EMERGENCY PREPAREDNESS BUREAU

HARVARD SCHOOL OF PUBLIC HEALTH
Emergency Preparedness and Response Exercise Program

Essential Functions and Considerations for Hospital Recovery

Harvard School of Public Health
Emergency Preparedness and Response Exercise Program
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Dear Hospital Representative,

The following document, *Essential Functions and Considerations for Hospital Recovery,* was developed by the Harvard School of Public Health Emergency Preparedness and Response Exercise Program (HSPH-EPREP) in collaboration with the Massachusetts Department of Public Health (MDPH) Emergency Preparedness Bureau and is meant to serve as a resource for hospitals to use as they prepare to manage their recovery from emergencies of all types. This document draws from an extensive literature review, review of many hospital plans, multiple interviews with hospitals that have had to recover from major incidents, and from lessons learned during the execution and evaluation of the 2013 MDPH statewide hospital recovery workshop series. We gratefully acknowledge their contributions and the hard work that many hospital leaders have undertaken to develop and expand healthcare recovery capabilities across the Commonwealth.

This resource was written for hospitals and is intended to complement the ongoing efforts of federal, state, and local agencies that are similarly committed to enhancing healthcare recovery capabilities. Many agencies, including the Federal Emergency Management Agency (FEMA), Office of the Assistant Secretary for Preparedness and Response (ASPR), Massachusetts Emergency Management Agency, MDPH, and their local partners are currently focused on updating recovery capabilities to address modern recovery challenges that may affect hospitals in the future. *Essential Functions and Considerations for Hospital Recovery* and all related documents have been developed through a contract with the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program. The views and opinions expressed as part of this document and all related documents do not necessarily represent the views and opinions of the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program.

Sincerely,

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1. Introduction and Acknowledgements

Essential Functions and Considerations for Hospital Recovery was developed by the Harvard School of Public Health Emergency Preparedness and Response Exercise Program (HSPH-EPREP) through a contract with the Emergency Preparedness Bureau at the Massachusetts Department of Public Health, with funding from the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program. This document is intended to assist hospitals with organizing, developing, and/or refining their recovery capabilities in accordance with federal guidance. This document is not intended to supersede any federal guidance; rather, *Essential Functions and Considerations for Hospital Recovery* is structured to help hospitals incorporate recovery capabilities into comprehensive hospital emergency operations plans. The views and opinions expressed in this document do not necessarily represent the views and opinions of the Office of Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program or the Massachusetts Department of Public Health.

In preparing this document, the Harvard School of Public Health reached out to dozens of hospitals, many of whom have had to recover from actual events, to discuss recovery planning. The essential functions for hospital recovery that are included in this document are informed by correspondence and discussions between our researchers and healthcare responders who went through difficult emergencies and were willing to frankly discuss their successes and challenges with our team. We are immensely grateful for the candid manner in which many hospital representatives discussed their experiences. Additionally, our researchers reviewed existing hospital recovery literature. A list of references used to support the development of this document can be found in Appendix A.

In the spring of 2013, the Massachusetts Department of Public Health Emergency Preparedness Bureau sponsored a series of interactive recovery workshops for the hospitals of the Commonwealth of Massachusetts that were facilitated by the Harvard School of Public Health Emergency Preparedness and Response Exercise Program. Six regional workshops were held

statewide to engage hospital emergency preparedness coordinators and members of hospital emergency preparedness committees in an open discussion of recovery challenges and best practices. Each region shared its own perspective on the challenges that recovery presents hospitals, and many of the sections in this document were improved upon following the discussions in the workshops. We are thankful for the insightful contributions made by each region and by the many hospitals that participated in the workshop series.

During these workshops, representatives from the Region 1 office of the Federal Emergency Management Agency provided support by presenting the National Disaster Recovery Framework. We sincerely appreciate the active involvement that our federal partners have taken in promoting recovery planning in accordance with the NDRF.

This document references and interprets information presented by several healthcare emergency preparedness and emergency management sources. Readers can identify the source of information presented throughout this document as well as interpretations of guidance by using the guide below:

Healthcare Emergency Preparedness Guidance (ASPR, TJC)

Emergency Management Guidance (DHS, FEMA)

Harvard School of Public Health Interpretation

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2. Recovery Defined

The Assistant Secretary for Preparedness and Response (ASPR) has outlined functions related to recovery that will assist healthcare organizations as they develop their emergency response plans. ASPR provided detailed descriptions of the associated functions required by healthcare systems in the Healthcare Preparedness Capabilities guidance document released in January of 2012.

ASPR Hospital Preparedness Program - Capability 2: Healthcare System Recovery

Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and 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 (ASPR 12).

The Federal Emergency Management Agency has outlined concepts and principles that federal, state, and local governments as well as other recovery stakeholders including hospitals can follow. FEMA provided detailed descriptions of recovery concepts and principles that are intended to ensure unified and collaborative recovery efforts in the National Disaster Recovery Framework which was released in September of 2011.

FEMA Emergecy Management Institute Disaster Recovery Definition

The process of restoring normal public or utility services following a disaster, perhaps starting during but extending beyond the emergency period to that point when the vast majority of such services, including electricity, water, communications, and public transportation, have resumed normal operations. Short-term recovery does not include the reconstruction of the built environment, although reconstruction may commence during this period. Long-term recovery (see reconstruction) is the process of returning the community, to the extent possible, to the conditions that existed prior to the event, preferably while taking the opportunity to mitigate against future disasters (Eadie 329).

For the purposes of this document a short, but comprehensive working definition of hospital recovery will be used.

Hospital Recovery - Definition

The process by which a hospital minimizes the impact an emergency has made on its operations in an effort to resume normal operations or establish new norms for operations.

3. The Joint Commission Standards Related to Recovery

Many emergency management elements of performance (EPs) that The Joint Commission (TJC) uses to accredit and certify hospitals can be related to hospital recovery. Four emergency management EPs that specifically relate to hospital recovery are listed below. Additional emergency management EPs relate to functions and plans that hospitals should develop in order to respond to and recover from emergencies.

The Joint Commission Recovery Elements of Performance

EM 02.01.01 EP4 - The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

EM 02.01.01 EP5 - The Emergency Operations Plan describes the processes for initiating and terminating the hospital's response and recovery phases of the emergency, including under what circumstances these phases are activated.

EM 02.02.03 EP2 – [EOP describes the following] How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.

EM 02.02.03 EP3 - [EOP describes the following] How the hospital will obtain and replenish non-medical supplies that will be required throughout the response and recovery phases of an emergency. (TJC Comprehensive Accreditation Manual for Hospitals: January 2013)

4. Principles for Recovery Planning

The Assistant Secretary for Preparedness and Response (ASPR) has divided Capability 2: Healthcare System Recovery into functions, tasks, and resource elements which consist of plans, equipment, and skills. Additionally, ASPR outlines principles that healthcare organizations should use when developing any emergency response plans.

ASPR Hospital Preparedness Program Planning Principles

1. **Planning must be community-based, representing the whole population and its needs**
2. **Planning must include participation from all stakeholders in the community**
3. **Planning uses a logical and analytical problem-solving process to help address the complexity and uncertainty inherent in potential hazards and threats**
4. **Planning considers all hazards and threats**
5. **Planning should be flexible enough to address both traditional and catastrophic incidents**
6. **Plans must clearly identify the mission and supporting goals (with desired results)**
7. **Planning depicts the anticipated environment for action**
8. **Planning does not need to start from scratch**
9. **Planning identifies tasks, allocates resources to accomplish those tasks, and establishes accountability**
10. **Planning includes senior officials throughout the process to ensure both understanding and approval**
11. **Time, uncertainty, risk, and experience influence planning**
12. **Effective plans tell those with operational responsibilities what to do and why to do it, and they instruct those outside the jurisdiction in how to provide support and what to expect**
13. **Planning is fundamentally a process to manage risk**
14. **Planning is one of the key components of the preparedness cycle (ASPR viii)**

The National Disaster Recovery Framework (NDRF) published by the Federal Emergency Management Agency (FEMA) has outlined nine core principles that should guide recovery. While the audience that the NDRF is targeted at is very broad and community-focused, hospitals should still review these core principles before writing the recovery elements of their hospital emergency operations plans. The Harvard School of Public Health recommends that hospitals consider both the ASPR and FEMA principles before establishing their own individual recovery planning principles. The list on the next page was created in an effort to merge the planning principles that ASPR has given hospitals with the NDRF recovery core principles.

