HOSPITAL INCIDENT COMMAND SYSTEM Guidebook

August 2006

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HOSPITAL INCIDENT COMMAND SYSTEM GUIDEBOOK

August 2006

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FOREWORD

Hospitals throughout the United States confront a myriad of operational and fiscal challenges on a daily basis. To effectively manage emergencies, whether external (e.g., fires, earthquakes) or internal (e.g., child abductions, utility failure), hospitals must invest the time and necessary funds to ensure adequate preparations are in place. Recent events such as the September 11, 2001 terrorism attacks, the Severe Acute Respiratory Syndrome (SARS) outbreak in 2004, and the Gulf Coast hurricanes of 2006 demonstrated the importance of hospital preplanning and personnel training.

Since its inception in the late 1980s, the Hospital Emergency Incident Command System (HEICS) served as an important emergency management foundation for hospitals in the United States. We recognized the value and importance of using an incident management system, not only in emergency situations but also in daily operations, preplanned events, and non-emergent situations. Therefore, the HEICS IV Project, sponsored by the California Emergency Medical Services Authority, has evolved to become HICS—the Hospital Incident Command System—a comprehensive incident management system intended for use in both emergent and non-emergent situations.

The HEICS IV project is not intended to be the only answer to a hospital's emergency preparedness needs. However, we believe this Guidebook and the accompanying materials can play a major role in advancing institutional preparedness while providing needed local, state, and national standardization of hospital emergency response and recovery.

We believe the new Hospital Incident Command System has built upon the benefits and successes of the original HEICS and provides hospitals of all sizes with tools needed to advance their emergency preparedness and response capability—both individually and as a member of the broader response community.

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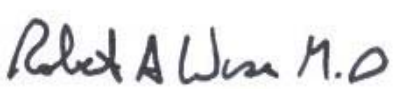

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ABOUT THIS GUIDEBOOK

Every significant incident or event, whether large or small, and whether it is even defined as an emergency, requires certain management functions to be performed. This Guidebook is intended to explain in a clear and concise manner the critical components of the Hospital Incident Command System (HICS) as well as the suggested manner for using the accompanying materials.

HICS is intended to be used by all hospitals, regardless of their size or patient care capabilities, and to assist with their emergency planning and response efforts for all hazards. By embracing the concepts and incident command design outlined in HICS, a hospital is positioned to be consistent with National Incident Management System incident command design guidelines and to participate in a system that promotes greater national standardization in terminology, response concepts, and procedures.

The primary beneficiaries of HICS will be physicians, nurses, hospital administrators, department heads, and other personnel in hospitals in the United States and internationally who will assume command roles during an incident. Students preparing for a career in medicine, nursing, and hospital administration, whose education should include understanding hospital emergency preparedness principles and practices, will also find the material useful.

Other community response partners need to understand the hospital command system design and the response activities and needs that hospitals will have during various types of incidents. Therefore, local/tribal, state, and federal public safety, emergency management, and public health officials will also benefit from reading this manual.

The Guidebook has not been written to be the definitive text on hospital emergency preparedness or to comprehensively teach the principles of incident command. Rather, the reader should find the short-paragraph and bulleted-information format helpful in quickly understanding vitally important tenets of response planning, incident command, and effective response. For detailed coverage on these subjects, the interested reader can seek out a growing number of textbooks and other reference material (see Appendix J: “Recommended Resources”) and attend workshops and seminars offered by expert organizations.

Neither has this Guidebook been written to become the Emergency Operations Plan (EOP) for any hospital. However, the principles detailed and concepts contained within will be helpful in revising or writing an EOP and can be integrated into a hospital’s Emergency Management Program where appropriate.

The recommendations offered are intended to assist the individual hospital fulfill its role during an internal or external crisis.[1]

The reader of this HICS Guidebook is encouraged to review three other published works on incident command and the hospital's relationship with its community partners in responding to emergency situations. They are:

- Medical Surge Capacity and Capability – A Management System for Integrating Medical and Health Resources – Dr. Joseph Barbera and Dr. Anthony Macintyre – CNA Corporation, 2004
- Medical and Health Incident Management (MaHIM)System – A Comprehensive Functional System Description - Dr. Joseph Barbera and Dr. Anthony Macintyre, 2004
- Emergency Management Principles and Practices for Healthcare Systems – Veteran's Administration Manual- Dr. Joseph Barbera, Dr Anthony Macintyre, and Pete Brewster, 2006

[1] Tier 1 in the Department of Health and Human Services – Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large Scale Emergencies Guide Book.

CHAPTER 1

Introduction to the Hospital Incident Command System

1.1 Context for Hospital Emergency Management

Hospital emergency preparedness efforts are influenced by a number of factors, including expectations identified in various regulatory standards. Over the past few years the importance of hospitals as members of the emergency response community has come to the forefront, including hospitals being viewed as " First Receivers" by local, state, and federal officials. Sources of pertinent federal regulatory standards and nongovernmental guidelines and recommendations for emergency preparedness include but are not limited to the following:

- Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards (e.g., Environment of Care (EC) C 4.10, which requires a hazard vulnerability analysis, and EC.4.20, on emergency exercises)
- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II)
- Superfund Amendments and Reauthorization Act (SARA)
- Occupational Safety and Health Administration Hazardous Materials Regulations 29 CFR Part 1910 (Hazardous Materials, Personal Protective Equipment, and Toxic & Hazardous Substances)
- Centers for Medicare and Medicaid Services (CMS)
- American Society for Testing and Materials (ASTM) F-1288 Guide for Planning for and Responding to a Multiple Casualty Incident
- National Fire Protection Association (NFPA) Standard 99 Healthcare Facilities, and Standard 1600 Disaster/Emergency Management and Business Continuity
- Occupational Safety and Health Administration – "Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances"

State and local regulations will vary but each must also be addressed in the Emergency Operations Plan (EOP). It is imperative that the Emergency Management Program Manager and/or the Emergency Management Committee regularly investigate for changes in these standards and regulations and keep abreast of newly published materials. This review process can be aided by ongoing education, Internet search, document reviews, and frequent conversations with other hospitals and local and state emergency management and public health personnel. Failure to comply with these frequently changing standards can result in fines, certification suspensions, and negative public perceptions.

