland Responds Paper Registration Form

MDRMRC Paper
Registration Form (2)

Maryland Responds Volunteer Request Form

2013 MDResponds
Volunteer Activation F

Appendix P: Table of Acronyms

- **AAR** –After Action Report
- **ARF** – Action Request Forms
- **CDC** – Centers for Disease Control
- **CHHS** – Center for Health and Homeland Security
- **COOP** – Continuity of Operations Plan
- **COP** – Common Operating Picture
- **CS** – Central Supply
- **DHHS** – U.S. Department of Health and Human Services
- **EMTALA** – Emergency Medical Treatment and Labor Act
- **EOC** – Emergency Operations Center
- **EOP** – Emergency Operations Plan
- **ESA** – Essential Supporting Activities
- **ESF** – Essential Support Functions
- **EPA** – Environmental Protection Agency
- **FAC** – Family Assistance Center
- **HHS** – United States Department of Health and Human Services
- **HCC** – Healthcare Coalition
- **HCO** – Healthcare Organization
- **HIC** – Hospital Incident Command
- **HIT** – Health Information Technology
- **HPP** – Hospital Preparedness Program
- **HR** – Human Resources
- **IRCT** – Incident Response Coordination Team
- **LHD** – Local Health Department
- **MAA** – Mutual Aid Agreements
- **MDH** – Maryland Department of Health
- **MDRMRC** – Maryland Responds Medical Reserve Corps
- **MEF** – Mission Essential Function
- **MIEMSS**—Maryland Institute of Emergency Medical Services System
- **MFO** –Maintaining Facility/Organization
- **MOA** – Memorandum of Agreement
- **MOU** – Memorandum of Understanding
- **NDRF** – National Disaster Recovery Framework
- **PCU** – Patient Care Unit
- **PMEF** – Primary Mission Essential Function
- **RHD** – Regional Health Department
- **RFO** – Requesting Facility/Organization
- **RSF** – Recovery Support Functions
- **SHA** – State Health Authority
- **SITREP** – Situation Report
- **UEVHPA** – Uniform Emergency Volunteer Health Practitioner Act

Appendix Q: Authorities and References

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Appendix R: Policies

- Maryland State Disaster Recovery Operations Plan (SDROP)
- State of Maryland Emergency Operation Plan (ESF 8 and ESF 11)
- FEMA, National Disaster Recovery Framework, September 2011
- FEMA, Recovery Federal Interagency Operational Plan, Annex C: Health and Social Services Recovery Support Function, July 2014

Appendix S: Supporting Federal Programs

- U.S. Department of Health and Human Services/Assistant Secretary for Preparedness and Response
- U.S. Department of Health and Human Services/Centers for Disease Control and Prevention
- U.S. Department of Health and Human Services/Food and Drug Administration
- U.S. Department of Health and Human Services/Substance Abuse and Mental Health Services Administration
- U.S. Department of Agriculture