FEMA National Disaster Recovery Framework Recovery Core Principles	
1. **Individual and Family Empowerment** 2. **Leadership and Local Primacy** 3. **Pre-Disaster Recovery Planning** 4. **Partnerships and Inclusiveness** 5. **Public Information**	6. **Unity of Effort** 7. **Timeliness and Flexibility** 8. **Resilience and Sustainability** 9. **Psychological and Emotional Recovery (FEMA NDRF 9)**

The hospital recovery planning principles as outlined in this document may be used as a starting point for discussion among hospital recovery planners and each hospital should determine if the planning principles listed below are sufficient for their healthcare organization.

Hospital Recovery - Planning Principles for Hospital Recovery

1. **<u>Do not plan in isolation:</u> Involve your whole hospital and partner agencies when developing your hospital's plans for recovery**
2. **Consider your hospital's hazard vulnerability analysis (HVA) when developing your hospital's plans for recovery**
3. **Integrate recovery plans into your hospital's emergency operations plan (EOP)**
4. **Use the Hospital Incident Command System (HICS) to manage recovery**
5. **Plan for system failures and/or shortages to occur during response and recovery**
6. **Leverage existing local and regional resources in your recovery plans**
7. **Plan to communicate recovery information to partner agencies so they can assist with your recovery (e.g. public, media, local agencies, vendors, regional partners, MDPH/ESF#8, DHHS/Recovery Support Function: Health and Social Services)**

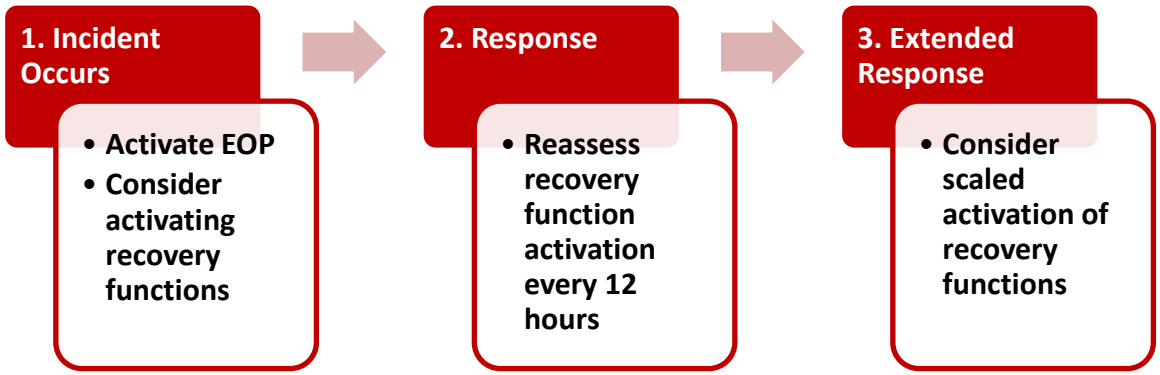
Developing hospital recovery capabilities will strengthen a hospital's ability to quickly respond to and recover from any emergency. Hospitals should not approach developing recovery capabilities by trying to build a stand-alone recovery plan. Rather than consider recover functions in a separate plan, hospitals should integrate essential recovery functions into established incident management structures or write recovery functions into hospital emergency operations plans from their inception. Effective hospital recovery functions and planning will compliment, coordinate with, and build upon existing hospital emergency response functions, capabilities, resources, and the hospital emergency operations plan.

5. Triggers for the Activation of Recovery Functions During Response

Both ASPR and FEMA are in full agreement regarding the importance of considering recovery during every phase of emergency preparedness and response. Capability 2: Healthcare System Recovery mentions alert and notification as they relate to continuity of operations (COOP) activities, but not specifically a healthcare organization's recovery functions. It is important for hospitals to consider how and when they will activate their recovery functions relative to other areas of hospital emergency management such as response plans and continuity of operations plans as there is overlap among all these plans. However, it is imperative that hospitals develop clear and specific triggers to activate elements of their recovery functions as early as possible during an incident. Many hospitals that have had to recover from significant events stated that they waiting too long to initiate recovery functions after they started responding to an emergency. This avoidable delay was one of the most difficult challenges for these hospitals to overcome when initiating recovery operations.

Hospital Recovery - Triggers for the Activation of Recovery Functions

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



6. Setting Recovery Objectives

ASPR outlines that hospitals should develop both short-term and long-term recovery priorities following a disaster in Capability 2: Healthcare System Recovery. However, Capability 2 does not specifically elaborate on how hospitals should set those recovery objectives. Federal agencies involved in Recovery Support Function: Health and Social Services describe several outcomes they believe health and social service organizations should generally strive for that help to establish objectives, but those aspirational outcomes often do not readily translate into concrete, incident-specific objectives.

NDRF Recovery Support Function (RSF): Health and Social Services Outcomes

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 (FEMA NDRF 54)**

Hospitals should set simple, measurable, achievable, realistic, and task-oriented (S.M.A.R.T.) objectives during recovery just as they do during response. Hospitals can consider their operations and organizational priorities in order to set S.M.A.R.T. objectives during recovery. Hospitals should consider response actions and decisions that will automatically generate recovery objectives. Anytime a service or normal business operation is altered, reduced, or shut off during response, there may be actions hospitals need to take during recovery to return to normal operations or to prepare for the next emergency. An example is turning on a generator in response to a power outage. Once power is restored and the generator is no longer needed, it will need to be serviced and refueled. Hospital recovery leadership will need to review and update objectives throughout recovery as new damage assessment information is collected from internal and external sources.

Hospital Recovery – Setting Recovery Objectives

1. **Develop Standing Recovery Objective(s)**
   - **A. Ensure the safety of staff and patients throughout all recovery efforts**
   - **B. Prioritize hospital functions as they relate to the mission of the hospital**
     - **Clinical functions**
     - **Teaching functions**
     - **Research functions**
     - **Administrative/Support functions**

2. **Prepare Pre-written Recovery Objectives that are Triggered by Response Actions**
   - **C. Examine response actions that require attention during the recovery phase to help the hospital 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 the 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)**
   - **D. Prioritize short-term and long-term department, unit, service, and/or utility recovery objectives based upon hospital-wide damage assessment, hospital needs, and community needs**

7. Assessment and Documentation of Recovery Needs

Rapidly conducting an accurate damage assessment following a major disaster is one of the most complex challenges that a hospital may ever face. ASPR focuses a planning resource element on "*Assessment of healthcare delivery recovery needs post disaster"* in Capability 2: Healthcare System Recovery. In this element, ASPR underlines the importance of hospitals preparing to coordinate the assessment of their recovery needs following a disaster with their external partners. Following a disaster, hospitals will need to both collect and share information with partners from federal, state, and local agencies as well as private and non-governmental organizations. Identifying what information these recovery partners collect, share, and need is an important step in preparing to assess a hospital's recovery needs.