Although standards and regulations play an important role in promoting hospital preparedness efforts, another important reason to prepare is the realistic possibility that any hospital could quickly find themselves responding with little or no notice to an emergency in their community or even within their facility. Recent experience with tornadoes damaging a hospital in the Midwest, gang-related violence in a Los Angeles Emergency Department, and the shooting of a security guard in a Virginia hospital should reinforce the importance of hospitals of all sizes and service delivery models making planning, training, and exercising for external and internal emergencies a top priority. Appendix A: “Incident Planning Considerations” provides important rationale for planning and valuable considerations in both planning for and responding to emergent situations

1.2 History of the Hospital Emergency Incident Command System (HEICS)

Since its inception in the late 1980s, the Hospital Emergency Incident Command System (HEICS) served as an important foundation for the more than 6,000 hospitals in the United States in their efforts to prepare for and respond to various types of disasters. In developing the fourth edition of HEICS, the value and importance of using an incident management system to assist as well with daily operations, preplanned events, and non-emergent situations became apparent. Thus, HEICS IV has evolved to become HICS—the Hospital Incident Command System—a comprehensive incident management system intended for use in both emergent and non-emergent situations. Federal funds were used in the development of the HICS material.

1.3 Objectives of the Revision

The intent of the HEICS revision project was to build upon the work accomplished in the previous three editions of HEICS and expand upon fundamental elements such as:

- Predictable chain of command
- Accountability of position and team function, including prioritized action checklists
- Common language for promoting interagency communication

The objectives in creating a fourth edition of HEICS were outlined by the California Emergency Medical Services Authority (EMSA) at the outset of the project. The intended outcomes of the HICS project were to:

- Update and incorporate current emergency management practices into the system
- Clarify the components of this system and its relationship to the National Incident Management System (NIMS)
- Enhance the system by integrating chemical, biological, radiological, nuclear, and explosive (CBRNE) events into the management structure
- Develop a standardized and scalable incident management system to address planning and response needs of all hospitals, including rural and small facilities
- Develop core materials and guidance for Hospital Incident Command System (HICS)
- Develop suggested qualifications for HICS instructors to better ensure standardization

HEICS was also revised to incorporate new hospital practices in emergency management, offer key operational tools for improved planning activities, and establish closer alignment with community partners through the incorporation of the 2004 NIMS guidelines and the 2006 NIMS Compliance for Hospital Guidance document.

Many hospitals viewed the usefulness of HEICS to be limited to managing emergency response. However, the new, more modular design and flexibility of HICS lends itself to be used also to manage non-emergent incidents or events, such as moving the facility, dispensing medications to hospital staff, or planning for a large hospital or community event.

Appendix K: “HEICS IV Project Organization” provides the reader with more background on the revision process.

1.4 Contributors

HICS was developed by a National Work Group of twenty hospital subject-matter experts from across the United States, representing all hospital types: large and small, rural and urban, and public and private facilities. In addition to the contributions of the National Work Group, ex officio members were included to ensure consistency with governmental, industrial, and hospital accreditation planning efforts and requirements. Ex officio members represented the:

- U.S. Department of Homeland Security
    - National Incident Management System Integration Center (NIC)
- U.S. Department of Health and Human Services
    - Health Resources and Services Administration (HRSA)

- American Hospital Association (AHA)
    - American Society for Healthcare Engineering (ASHE)
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Also critical to the development effort was the contribution of the more than seventy expert members of the Secondary Review Group, who reviewed and commented on the work throughout the development process.

See Appendix K: “HEICS IV Project Organization” for a list of these contributors.

1.5 Core HICS Materials

The resulting *Hospital Incident Command System Guidebook* is divided into two components.

1.5.1 High-Level and Specific Guidance

The first component provides high-level guidance for developing a hospital Emergency Management Program, including key considerations and assumptions.

It also imparts specific guidance for incorporating an incident management system that can be adapted to each situation according to the availability of personnel to assume command positions. For example:

- The original Job Actions Sheets have been restructured and new ones added to accompany the Incident Command structure described.
- Scenario-specific Incident Planning Guides (IPGs) have been added that outline strategic considerations for hospitals when writing their response plans to various situations, including the key incident command positions to consider activating. The new IPGs have been written to assist hospital Emergency Management Committees and emergency program managers in writing or revising their response plans for thirteen (13) common internal hospital emergencies (e.g., fire, child abduction, bomb threat) and fourteen (14) national scenarios (e.g., earthquake, chlorine leak, anthrax release) that the federal government is expecting federal, state, and local/tribal community responders to plan for and exercise.
- Twenty (20) incident management forms have been included to provide guidance on the documentation needs associated with hospital response to an incident.
- Incident Response Guides (IRGs) have also been created for use as “brain teasers” for command personnel to consider when managing a particular type of incident. The IRGs provide the Incident Commander with a concise outline of response issues likely to be encountered in a particular incident and thereby promote more immediate and higher quality decision-making. They are not intended to be a replacement for a hospital’s Emergency Operations Plan or its accompanying appendixes.

1.5.2 Training Materials

The second component includes a training curriculum for how to implement and teach HICS. PowerPoint presentations have been written for thirteen (13) modules. Each module presents key information from this Guidebook in a summarized format and is accompanied by a lesson plan for instructors to use. Instruction is provided on topics such as principles of incident command, incident planning and response, and using the forms for documentation. Twenty seven (27) internal and external scenarios have been included for use by those responsible for conducting training.

The effective use of these materials, combined with an integrated and continuously updated hospital Emergency Management Program, will help all types and sizes of hospitals better prepare for and respond to emergent and non-emergent incidents that require effective leadership to meet mission objectives.

CHAPTER 2

Overview of the Principles of the Incident Command System

LEARNING OBJECTIVES

After completing this chapter the reader will be able to:

- **Discuss the history of the Incident Command System (ICS)**
- **List four (4) ICS design principles**
- **Describe the five (5) basic management functions**
- **Discuss the role of the Incident Commander**
- **Define:**
  - **Section**
  - **Branch**
  - **Division**
  - **Group**
  - **Unit**
  - **Task Force**
  - **Strike Team**
- **Discuss the role of the following Command Staff members:**
  - **Public Information Officer (PIO)**
  - **Safety Officer**
  - **Liaison Officer**
  - **Medical/Technical Specialist**
- **Discuss the six (6) essential steps of incident planning**

2.1 Origin of the Incident Command System

The Incident Command System (ICS) was developed in the 1970s by an interagency task force working in a cooperative local, state, and federal effort called FIRESCOPE (Firefighting Resources of California Organized for Potential Emergencies) to combat wildland fires. Prior to the development of ICS, research into response to major incidents revealed weaknesses in a number of areas:

- Inadequate communication because of conflicting terminology or inefficient or improper use of technology
- Lack of a standardized management structure that would allow integration, command and control, and workload efficiency
- Lack of personnel accountability
- Lack of a systematic planning process

As a result of these and other failures, incidents of all sizes and types were often mismanaged, resulting in health and safety risks, unnecessary damage, ineffective resource management, and economic losses.

To meet those challenges, ICS is designed to:

- Be useable for managing all routine or planned events, of any size or type, by establishing a clear chain of command
- Allow personnel from different agencies or departments to be integrated into a common structure that can effectively address issues and delegate responsibilities
- Provide needed logistical and administrative support to operational personnel
- Ensure key functions are covered and eliminate duplication

2.2 Incident Management Functions

It is important to understand that ICS is a management system—not an organizational chart. It is predicated on a number of principal tenets:

- Every incident or event requires that certain management functions be performed. The problem encountered is evaluated, a plan to remedy the problem identified and implemented, and the necessary resources assigned. Management by objective (MBO) is thus a critically important component to the successful implementation of an incident command system and involves the inclusion of both control and operational period objectives.
- The ICS organization frequently does not correlate to the daily administrative structure of the agency or hospital. This practice is purposeful and done to reduce role and title confusion.
    - The ***Incident Commander*** is the only position always activated in an incident regardless of its nature. In addition to Command, which sets the objectives, devises strategies and priorities, and maintains

overall responsibility for managing the incident, there are four other management functions.

- ***Operations*** conducts the tactical operations (e.g., patient care, clean up) to carry out the plan using defined objectives and directing all needed resources.
- ***Planning*** collects and evaluates information for decision support, maintains resource status information, prepares documents such as the Incident Action Plan, and maintains documentation for incident reports.
- ***Logistics*** provides support, resources, and other essential services to meet the operational objectives set by Incident Command.
- ***Finance/Administration*** monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses.

The Incident Commander may be able to accomplish all five management functions alone on small-scale incidents, but on larger incidents effective management may require that the Incident Commander establish one or more of the four other functions (Fig. 1) and appoint Section Chiefs.

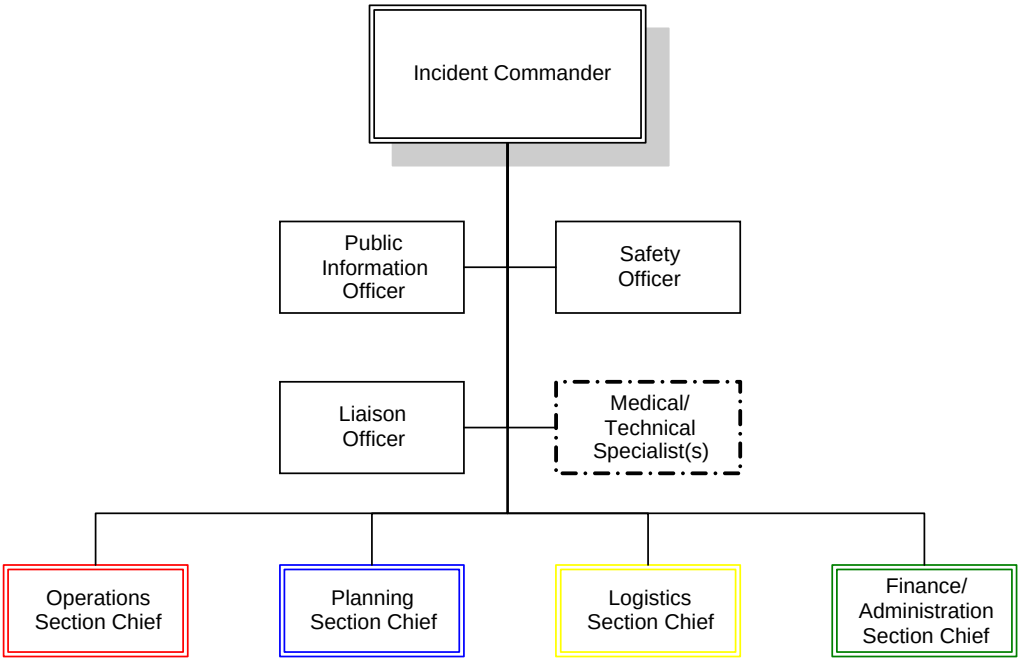

Fig. 1. Distribution of Authority and Responsibility for Primary ICS Management Functions within Incident Management Team Structure.