The recovery procedures described in the NDRF stress the importance of local and state damage assessments following a disaster. While legislation such as the Post-Katrina Emergency Management Reform Act passed in 2006 allows federal agencies to be more forward leaning when it comes to response, federal recovery assets are still largely dependent upon local and state damage assessments (Bea 8). Federal agencies rely upon local and state responders to communicate needs clearly, so they can direct federal assets to where they can be of greatest assistance. Federal assets will only be necessary for response and recovery when local and state capabilities are overwhelmed. Consequently, substantial resources will be requested from federal partners when they are needed. This significant need at the local and state level translates directly into financial considerations for federal partners who will be reluctant to dedicate funding to any organization that is not transparent about how their damage assessment was completed.

NDRF Assessment Protocol for Recovery Support Function Activation

The NDRF employs an assessment protocol to ensure a scalable, flexible, adaptable, and cost-effective approach to recovery activities and to determine which coordination structures are necessary and appropriate under the circumstances. From this assessment, the [Federal Coordination Officer] (FCO), in coordination with the State, activates the appropriate Recovery Support Functions (RSFs), if necessary (FEMA NDRF 31).

Hospitals should meet with their local emergency management agency and discuss when it may be appropriate to coordinate their hospital damage assessment with local authorities. Some circumstances when this may be beneficial include declared state of emergencies and presidentially declared disasters. Private nonprofit facilities that provide medical care or the essential service of emergency medical care as defined by the President and outlined in the Robert T. Stafford Disaster Relief and Emergency Assistance Act may be eligible for reimbursement under the Stafford Act. [1]

[1] For more information on the Stafford Act visit: http://www.fema.gov/media-library-data/20130726-1646-20490-1658/stafford_act_booklet_042213_508d.pdf

ASPR Hospital Preparedness Program Capability 2: Healthcare System Recovery - P2. Assessment of Healthcare Delivery Recovery Needs Post-disaster

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, local, state, and Federal recovery coordinators, relevant response partners, and stakeholders, perform an assessment of healthcare organizations recovery needs post-disaster. This process should include but is not limited to the following elements:

1. **Coordination with healthcare organizations to identify immediate operating needs for the delivery of essential healthcare services**
2. **Coordination with partner healthcare organizations to identify possible long-term healthcare recovery priorities**
3. **Processes to communicate healthcare recovery priorities to the local and state agencies responsible for recovery**
   (ASPR 14)

Hospitals should thoroughly review their insurance policies to determine their coverage and what information their insurance providers will require if the hospital is making a claim. Ideally, hospitals will be able to provide any organization they are requesting assistance from with documentation of damages using inventories and pictures of property collected both before and after the incident. Maintaining adequate insurance coverage will help hospitals quickly recover from a major disaster while failing to do so could be compound the impact of a disaster. For example, hospitals located in a flood plain that fail to participate in the National Flood Insurance Program jeopardize their ability to secure insurance payments.[2] Additionally, hospitals should prospectively discuss the details of the process for filing a major claim with their insurance providers. Repeatedly, hospitals damaged by severe weather have estimated their loses to be in excess of $1 Billion (NYT, Hayes).

Every hospital is a complex organization that is dedicated to providing medical care that meets the unique needs of their community. The high amount of variability among both communities and hospitals makes it difficult to find a one-size-fits-all solution to hospital damage

[2] For more information on the National Flood Insurance Program visit: http://www.floodsmart.gov

assessment[3]. However, the variability among hospitals also affords each hospital the opportunity to tailor their damage assessment procedure to its organization. Each hospital should create a method for collecting the most accurate information regarding their needs following a disaster and ensure they develop their assessment so that it is simple and transparent. Reported damage assessments can dictate the amount of recovery funds that are available to hospitals and attempts to change assessments can result in years of litigation.

Performing a hospital-wide damage assessment following a disaster will be an incredibly resource-intensive activity involving data collection, complication, and analysis. It is important to develop methods for hospital staff to report urgent matters that require immediate attention so these significant issues are not lost among the large volume of less urgent, minor concerns that will be also be reported during the damage assessment. Hospitals should prepare to manage their damage assessment using the Hospital Incident Command System. Hospitals should also consider their hazard vulnerability analysis and prepare methods to speed their damage assessment following both highly likely and catastrophic incidents. Hospitals that approach their hazard vulnerability analysis in a compressive manner will be able to identify how to mitigate threats, how to respond to incidents effectively, and how to speed recovery from an incident. For example, a hospital that is in a flood plain could consider developing an assessment tool that provides an initial assessment of damage depending upon the height of

[3] Additional information on how to conduct a hospital-wide assessment following a disaster can be found in the *Hospital Assessment and Recovery Guide* written by Richard Zane M.D. and Paul Biddinger M.D. available from: http://archive.ahrq.gov/prep/hosprecovery/

floodwater. Hazard specific assessment tools should complement, rather than replace general all-hazards assessment methods that hospitals have prepared for response and recovery.

Hospital Recovery – Damage Assessment Considerations

1. **Hospitals should prepare a simple and transparent method for conducting a comprehensive damage assessment that covers all areas of the hospital**
2. **Hospitals should consider threat/hazard-specific assessment tools that can be used to standardize assessment across the entire hospital and simplify initial assessments**
    A. **Ex. 1: Hospital surge inundation model that estimates damage based upon flood or surge level (e.g. 4" floodwater = subbasement, basement, and first floor flooding)**
    B. **Ex. 2: IT system specific assessment tool(s) that helps track status/functionality of multiple and various IT systems used throughout the hospital**
3. **Damage assessment begins during response and will need to be repeated throughout recovery to monitor progress as a hospital works to achieve recovery objectives**
4. **Communication flow of damage assessment information should be clearly defined from inside the hospital out to recovery partners**
5. **Each department, unit, service should be asked to identify at least the following:**
    A. **Operational status (e.g. fully operational, partially operating, non-operational)**
    B. **Status of staff**
    C. **Damage to physical space & equipment**
    D. **Disruptions to communication/information technology systems**
    E. **Immediate needs & long-term needs**
    F. **Estimated time to resume department-level, unit-level, service-level functions**

A cyber-disruption will present unique challenges for hospitals as they work to recover from a disaster. A variety of hazards can render information technology (IT) systems inoperable, which may prevent hospitals from effectively gathering information and coordinating recovery activities. Hospitals can reduce the effect that an IT disruption will have on their recovery efforts by planning to use redundant and resilient forms of communication during recovery. Hospitals should consider building assessment into standard operating procedures for their services, departments, and units so assessments begin as soon as possible once a cyber-disruption occurs. In the event of a cyber-attack, hospitals may need to spend time identifying the vulnerabilities that were exploited in their IT systems that and to what extent their systems and data were corrupted before implementing strategies to restore their networks.

8. Recovery Team

Who should be involved in recovery efforts is difficult for hospitals to determine. Everyone at the hospital including administrative, clinical, and support staff can potentially be involved in emergency response and recovery and there will be many competing priorities for hospitals to balance as they transition from response to recovery. Some constraints that hospitals will need to consider when assigning staff to recovery functions include response needs and staff fatigue. Hospitals will need to proactively staff their recovery team in a practical manner. Considering potential recovery needs and setting clear recovery objectives will help hospitals determine appropriate recovery team staffing levels.

Both ASPR and FEMA identify the need for organizations involved in recovery to identify a local-level disaster recovery coordinator who can coordinate recovery efforts with state and federal recovery coordinators. Hospitals should maintain a clear Hospital Incident Command System (HICS) and include a hospital disaster recovery coordinator, and perhaps larger disaster recovery team, as part of their HICS organization. Hospital should consider how and where the role and responsibilities of a disaster recovery coordinator fit into their HICS organization.