Each of the primary Sections (known as General Staff) can be subdivided as needed to meet the demands of the incident. Smaller-scale incidents will normally require fewer personnel to serve an Incident Command role; the type of incident and available personnel resources will also dictate the composition of the incident management team. A Deputy position can be appointed for the

Incident Commander, Section Chief, and Branch Director to allow for their absence or provide other delegated assistance. An Assistant is a subordinate to a command position who performs technical capabilities and responsibilities. He or she may also be assigned to a Unit Leader as situational needs dedicate and resources allow.

Depending on the incident, the Incident Commander may choose to appoint Command Staff that include a:

- ***Public Information Officer*** to serve as a conduit for information to internal personnel and external stakeholders, including the media or other organizations.
- ***Safety Officer*** to monitor safety conditions and measures for assuring the safety of all assigned personnel.
- ***Liaison Officer*** to be the primary contact for supporting agencies assigned to the hospital. In some cases the Liaison Officer may be assigned to represent the hospital at the local Emergency Operations Center (EOC) or field Incident Command post.
- ***Medical/Technical Specialist(s)*** who may serve as a consultant, depending on the situation. Persons with specialized expertise may be asked to provide needed insight and recommendations to the Incident Commander during and/or after a response.

Whereas in a hospital there will be a single command initiated with one person fulfilling the role of Incident Commander, at the incident scene (fire, major accident etc.) a “unified command” may be established. In this case, Incident Commanders or their agency representatives, healthcare facilities who are receiving patients, and representatives from jurisdictions who share the responsibility for the incident will manage the response from a single Incident Command Post and use a consolidated Incident Action Plan (IAP)to direct response activities. These commanders will supervise a single Command and General Staff organization and speak with one voice.

ICS recognizes that personnel “in charge” can delegate authority to others when necessary (chain of command). In addition, it is important that an effective “span of control” be maintained to ensure proper safety and accountability: proper practice will limit personnel management to a ratio of one supervisor to three to seven (1 : 3–7) reporting elements. There can be exceptions for situations involving low-risk assignments or personnel working in close proximity to one another.

Distinct, standardized ICS position titles serve three essential purposes:

- They reduce confusion within a hospital or with outside agencies or other healthcare facilities by providing a common standard for all users.
- They allow the position to be filled with the most qualified individual rather than by seniority.
- They facilitate requests for qualified personnel, especially if they come from outside the hospital.

To further assist in managing an incident, the ICS may be broken down into organizational components with a distinct title given to those in charge (Fig. 2).

- ***Sections*** are organizational levels with responsibility for a major functional area of the incident (e.g., Operations, Planning, Logistics, Finance/Administration). The person in charge is called a Chief.
- ***Branches*** are used when the number of Divisions or Groups exceed the recommended span of control. (e.g. Medical Care Branch, Service Branch).A Branch is led by a Director.
- ***Divisions*** are used to divide an incident geographically (e.g., first floor). A Division is led by a Supervisor. This command function is typically used more frequently among non-hospital response agencies, such as Fire and Law Enforcement authorities.
- ***Groups*** are established to divide the incident management structure into functional areas of operation. They are composed of resources that have been assembled to perform a special function not necessarily within a single geographic division. A Supervisor leads a Group.
- ***Units*** are organizational elements that have functional responsibility for a specific incident planning, operations, logistics, or finance/administration activity (e.g., Inpatient Unit, Situation Unit, Supply Unit).
- ***Single resources*** are defined as an individual(s) or piece of equipment with its personnel complement (e.g., perfusionist) or a crew or team of individuals with an identified supervisor.

There are two other organizational components used by police, EMS, and fire to manage incidents that may not as rountinely be used in the hospital setting. ***Task Forces*** are a combination of mixed resources (e.g., an ICU staff of RNs, Techs, and Station Secretaries) with a common communication capability and led by a Task Force Leader. ***Strike Teams*** are a set number of similar resources (e.g., Burn RNs) with a common communication capability who operate under the command of a Strike Team Leader.

Organizational Level	Title	Support Position
Incident Command	Incident Commander	Deputy
Command Staff	Officer	Assistant
General Staff (Section)	Chief	Deputy
Branch	Director	Deputy
Division/Group	Supervisor	N/A
Unit	Leader	Assistant
Task Force/Strike Team	Leader	Single Resource Boss

Fig. 2. Command Support Position Titles.

The ICS also recognizes that personnel initially assuming a command position may be relieved by someone with more experience or during a shift change. This “transfer of command” begins with a transition meeting in which the outgoing commander briefs the replacement on the situation (situation report), response needs, and available resources. Health, medical, and safety concerns are addressed when appropriate, and, if relevant, political sensitivities may also be

discussed. After the transfer of command is completed, proper documentation is prepared and, where appropriate, broadly announced over the radio, overhead pager, e-mail, or other appropriate communication resources. It is important that the Incident Commander ensure that each appointed command officer is properly briefed on response issues and objectives.

2.3 The Incident Planning Process

The incident planning process is another core concept of ICS and takes place regardless of the incident size or complexity. This planning involves six (6) essential steps:

- Understanding the hospital's policy and direction
- Assessing the situation
- Establishing incident objectives
- Determining appropriate strategies to achieve the objectives
- Giving tactical direction and ensuring that it is followed (e.g., correct resources assigned to complete a task and their performance monitored)
- Providing necessary back-up (assigning more or fewer resources, changing tactics, et al.)