Hospital Recovery – Recovery Team

1. **Recovery should be managed using the Hospital Incident Command System (HICS)**
2. **Roles, responsibilities, and authorities of recovery team members should be clearly identified in the hospital emergency operations plan**
    a. **The Incident Commander is responsible for managing an incident from response through recovery. He/she should consider delegating recovery planning efforts if response efforts require his/her full attention**
    b. **The IC may consider delegating recovery planning to their Planning Section Chief, Finance Section Chief, or to a Deputy Incident Commander**
3. **Hospitals should plan to use the staff they have as efficiently as possible**
    a. **Consider assigning staff who are not normally involved in response a role on the hospital recovery team**
    b. **Staff who have responsibilities assigned during both response and recovery should be phased out of their response roles as soon as possible in order to give them rest before they assume their recovery roles**

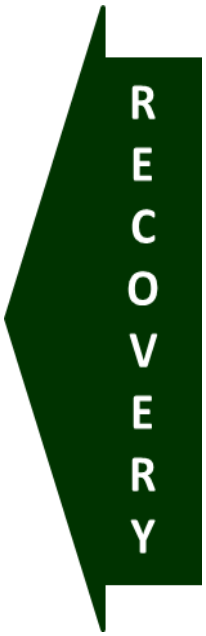
9. Integrating Recovery Functions into Emergency Operations Plans

Another step in recovery planning is creating appropriate structures and systems to manage all aspects of recovery including both short-term and long-term recovery needs. Hospitals should consider how each element of their emergency operations plan that addresses how the hospital will respond to an incident will be affected and can be leveraged as an incident transitions from response to recovery. Recovery needs that hospitals can plan to manage with their EOPs may include communications and information management, materials management, personnel management, security, behavioral health, and financial and legal issues.

FEMA Comprehensive Preparedness Guide 101: Developing and Maintaining EOPs

Traditional Functional EOP Format (excerpt)

1. **Basic Plan**
   - A. **Introductory Material**
   - B. **Purpose, Scope, Situation Overview, and Assumptions**
   - C. **Concept of Operations**
   - D. **Organization and Assignment of Responsibilities**
   - E. **Direction, Control, and Coordination**
   - F. **Information Collection, Analysis, and Dissemination**
   - G. **Communications**
   - H. **Administration, Finance, and Logistics**
   - I. **Plan Development and Maintenance**
   - J. **Authorities and References**
2. **Functional Annexes**
3. **Hazard-, Threat-, or Incident-Specific Annexes (FEMA CPG 3-4)**



A. Communications and Information Sharing

A comprehensive communication plan is an integral element of an emergency operations plan, an incident action plan, and of the recovery process. During recovery, sending and receiving messages as well as maintaining situational awareness may be challenging for hospitals. Hospitals should prepare to actively maintain situational awareness as they work from response through recovery. It will be important to leverage technology and systems innovations to

enhance greater information sharing, accountability, and transparency. Hospitals should prepare to communicate both internally and externally during the recovery phase using redundant and resilient forms of communication as normal communication methods may be less than fully functional.

Depending upon the incident, hospitals may be unable to take desired recovery actions until after an external agency has taken an action. This may mean waiting for the local public works department to clear debris from a roadway or waiting for a utility provider to restore electricity to the hospital. Similarly, a hospital may need to wait to pursue a recovery objective until after a regulatory or life-safety agency has inspected a space and deemed it appropriate for use. Incidents requiring a criminal investigation by law enforcement or an arson investigation by the fire department will call for communication and cooperation among public safety, public health, and healthcare agencies. Primary recovery objectives such as rebuilding or cleaning a space will be delayed until investigators have collected the evidence they need. Clearly communicating hospital status, needs, and estimated timeframes to complete recovery tasks with both internal and external stakeholders is essential in managing expectations during recovery from an event. Following a disaster, the situation that both the hospital and the community it serves will face will rapidly change and new challenges or resources may present that will impact the strategies and tactics hospitals use to recover. Hospitals should provide regular situation reports and updates both internally and externally as early as possible and often as the hospital works through recovery. Actively monitoring and posting updates on social media sites can be an effective method of sharing information with and gathering information from the media, partner agencies, and the public during recovery.

B. Materials and Personnel Management

Recovery planning should develop a structure and system to manage recovery resource needs. The capabilities requested, the priority requests are assigned, and the allocation of resources as they become available should be considered in relation to overall hospital recovery objectives.

All requests for resources and services should flow through the Hospital's Incident Command System. Hospitals should consider developing an electronic process, with redundant non-electronic methods, to formally release and accept all resources internally, among lending and receiving hospitals as well as other response partners.

Over the past decade, routine resource management among many hospitals has transitioned from supply room stockpiling of resources to reliance upon electronic inventory tracking and purchasing systems to order resources when they become scarce. While this just-in-time system is very efficient, it relies heavily upon information technology and shipping systems to be fully functional and to get hospitals essential supplies before they run out. A planning target for many hospitals when considering the supplies they should have on-hand at any moment is the amount of resources that would be required to make the hospital capable of "standing-alone" for 96 hours. When planning how to manage limited resources, hospitals must consider all variables in their estimate including on-hand supply, the use rate of that supply, and the length of time hospitals will be without the resource. It is possible that hospitals will enter recovery facing either one of or a combination of the following challenges: a resource shortage, a higher than average rate of use for a resource, or a longer than expected delay in supply shipments. During pre-incident recovery planning, hospitals should first identify the resources they have on hand that would become limited if their supply chain was disrupted. Then hospitals should develop resource management triggers and strategies that will maximize the utility of those critical resources.

After potential recovery needs have been identified, hospitals can work with vendors or partner agencies to establish agreements or contracts that would be used in the event that a hospital activates recovery functions. Hospitals should prepare to secure recovery resources from outside normal supply chains and should prepare to operate recovery functions with limited resource availability. Recent major events have disrupted supply chains of critical resources including fuel and medical supplies for at least 7-10 days after an emergency.

The most important resource for hospitals to consider during their recovery planning is their staff. A disaster that impacts the hospital may also significantly impact staff and their families. Hospitals should develop plans to care for the physical and psychological needs of staff members and their families. This may require allowing staff time off to attend to personal matters, assisting with transportation to and from work, assisting with meals and temporary lodging, laundry services, or elder and child care services. Additionally, following a significant event, hospitals may need to care for the behavioral health of their staff and/or family members. The behavioral health function is discussed in more detail in the next section.

C. Behavioral Health

Hospitals need to consider how they will care for the mental health of their employees following a disaster. Hospitals should create behavioral health plans and prepare to take interventions that will help hospital workers recover from an event. Hospitals should take into consideration that the signs of psychological trauma following a disaster may be delayed or difficult to recognize. Behavioral health plans should be scalable and flexible and may entail individual, family, and group crisis counseling, educational presentations, distribution of educational literature, and connecting individuals, families, and communities with resources that they may need to restore social and psychological functioning. Behavioral healthcare should include mental health services, treatments for substance misuse and other addictions, and a broad range of social and emotional supports designed to restore the psychological wellbeing of individuals, their families, and communities.

Following an event where hospital staff or patients are injured or killed, the psychological impacts of response may disrupt both clinical and support services throughout the entire hospital. Recovery can present its own challenges when attempting to care for the welfare of hospital staff, particularly following an incident where an injury or loss of life occurs at the facility. Hospitals should prepare to bring in clinicians and outside vendors to perform services that normally hospital staff would provide. This may mean bringing in traveling nurses to

support clinical units or contracting with vendors for short-term support in other areas. If an employee or patient is hurt or killed at the hospital and cleaning or construction is required to restore an area, then hospital leaders should strongly consider using contracted services for those efforts. It is likely that the injured party is or the deceased was a colleague of the environmental services and facilities employees who would be assigned those tasks.

D. Safety & Security

Recovery efforts cannot begin at a hospital until the facility is safe. Hospitals should establish contracts for additional security staff, fences and barricades, and debris removal. If hospitals intend to seek reimbursement from the federal government or other sources, they should also establish debris removal monitoring contracts. Hospitals should also determine what local or state debris removal contracts they may be eligible to use in the event a disaster affects their facility.

It is important for every hospital to identify the normal functions and support mechanisms that ensure the security and safety of their hospital. It is very likely that security and safety needs both inside the hospital and in the community will be increased following any disaster either natural or manmade. Hospitals should prepare for situations when internal plans and resources that promote a safe environment of care are disrupted during the response phase of an incident. Hospitals should also prepare for situations during recovery when local resources, including public safety agencies, may be unavailable to assist with hospital safety and security needs at normal levels. Hospitals can address some potential internal and external gaps before an event by introducing redundant and resilient measures into their security and life-safety plans.

During day-to-day operations, hospitals rely upon detailed and tested life-safety procedures to promote an environment of care that is both safe and secure. These procedures address the unique characteristics of each hospital and rely upon trained staff, communication systems, and

material resources working in concert to function properly. A disaster may disrupt or alter a hospital's community, the physical facilities of a hospital, or other internal resources that support established life-safety procedures. It is important for hospital emergency planners to consider that established life-safety procedures may not be fully effective during a hospital's recovery. Hospitals should plan to quickly and thoroughly assess hospital life-safety plans during the recovery phase of an incident to determine if changes to these plans need to be made.

Life-safety and security considerations following a disaster can relate to both routine and emergent operations. An example of a routine safety plan that hospitals should reevaluate during recovery is the plan for hospital access. Hospitals should plan for how safe access to their facilities for staff, patients, visitors, deliveries, ambulances, and contractors will be established and maintained if normal security measures and pathways for entrance and egress to and from the hospital are less than fully functional or they are affected by recovery efforts. An example of an emergent safety plan that hospitals should reconsider during recovery is the hospital evacuation plan. Depending upon the condition of the hospital's facilities and the resources available following a disaster, there may be a need to establish interim or new shelter-in-place and evacuation plans.

It is important to remember that many of the challenges that a hospital will face during recovery related to safety and security can be addressed before a disaster occurs. Hospitals should prepare clear methods for communicating changes in life-safety plans among hospital staff, appropriate partner agencies, patients, and the public. Hospital staff will likely be fatigued during the recovery phase and may be reluctant or too exhausted to consider the next emergency that a hospital may face. However unfortunate it is, the fact remains that significant events such as once-in-a-hundred-year natural disasters and man-made disasters do not occur on any regular timeframe and therefore hospitals must always hope for the best, but prepare for the worst.

E. Financial and Legal

The financial and legal aspects of recovery can take years to resolve following a disaster if proper care and attention is not devoted to them before an incident occurs. Hospitals should have a clear understanding of what their insurance plans will and will not cover during recovery efforts and should prepare clear and transparent documentation that can be shared with recovery stakeholders when applying for aid, assistance, or reimbursement. Federal assistance following any disaster is not a guarantee.

Disaster	Hospital(s) Affected	Damages and/or Reimbursements
Moore, OK Tornado 2013	**Moore Medical Center**	**$50-70M estimated insurance reimbursements from four policies (Hampton)**
New York, New York Hurricane Sandy 2012	**NYU Langone Medical Center & other NY hospitals and healthcare facilities**	**$3B estimated total damages (Hurricane)**
Joplin, MO Tornado 2011	**St. John's Hospital**	**$950M estimated cost of new medical facility to replace destroyed hospital (Community)**
Galveston, TX Hurricane Ike 2008	**University of Texas Galveston Medical Branch**	**$1.2B estimated damages (UTMB)**
New Orleans, LA Hurricane Katrina 2005	**Charity Hospital**	**$475M arbitrated reimbursement for damages (Moller)**

Fortunately, many hospitals have never had the need to file insurance claims and reimbursements on the scale of tens of millions of dollars. Unfortunately, during the past ten years, several hospitals have suffered losses on the scale of a billion dollars because of a natural disaster. The chart on this page outlines a few major disasters, the hospitals those disasters affected and some of the financial results for those affected institutions. Hospitals should consider all of their assets and be prepared to file a claim for the partial or complete loss of these assets. Hospitals should engage in frank discussions with the underwriters of their insurance policies as well as the major claim representatives from their insurance providers

about the limits on their policies and what claims will be covered in the event that their hospital experiences catastrophic losses.

Hospitals should also prepare to deal with uncompensated care following a disaster. As hospitals work to provide healthcare during the response to an incident, normal financial tracking methods may be unavailable and reimbursement for services provided can be challenging to obtain during recovery. Finally, hospitals should consider what their operating costs will be following a disaster and what it will take to balance their operating budget. Renovations and staff turnover are two potentially crippling financial challenges that hospitals may face following a catastrophic disaster (GAO 4).

F. Volunteer & Donations Management

Whether volunteers and donations are considered a blessing or a burden depends upon what hospitals have done to prepare to manage assistance during recovery. Hospitals should prospectively prepare lists of donated materials they would accept or request. Hospitals may consider preparing or establishing an account where donations may be directed following a disaster. In this case, hospitals should also create detailed rules and management structures to ensure donations are effectively managed and appropriately spent.

The contributions of skilled and unskilled volunteers can be immensely helpful for hospitals that are working through recovery as long as volunteer efforts are properly managed. Hospitals should clearly explain to potential volunteers the positions they could fill within the hospital. Any hospital that plans to use volunteers should develop an intake procedure that includes registration, orientation to the hospital, and training volunteers for the tasks they will be expected to complete. The intake procedure should also verify any credentials or certifications volunteers state they have and background checks may be appropriate depending upon the tasks hospitals expect volunteers to complete. Hospitals in Massachusetts can turn to the

MDPH for assistance in locating volunteers who are registered through MA Responds, a system that tracks and verifies credential of both medical and non-medical volunteers.[4]

Even if recovery needs are currently being met at the hospital, it is wise for hospitals to consider encouraging volunteers or donors to provide their contact information or to contact the hospital again at a later date when the need for resources may again be scarce. For example, after some disasters, large numbers of people donate blood and the supply of blood can exceed the demand for blood in the short term. However, in the long term, there will likely be blood shortages that could be addressed if the "disaster donors" spread out their donations over time rather than donate at once causing a surplus. Hospitals may consider redirecting volunteers who hope to be involved in the response to public health emergencies to contact the local Massachusetts Medical Reserve Corps (MRC)[5] unit or an organization that is involved with Massachusetts Voluntary Organizations Active in Disasters (MAVOAD)[6]. Another excellent resource for hospitals to consider redirecting donors or volunteers to is the United Way's Massachusetts 2-1-1 Helpline[7]. Calls to 2-1-1 are answered by trained operators who can connect callers with appropriate community services in their area.

[4] For more information on MA Responds visit https://www.maresponds.org/
[5] For more information on MRC units visit: www.mamedicalreservecorps.org
[6] For more information on MAVOAD visit: www.mavoad.org
[7] For more information on MA 2-1-1 visit: www.mass211.org or call 2-1-1, (877) 211-MASS (6277), (508) 370-4890 TTY

10. Hospitals, Emergency Management, and Partner Agencies

A hospital's recovery functions and capabilities will be stronger if the hospital takes time to integrate into their community's existing emergency management structure. In addition to forming positive relationships with local police, fire, EMS, public health, and emergency management agencies it is important to reach out to other organizations active in the city or town where the hospital is located. This includes private sector partners and non-governmental organizations as discussed in the previous section. Local media outlets are also a key partner to engage before an event occurs. External agencies will have response and recovery objectives that will not always align with hospital recovery objectives; however, hospitals cannot predict which organizations may be able to offer them support and assistance when they are faced with a challenging recovery.

Hospital Recovery – Local Agency/Organization Directories

Local Emergency Management Directors Listing –
Maintained by MEMA: Local Emergency Management Directors Listing[8]

Local Board of Health Directory –
Maintained by MA Association of Health Boards: Local Board of Health Directory[9]

Massachusetts VOAD Resource Guide –
Maintained by MA VOAD: Massachusetts VOAD Resource Guide[10]

It is also important for hospitals to look beyond their local partners and consider their interdependence with the communities that make up their clinical catchment area or region. Hospitals should reach out to municipalities beyond where they are located, particularly if healthcare resources surrounding the hospital are scarce. The following pages contain some suggestions on how to integrate the hospital into community emergency preparedness.