The ICS organization used for an incident reflects the principle of management by objectives. Incidents may be different but the ICS fundamentals remain unchanged. That is, the size and structure of the Incident Command organization for an incident reflects only what is needed to meet and support the identified incident objectives. As objectives are achieved, elements that are no longer needed are reassigned or demobilized. Appendix A: "Incident Planning Considerations" contains important incident planning considerations that have originated from various hospitals' responses to exercises and real-world events.

CHAPTER 3

National Incident Management System Compliance for Hospitals

LEARNING OBJECTIVES

After completing this chapter the reader will be able to discuss the:

- **Importance of Homeland Security Presidential Directive-5 (HSPD-5)**
- **National Incident Management System (NIMS)**
- **NIMS compliance expectations for hospitals**

3.1 Homeland Security Presidential Directive-5 (HSPD-5)

The Homeland Security Presidential Directive-5 (HSPD-5), issued by President George W. Bush in February 2003, created the National Incident Management System (NIMS). NIMS is intended to provide a consistent template for governmental, private sector, and nongovernmental organizations to work together during an incident. The system is applicable to a variety of incidents and hazard situations and is intended to improve coordination and cooperation between public and private responders. Until NIMS, there had been no standard for domestic incident response that united all levels of government and all emergency response agencies.

HSPD-5 requires adoption of NIMS by September 6, 2006, across all sectors of the federal, state, and local government and by local organizations except hospitals, which have until August 2008 to comply. Compliance is a condition for receiving federal assistance (e.g., grants, contracts). This includes hospitals seeking Health Resources and Services Administration (HRSA), Agency for Healthcare Research Quality (AHRQ), or Centers for Disease Control and Prevention (CDC) monies.

3.2 Purpose of the National Incident Management System

The National Incident Management System is designed to provide a framework for interoperability and compatibility among the various members of the response community. The end result is a flexible framework that facilitates governmental

and nongovernmental agencies working together at all levels during all phases of an incident, regardless of its size, complexity, or location. NIMS also provides standardized organizational structures and requirements for process and procedures.

3.3 NIMS Organizational Systems

NIMS incident management structures are based on three key organizational systems:

- The ***Incident Command System*** defines the operating characteristics, management components, and structure of incident management organizations for the duration of an incident.
- The ***Multiagency Coordination System*** defines the operating characteristics, management components, and organizational structure of supporting entities.
- The ***Public Information System*** includes the processes, procedures, and systems for communicating timely and accurate information to the public during an emergency.

3.4 NIMS Compliance for Hospitals

The specific compliance requirements outlined for hospitals by the NIMS Integration Center (NIC) are found in Appendix I*:* "NIMS Implementation Activities for Hospitals and Healthcare Systems." The seventeen (17) hospital-specific elements outlined in the fact sheets address a variety of expectations, including preparedness activities, resource management, communications and information management, supporting technologies, and training and exercises. Thus, NIMS compliance does not entail a hospital undertaking a single approach to emergency preparedness but a series of steps intended to improve institutional readiness and integration into a community-based response system.

Persons expected to assume an Incident Command position must receive formalized training intended to teach fundamental incident command principles and specific information about command roles and responsibilities. The coursework to be completed is outlined in the NIMS guidance and is determined by the command position being assumed. The identified coursework can be completed through traditional classroom instruction from qualified instructors or online education from the Emergency Management Institute (EMI). For further information on emergency preparedness training, see Chapter 4, section 4.10, "Education, Training, and Exercises" in this Guidebook.

It is expected these guidelines will be periodically updated and new editions released on the NIMS Web site at www.fema.gov/emergency/nims/index.shtm.

CHAPTER 4

The Hospital Emergency Management Program

LEARNING OBJECTIVES

After completing this chapter the reader will be able to:

- **Discuss the content and importance of the Emergency Management Program**
- **Describe the role of the following:**
  - **Emergency Program Manager**
  - **Emergency Management Committee**
  - **"All Hazards" Emergency Operations Plan**
  - **Hazard Vulnerability Analysis**
- **Identify external partners with which hospitals should plan, train, and exercise**
- **Describe the role of training and exercises in promoting hospital emergency preparedness**

4.1 Emergency Management Program Development

A hospital Emergency Management Program (EMP) contains a number of critical elements that serve as the foundation for mitigating, preparing for, responding to, and recovering from any type of threat, hazard, or incident. The traditional four phases of emergency management (mitigation, preparedness, response, and recovery) serve as the basic framework for the planning, training, and exercises that hospitals must undertake to be adequately prepared and compliant with pertinent regulations, standards, and guidelines. Prevention-related activities should also be undertaken where appropriate.

To develop the EMP, hospitals should draw guidance from a number of sources. These include the National Incident Management System (NIMS)/Incident Command System (ICS), The National Response Plan (NRP), Homeland Security Presidential Directive-5 (HSPD-5), and Federal Preparedness Circular 65 (FPC 65) on Continuity of Operations (COOP). Appropriate state, local, and

nongovernmental regulatory standards (see below) should also be considered in developing the EMP.

Recent history has shown that disaster research is another valuable tool that should be carefully reviewed and considered when developing both the EMP and the Emergency Operations Plan (EOP). In Appendix J: "Recommended Resources" the reader will find a listing of reference materials and Web sites that pertain to hospital emergency preparedness.