[8] To access the MEMA Local Emergency Management Directors Listing visit: http://www.mass.gov/eopss/agencies/mema/emergency-management-directors-listing.html
[9] To access the MAHB Local Board of Health Directory visit: http://www.mahb.org/Directory.aspx
[10] To access the Massachusetts VOAD Resource Guide visit: http://massvoad.org/news/wp-content/uploads/2011/05/MASTER_MA_VOAD_Disaster_Resource_Guide_2011.pdf

A. Invite Local First-Responders, Municipal Agencies, and other Key Stakeholders to Participate as Members of Your Hospital's Emergency Preparedness Committee

- Establish relationships with police, fire, EMS, public health, and emergency management agencies in the hospital's home municipality, and preferably with all adjacent cities and towns as well.
- It is best practice, and encouraged by The Joint Commission, that representatives from these agencies be invited to join the hospital's Emergency Management Planning Committee. An honest dialogue regarding hospital and community capabilities will foster a collaborative relationship and help prevent agencies from forming unrealistic expectations or invalid assumptions during a disaster.

- A strong relationship with first-responders will be critical to a successful recovery and these relationships must be forged prior to an event.
- Hospitals should discuss with agencies in their jurisdiction how local recovery plans are structured to determine if hospitals will work directly with the local emergency management agency or with the local public health agency in an ESF/RSF structure.

B. Participate in Your Local/Regional Emergency Preparedness Committee (REPC/LEPC)

- At a minimum, LEPC/REPCs provide a forum for emergency management agencies, first-responders, private businesses and the public to work together to evaluate, understand, train, coordinate, and communicate about chemical hazards in the community and develop jurisdictional hazmat response plans.
- Over the past ten years, many LEPCs/REPCs have expanded their scope beyond chemical hazards to addressing "all hazards" in the community.
- Ideally, the hospital would have representation on the LEPC/REPCs for each municipality in its Primary Service Area. If this is not feasible, the hospital should be represented on the LEPC/REPCs in the municipality where it is located as well as neighboring communities.
- One effective means of delegating this responsibility is to require each member of the hospital's Emergency Management Planning Committee belong to at least one LEPC.
- Representation on the LEPC(s) will establish the relationships necessary for an efficient recovery. The hospital will have a better understanding of the available resources in the community and how to access those resources. Similarly, and of equal importance, the community first-responders will have realistic expectations of the capabilities of the hospital.

Local Emergency Planning Committee (LEPC) Mission / Requirements

- **A response plan must be written for responding to a hazardous material incident with the jurisdiction(s). It must also be reviewed annually.**
- **Emergency responders (police, fire, emergency medical services, public works, etc.) must be trained to levels indicated in the plan. At a minimum, first-responders must be trained to the awareness level.**
- **The emergency response plan must be exercised at least once a year.**
- **The committee must create a system to collect, store, and respond to public requests. (MA EOPSS)**

C. Represent Healthcare on a Regional Homeland Security Advisory Council

- Each region of Massachusetts has a Homeland Security Advisory Council. Each council has seats delegated for members of 12 different disciplines, including hospitals.
- A staff member of the hospital should contact the hospital representative serving on the Homeland Security Advisory Council. The council representative should provide the hospital with a summary of council projects and establish a time for someone from the hospital to sit in on a council meeting as an observer. If the position of hospital representative is vacant, the hospital should consider nominating someone to that position and work with the Homeland Security Advisory Council on the process of filling the vacant position.
- Integration with the Homeland Security Advisory Council will make the hospital aware of potentially available resources outside of the hospital's immediate community that often are underutilized.
- Additionally, by becoming involved in the Homeland Security Advisory Council the hospital will broaden its base of contacts from which to rely upon during a recovery.

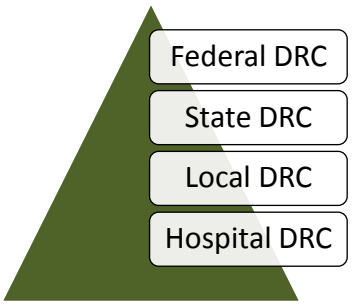
Regional Homeland Security Planning Regions & Advisory Councils

Each region of the Commonwealth has a multi-disciplinary and multi-jurisdictional advisory council of responders to ensure homeland security funds meet the planning, organization, equipment, training, and exercise needs of the region (MA EOPSS).

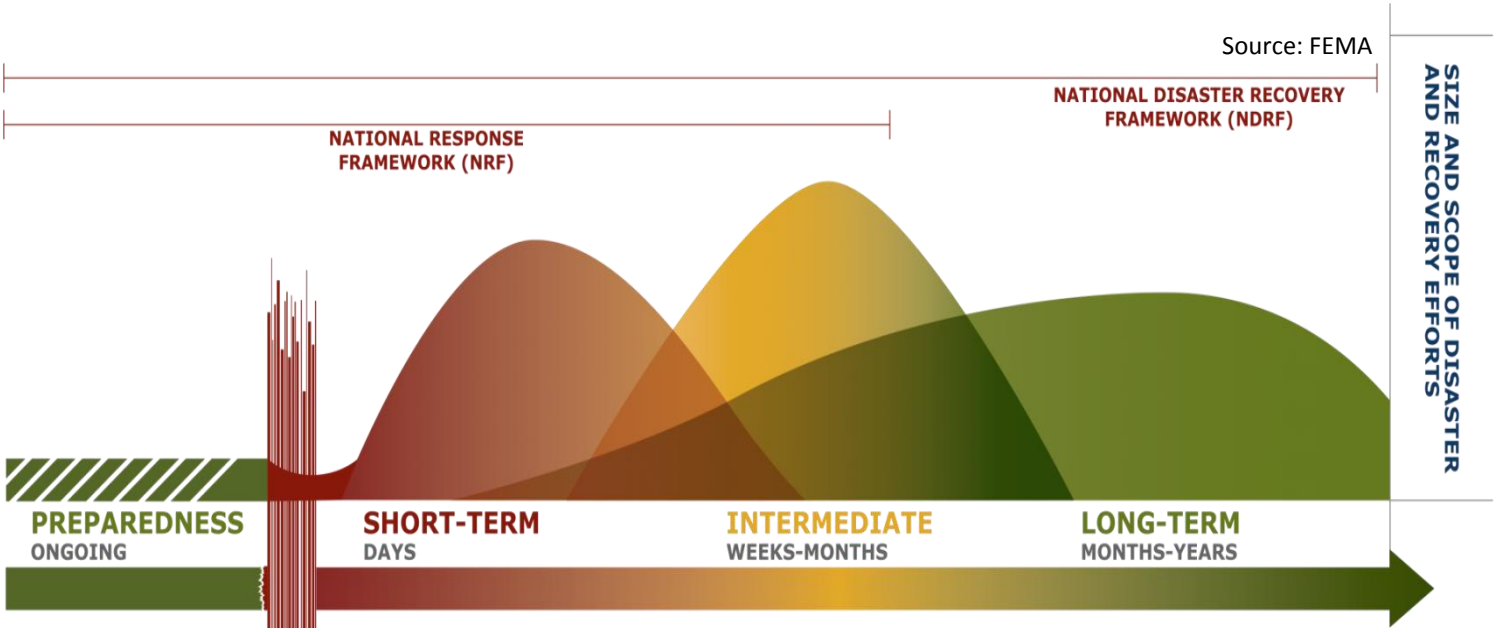
- **Metro Boston Homeland Security Planning Region & Advisory Council**
  - **MDPH Region 4C, Region 4B**
- **Northeast Homeland Security Planning Region & Advisory Council**
  - **MDPH Region 3, Region 4AB**
- **Southeast Region Homeland Security Region & Advisory Council**
  - **MDPH Region 5, 4AB**
- **Central Homeland Security Planning Region & Advisory Council**
  - **MDPH Region 2**
- **Western Homeland Security Planning Region & Advisory Council**
  - **MDPH Region 1**

D. Understand the National Disaster Response Framework

- The NDRF is built upon nine core principles that support three key elements:
  1. Leadership at every level: Disaster Recovery Coordinators (DRCs)
     1) Hospital Disaster Recovery Coordinator
     2) Local (City/Town) Disaster Recovery Coordinator
     3) State Disaster Recovery Coordinator
     4) Federal Disaster Recovery Coordinator
  2. Pre-disaster and post-disaster recovery planning
  3. Recovery Support Functions (RSFs)



Source: FEMA

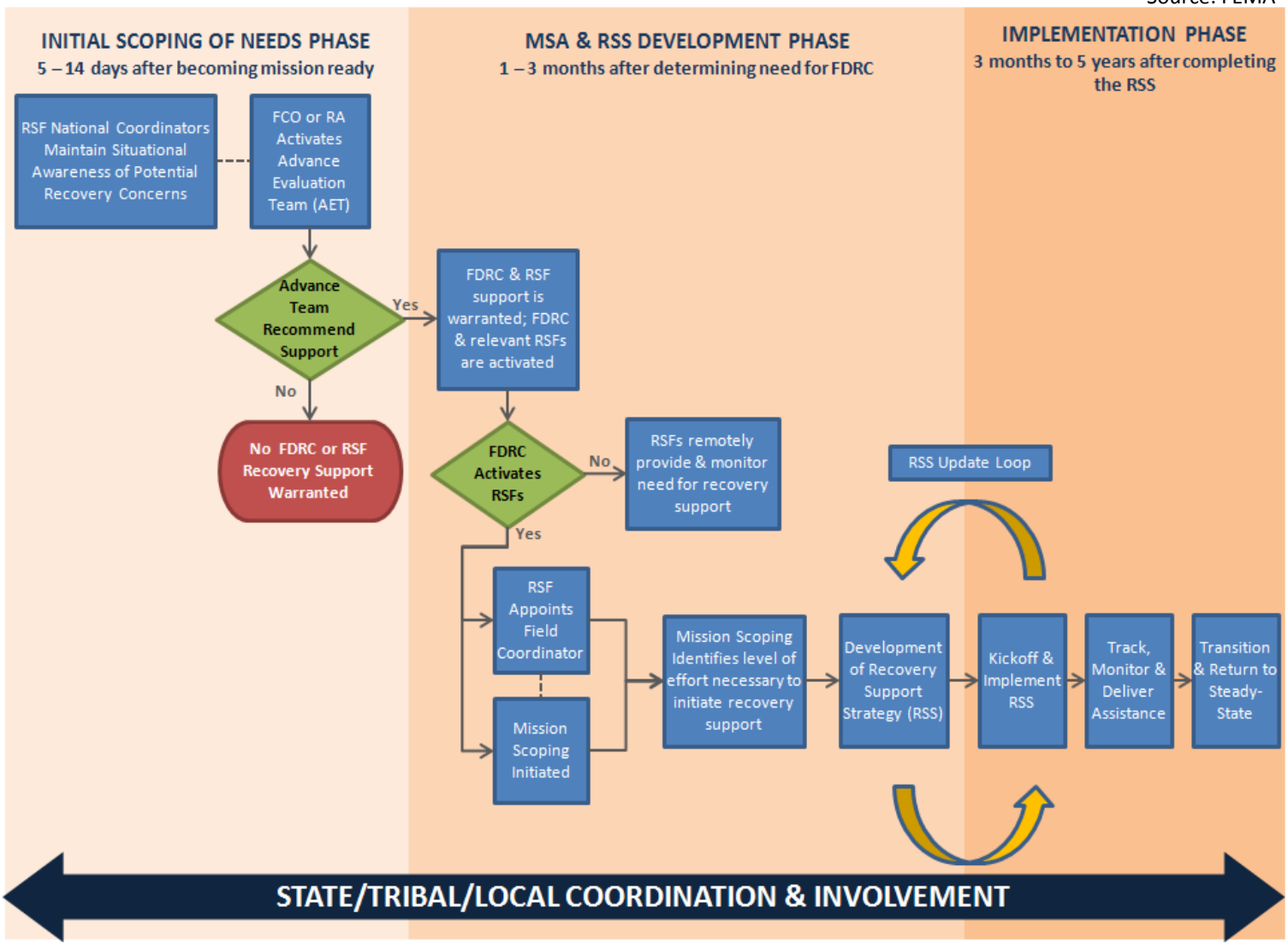


When Recovery Support Functions are activated, hospitals are most likely to coordinate recovery efforts through the Health and Social Service Recovery Support Function. At the Federal level, the Department of Health and Human Services coordinates the Health and Social Service RSF and provides state and local entities with assistance so they can address disruptions in public health services, healthcare operations, school systems, and many other areas. Within Massachusetts, recovery functions for the healthcare sector will be coordinated by MDPH in collaboration with MEMA. Statewide recovery plans for the Commonwealth are currently being revised to better align with federal structures outlined in the NDRF.

- NDRF activation occurs in three phases (see below):
    1. The **Advance Evaluation Team (AET)** is responsible for the initial scoping of community needs and determining whether federal support is warranted.
    2. Next, activated Recovery Support Functions help to evaluate recovery needs and support the development of **Mission Scoping Assessment (MSA)** that determines the level and type of RSF support.
    3. Finally, the Mission Scoping Assessment informs the **Recovery Support Strategy (RSS)** document that establishes initial recovery objectives and milestones. The RSS is updated as recovery operations progress toward restoring a steady-state/normal/new normal level of operations.

FDRC/RSF Activation – Deployment

Source: FEMA



11. After Action Reports and Improvement Planning

Hospitals should prepare a detailed after action report (AAR) following any significant event. An AAR should summarize the timeline of events as well as successes and challenges that a hospital encountered during response to and recovery from an incident. The Homeland Security Exercise and Evaluation Program (HSEEP) provides training and guidance for responders as well as templates that hospitals can use to create their own AARs.[11]

The Joint Commission requires a hospital designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement in EM.03.01.03 and specifies that all emergency response exercises include the identification of deficiencies and opportunities for improvement. Developing an AAR meets the criteria.

Recommended HSEEP AAR Format		
	Executive summary	
	Event overview	**Background information**
		Date, time, location
		Hazard/scenario type
	Response/Recovery goals and objectives	
	Event synopsis	
	Analysis of mission outcomes related to *core healthcare preparedness capabilities*	
	Analysis of critical task performance	
	Conclusion	
	Appendix A: Improvement plan matrix	**Root causes & observations**
		Recommendations
		Due dates
		Responsible organizations

[11] For more information on HSEEP visit: http://www.hseep.dhs.gov

12. Questions to Consider During Recovery Planning

A. Scope and Objectives

- What are your key planning assumptions?
- Who do you collaborate with internally and externally in defining these?
- What are the processes in place to do this?
- How are goals, objectives, and strategies identified, selected, and prioritized?

B. Activation

- What is the process for activation of recovery functions? Is it scalable?
- What are the criteria/triggers for activating the recovery functions?
- Who activates it?
- How is it activated?
- How do you transition from response to recovery?

C. Recovery Organizational Structure and Teams (HICS)

- What does your recovery organizational structure look like?
- Who is in charge of recovery? How does he/she fit into the HICS?
- What are the roles and responsibilities in recovery?
- How are the teams staffed? Is there a difference in early vs. late recovery?
- Who has the decision-making authority?