The Department of Veteran's Affairs, Veterans Health Administration (VHA) Emergency Management Program for Healthcare Facilities outlines a nine-step process for the development, maintenance, and evaluation of a hospital Emergency Management Program. The *Emergency Management Program Guidebook* outlines how to develop a "fully functional EMP." The essence of the process includes the following steps:

- Designating an Emergency Program Manager Program
- Establishing the Emergency Management Committee
- Developing the "all hazards " Emergency Operations Plan
- Conducting a Hazard Vulnerability Analysis
- Developing incident-specific guidance (Incident Planning Guides)
- Coordinating with external entities
- Training key staff
- Exercising the EOP and incident-specific guidance through an exercise program
- Conducting program review and evaluation
- Learning from the lessons that are identified (organizational learning)

4.2 Emergency Program Manager

Because of the increasing complexity and importance of emergency preparedness for hospitals and healthcare systems, a growing number of facilities are designating a qualified and motivated individual to serve in the part-time or full-time role of Emergency Program Manager This person provides overall support to the hospital's preparedness efforts, including developing needed procedures, coordinating production or revision of the Emergency Operations Plan (EOP), planning and executing training and exercises, and writing After Action Reports (AAR). The manager should also represent the hospital at various preparedness meetings at the local, regional, and state levels. The desired background for an Emergency Program Manager includes formal and informal training, education, and/or experience in emergency management; incident command; and hospital operations and familiarity with local, regional, and state healthcare system design and emergency response procedures.

4.3 The Emergency Management Committee

Vital to successful planning for any disaster is the identification and tasking of a select group of multidisciplinary hospital representatives to become members of the hospital's Emergency Management Committee (i.e., the Environment of Care Committee in some hospitals). Involving local agencies such as police, fire/emergency medical services, emergency management, and public health in committee deliberations will help clarify roles and responsibilities and encourage personal networking. This familiarization will help promote much needed priority-setting, information-sharing, and joint decision-making during a real incident.

The committee should meet regularly and consist of clinical and nonclinical representatives from key departments and functioning units of the facility. A well qualified and motivated committee chairperson should be selected according to hospital policies or bylaws.

The committee should focus on activities such as:

- Developing and updating a comprehensive "all hazards" Emergency Management Program on an annual basis
- Conducting a Hazard Vulnerability Analysis (HVA) on an annual basis
- Developing an Emergency Operations Plan (EOP) and standard operating procedures to address the hazards identified
- Providing for continuity of operations planning by writing needed hospital operations plans
- Ensuring that all employees and medical staff receive training in accordance with hospital requirements and regulatory guidelines and understand their role(s) and responsibilities for a disaster response

The chairperson should set each meeting's agenda and facilitate the committee's work to achieve an annually established set of objectives. Subcommittees should be appointed to accomplish identified projects or to plan training and exercises. Minutes of each meeting should be published and widely disseminated to apprise all hospital staff of committee activities and changes to the Emergency Management Program and Emergency Operations Plan.

Other effective means of keeping hospital staff informed with "need to know" emergency planning and response information include publishing response-planning updates in hospital newsletters and making presentations at employee orientation and safety fairs.

To ensure overall readiness and support, the chairperson must regularly inform the hospital's Chief Executive Officer and other senior administrators of committee activity, obstacles encountered, and assistance that is needed.

If a hospital is part of a healthcare corporation, the appropriate administrators should be regularly briefed on each hospital's emergency preparedness activities. Whenever possible, these efforts should be integrated and standardized to ensure a seamless corporate response when necessary.

4.4 The "All Hazards" Emergency Operations Plan

The Emergency Operations Plan (EOP) outlines the hospital's strategy for responding to and recovering from a realized threat or hazard or other incident. The document is intended to provide overall direction and coordination of the response structure and processes to be used by the hospital. An effective EOP lays the groundwork for implementation of the Incident Command System and the needed communication and coordination between operating groups. Critical areas that should be comprehensively and succinctly addressed include:

- Management and planning
- Departmental/organizational roles and responsibilities before, during, and after emergencies
- Health and medical operations
- Communication (internal and external)
- Logistics
- Finance
- Equipment
- Patient tracking
- Fatality management
- Decontamination
- Plant, facility, and utility operations
- Safety and security
- Coordination with external agencies

It is important that the hospital's EOP is consistent with local/tribal, state, and regional EOPs and that it adheres to the fundamental tenets found in the National Response Plan. Information from inside as well as external to the hospital will be vital to decision making. Therefore, particular importance should be given to identifying what information will be needed and how it will be acquired, used, and shared; and to the development of redundant systems to ensure its availability.

Hazard- or incident-specific guidance, such as the HICS Incident Planning Guides, are appendixes to the EOP and articulate how the EOP is applied to a particular response situation. The significant hazards a hospital might face are identified through the HVA.

4.5 Hazard Vulnerability Analysis

The Hazard Vulnerability Analysis (HVA) process is a key element for developing an EOP and drives incident-specific planning. It helps identify, prioritize, and define threats that may impact business operations. With this knowledge, specific steps may be taken to reduce the impact caused by threat occurrence and, subsequently, better ensure ongoing business function.

Two primary elements of threat evaluation are considered in the HVA process:

- *Probability* is the likelihood of an event occurrence. It can be calculated through a retrospective assessment of event frequency or predicted through a prospective estimation of risk factors.
- *Impact* is the severity or damage caused by a threat and should include effects on human lives, business operations/infrastructure, and environmental conditions.

Risk is the calculated score of the interactions between probability and impact that is applied to each threat type. Risks can be reduced by implementing threat-mitigation activities for probability (e.g., reduced likelihood of electrical failure through routine generator testing) or severity (e.g., fewer earthquake injuries by securing heavy wall cabinets).

Many tools are available to assist hospitals in performing an HVA. These tools can be obtained through publishers or on the Internet. Choosing the HVA tool that best meets the facility's needs will require some investigation (Appendix J: "Recommended References").

The HVA should be reviewed at least annually and whenever a new threat emerges. Within the hospital or healthcare system setting, this is typically accomplished through the Emergency Management Committee. After review, changes to the HVA should be updated in the hospital EOP, with high priority threats being tested during annual disaster exercises.

Developing a hospital-specific HVA as part of the overall community planning effort can further reduce risk. All businesses, governmental agencies, and community organizations should review their threats. However, the most powerful tool for threat reduction is gained by an integrated review of threats and planning efforts. The community HVA can lead to clearer expectations for preparedness and response activities. All parties can thus strategically align multiple approaches to maximize the value and effectiveness of limited resources. Many communities already support this type of forum through local Emergency Planning Committees (EPCs).

Ongoing and realistic review of individual and community threats will help reinforce core disaster planning efforts and provide flexibility for addressing new threats within the same established framework.

4.6 Developing Hospital Incident Planning Guidance

Hospital planning for potential disaster-related incidents can be time-consuming and filled with uncertainty. In addition, the experience of those involved in doing the planning can vary and impact on the quality of the plan. Planning guidance from governmental agencies and professional associations is available in print form and on Web sites. Some suggested materials can be found in Appendix J: "Recommended Resources." A series of Incident Planning Guides (IPGs) have been developed to assist hospitals with evaluating existing plans or writing needed plans. The IPGs have been written to address fourteen (14) of the 15

hospital-related national scenarios for which the Department of Homeland Security expects each community to prepare. An additional thirteen (13) internal scenarios that the average hospital might confront have also been prepared. Each IPG is formatted according to four specific time periods (Immediate 0-2 hours, Intermediate 2-12 hours, Extended >12 hours, and Demobilization and System Recovery) and contains planning considerations for each time period. These guides are simply intended to prompt the plan writer and reviewer(s) to consider what the EOP should address based on the nature of the incident, available resources, and response needs. Although the probability of any one of these incidents occurring in a community is variable, these planning IPGs have been included to help promote more thorough planning activities and standardization among hospitals throughout the United States.

Appendix H: "Working with the Scenarios, Incident Planning Guides, and Incident Response Guides" contains more information regarding the IPGs.

4.7 External Agency Coordination and Professional Support

It is crucial for hospitals to realize that effective emergency preparedness and response cannot be achieved without consistent and effective practiced integration with the other members of the response community, especially those at the local, regional, and state level. The importance of this practice is reinforced by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) guidance and the Department of Health and Human Services Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, which promotes hospital participation in community planning, training, and exercises. Thus, hospital representatives should be actively engaged in meeting with their emergency management colleagues from public safety (police, Emergency Medical Services, and fire), public health, emergency management, behavioral/ mental health, and other appropriate public and private agencies (Fig. 3).

These meetings should be held to share insights on roles and responsibilities; craft regional response plans and procedures; solicit available funding; and plan, conduct, and evaluate joint training and exercises. Beyond these critical agenda items, such meetings also are important to create personal relationships among responders that will lead to improved planning initiatives and the likelihood of a more coordinated and effective response.

4.7.1 Other Hospitals and Healthcare Facilities, Primary Care Clinics

It is important that hospitals in each community regularly meet with each other to discuss planning, training issues specific to their individual and collective needs, and conducting joint drills and exercises. Discussion should include how terminology, as well as plans and procedures, can be standardized and how limited resources can be shared among the hospitals. A hospital mutual aid agreement or memorandum of understanding should be developed and signed by all the hospitals. The agreement should address topics such as how to request assistance, sharing of resources, credentialing, and how to initiate