D. Risk Assessment / HVA / Identification of Recovery Needs

- Who is assessing the hospital's recovery needs?
- How are they communicating with those working on recovery? How is this communicated to senior management (within HICS)?
- What processes are in place to identify and prioritize recovery needs?
- What are the risks and vulnerabilities that may impede recovery?

E. Continuity of Operations Plan (COOP) / Recovery Interplay

- Do you have a functional COOP?
- How is it activated?
- What is its organizational structure? Who is in charge of the COOP?
- Who sets the goals and objectives and how are these monitored?
- What are your COOP capabilities?
- What are your essential services in recovery?
- How is continuity of care (short-term and long-term) accomplished?
- How are short-term and long-term recovery needs identified and prioritized?
- How are resources used to support essential services? Have you included food services in your COOP plan?—many patients have specific dietary needs that must be met.
- Be as specific as possible. Identify what units would open first; what surgeries or procedures would start back up first.
- How do you transition back to normal operations?

F. Communications and Information Sharing

- What is your organizational structure?
- How do you transition from JIC to recovery communications?
- How is this structure activated and staffed?
- Where is the structure located?
- Who at the state-level do you communicate with during recovery?
- How do you communicate with the state during recovery? What are the processes in place?
- How do you communicate with your partners and other stakeholders during recovery? With the general public?
- Does your Healthcare coalition have tools and capabilities to communicate and coordinate with its member organizations during recovery?

F. Communications and Information Sharing (continued)

- Who would provide situational awareness to all the hospitals during recovery?
- What are your triggers to post recovery information?
- Who has authority to post, where would it be posted, what should be post; where would hospital post/ how would they relay recovery information for staff?
- What information goes to patients and the general public?
- How will you leverage technology and systems innovations to achieve goals that result in greater information sharing, accountability, and transparency?
- How do you ensure bi-directional communication with affected area?
- Are your Emergency communications protocols during recovery well-defined for all staff and regional partners?
- Are redundant forms of communication equipment tested and used regularly to increase staff competence?
- Have you worked with regional/state partners to develop the sequential order that redundant forms of communications should be used during an incident?
- How does every hospital responding to or recovering from the disaster move to the same operational mode of communication redundancy if landlines, cellular phone systems, and internet are not functioning?
- How are you communicating with vulnerable populations to ensure they understand and can access the recovery resources?
- How will you use social media to enhance your communications during recovery?

G. Personnel Management

- How do you deal with the staffing issues early on while response and recovery are occurring simultaneously?
- How will you identify staff who have lost their badges/credentials?
- How are personnel needs in recovery identified and prioritized?

G. Personnel Management (continued)

- How are personnel needs requested and obtained during recovery?
- Do you have readily available surge staffing and management structures that support the increased workload during recovery?
- Have you establish shifts of roles and responsibilities in stages of recovery?
- What are the challenges you would encounter in taking care of your staff during recovery? Have you identified ways in which staff can assist in recovery efforts from remote locations?

H. Volunteer and Donation Management

- Who is in charge of volunteer management? What is your organizational structure?
- How are volunteer needs identified and prioritized?
- Who is in charge of donation management? What is your organizational structure?
- How are donation needs identified and prioritized?
- What are your procedures for the coordination, acceptance, control, receipt, storage, distribution, and disposal of donations-in-kind, volunteers, donated services, and funding? For these purposes, a volunteer is defined as a person who provides a service without compensation; donations are defined as materials, goods, and supplies which are given, not purchased.
- Identify a process for the timely release of information to the public regarding the needs of the incident, agencies involved in disaster relief, acceptable donations, and a readily available point of contact for donations management.
- Identify how donated goods will be transported to distribution points
- Identify checkpoints and staging areas for donated goods.
- Identify process for disposal of excess donated material (unusable or unneeded).

I. Materials Management

- Who is in charge of materials management during recovery?
- Do staff know their roles and responsibilities during recovery?
- How are recovery resource needs identified and prioritized? Are there criteria to rank needs?
- How are critical supplies monitored?
- How are resource needs requested and obtained? Where will you get support for resource requests?
- Is there an electronic process, with redundant capabilities, to formally release and accept all resources from lending and receiving hospitals?
- How are needs monitored throughout recovery?
- How are challenges identified and resolved?
- How does your hospital communicate status of operations and supply chains as well as restoration challenges and timelines to all partners?
- How does your hospital identify the process for how requests are handled (vendors/local/regional/state/federal)?

J. Financial and Legal Issues

- What is your organizational structure?
- Who manages the money in recovery? How are financial decisions made and communicated?
- How are material and personnel resources that are requested and /or used monitored, tracked and how is this documented and shared within your organization?
- Do you know what your processes for reimbursement, reconstitution and/or re-supply are?
- Do you have contracts or blanket purchase orders set up with vendors in advance to prepare for disaster assistance?

J. Financial and Legal Issues (continued)

- Have you identified funding sources available for recovery?
- Do you have a plan to support the development and maintenance of adequate financial monitoring and accounting systems—including systems that detect and deter fraud?
- How will you deal with uncompensated care after the event?
- How will you document all expenses incurred from the incident?
- Have you communicated with licensing and regulation agencies to know what needs to be done for various incidents? What are the challenges and barriers identified?

K. Security Management

- How will you implement and maintain site security?
- Who will provide security during the recovery phase?
- How will you ensure staff have identification cards/badges? It is important that verification is strictly enforced for entry into all patient care and IC locations.
- How will you ensure security guards can be easily and officially recognized? Contract services need to be identifiable. Consider one standardized uniform and badge system.
- How will you deal with debris removal to ensure safe passage to appropriate areas within and around your facility?

L. Health, Safety, and Welfare of Hospital Workers

- Have you developed a plan to monitor the health and wellbeing of your staff?
- Who will monitor the health and wellbeing of your staff?
- How will this be accomplished?
- How will any issues be dealt with?
- How will the plan be communicated to staff?

M. Mental Health Issues

- 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 or promoted among hospital employees, patients, and their families?
- Have you assessed the capacity of mental health services that your hospital provides/uses?
- How do you track and record mental health counseling that your hospital provides?
- Does your hospital promote psychological first-aid and/or psychological resiliency among hospital staff, patients, and their family members? What routine services or outreach is available to hospital 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 hospital request additional mental health resources from local/state/federal/non-governmental agencies?
- Following an emergency, how are mental health resources coordinated among hospitals and other providers at the local level, within your hospital's service area, and statewide?
- Does your hospital have plans to establish and operate a family assistance center if necessary?
- What public information is your hospital prepared to disseminate informing the public how to seek mental health counseling following a disaster.

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Appendix C: Acronyms

Advance Evaluation Team	AET
Assistant Secretary for Preparedness and Response	ASPR
Continuity of Operations Plan	COOP
Department of Health and Human Services	DHHS
Emergency Management Institute	EMI
Emergency Operations Plan	EOP
Element of Performance	EP
Emergency Preparedness and Response Exercise Program	EPREP
Emergency Support Function	ESF
Federal Disaster Recovery Coordinator	FDRC
Federal Emergency Management Agency	FEMA
Harvard School of Public Health	HSPH
Hazard Vulnerability Analysis	HVA
Hospital Incident Command System	HICS
Information Technology	IT
Joint Commission on Accreditation of Healthcare Organizations	JCAHO
Management	Mgmt.
Massachusetts Association of Health Boards	MAHB
Massachusetts Department of Public Health	MDPH
Massachusetts Emergency Management Agency	MEMA
Massachusetts Voluntary Organizations Active in Disaster	MA VOAD
Memorandum of Agreement/Understanding	MOA/MOU
Mission Scoping Assessment	MSA
National Disaster Recovery Framework	NDRF
Recovery Support Function	RSF
Recovery Support Strategy	RSS
Specific, Measurable, Accurate, Realistic, Time-Oriented	S.M.A.R.T.

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