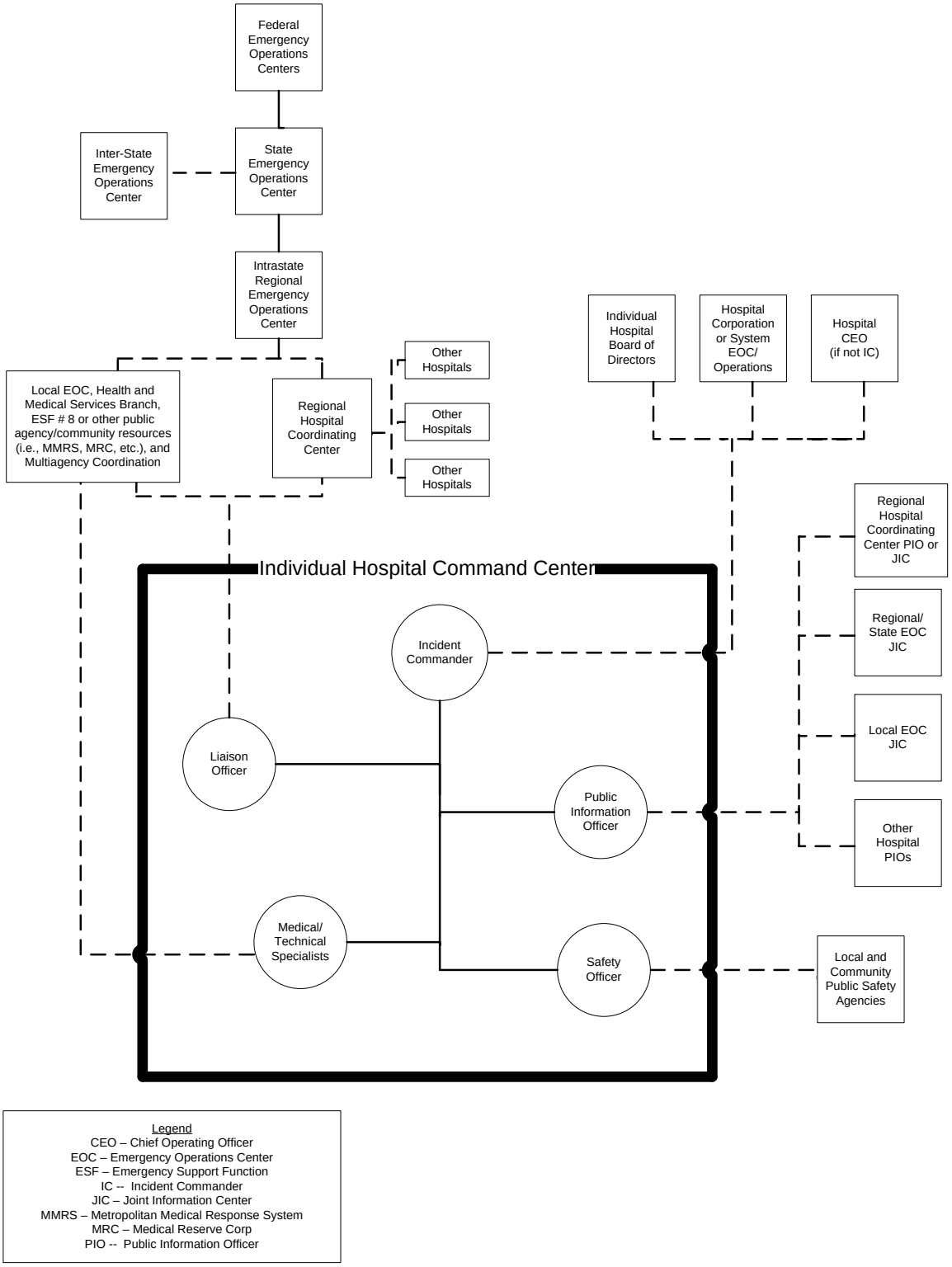

Fig. 3. Illustration of Hospital Relationship to Community Response Partners.

patient transfers. Some hospitals have also joined together to purchase standardized equipment and supplies, thus enjoying a cost savings and an increased capability to share common resources. Consideration should be given

to including other healthcare facilities, such as nursing homes and primary care centers, in the agreement.

Although hospital collaboration is an important part of the emergency response system development, non-hospital healthcare facilities (e.g., large clinics, urgent care centers, physician offices, extended care facilities, and nursing homes) should also be included in planning meetings, training activities, and exercises. Their participation can help clarify perceived roles and responsibilities, resource assets and limitations, and response capabilities including patient transfer. This information, coupled with active participation in preparedness initiatives by all parties, will better ensure that these important system components remain part of the solution rather than compounding the problems already being addressed during a response.

4.7.2 Fire and Emergency Medical Services

Fire Departments, private ambulance providers, air medical services, and a governing Emergency Medical Services (EMS) entity all have significant roles and interface with hospitals in the United States.

Fire departments provide any or all of the following services: first responder BLS and/or ALS medical care; ambulance transport; hazmat response; and search and rescue.

Private ambulance companies provide BLS and/or ALS transport for 911 responses; inter-facility transports; and standby for prescheduled events, hazmat events, or search and rescue events.

EMS governing entities (which may be fire departments) provide medical direction to pre-hospital emergency medical technicians (EMTs) and paramedics and system oversight for all ambulance activities, to include licensure, inspection, and approval or agreement for operating areas. The medical oversight often extends to the interface between pre-hospital and hospital EMS, and in many communities this entity acts as the disaster coordinator/manager in a large-scale emergency.

Hospitals should also be familiar with air medical services that may be used and have an individual or community plan for how best to coordinate multiple requests for assistance. Planning consideration should be given to how helicopters or fixed wing aircraft can assist with personnel, patient, and equipment/supply transport if necessary.

During an emergency, EMS (which we define as the combination of any of the services described above) can be expected to bring a significant segment of the involved population to the hospital for medical care. For this reason, information-sharing procedures must be well known by both parties, and dependable and redundant communication systems and technology must be in place and properly used.

Hospitals should also be familiar with their community multiple/mass casualty plan, including appropriate response codes and terminology, as well as the

triage, treatment, and transportation practices to be employed. EMS personnel should have a fundamental understanding of how the hospital will respond, including what information is needed to declare a disaster, alternative travel routes into the facility, and where triage and decontamination will be conducted. Preplanning should also address issues such as what personnel supplementation can be provided by either party, including trained decontamination team supplementation, and how response information will be shared. In addition to patient transport and possible staff and equipment augmentation, EMS responds when the hospital itself is the scene of an incident; plans for such response should also be mutually developed.

4.7.3 Law Enforcement

Hospitals have a good daily working relationship with local law enforcement, especially through the hospital's police and security forces. This foundation can help ensure effective communication and mutual understanding of response capabilities and needs during a disaster. Prudent planning will address what security supplementation local and state law enforcement can provide, integration of law enforcement personnel into hospital operations and incident command (including response decision-making), what rules of engagement will be used for crowd control, and the chain-of-custody practices to be followed. Ideally, a formal memorandum of understanding between the two parties or with all the hospitals in a community should be developed and periodically exercised.

4.7.4 Public Health Department

Select hospital staff members such as the infection control practitioner, infectious disease physician, or laboratory director have frequent communication with the local and/or state health department. However, the importance of the relationship between the two organizations grows significantly during a disaster response. In most communities, the public health agency not only has responsibility for investigating disease outbreaks and coordinating medication distribution sites but also, per the National Response Plan, is the lead agency for Regional Emergency Support Function ESF 8 – Health and Medical Services. ESF 8 involves coordinating all health and medical response activities and ensuring that equipment, medications, and supplies are acquired when needed, including those for hospitals. The development of risk communication and public education messaging will be another important joint activity that should be undertaken. Thus, it is important that representatives from each party regularly meet to define roles and responsibilities, discuss response needs, and develop plans and procedures directed at keeping the healthcare system operational, regardless of the problems encountered.

In a growing number of communities the Public Health Department provides leadership for the operation of a Medical Reserve Corps (MRC). The MRC is composed of volunteer healthcare providers who can give medical assistance during a crisis. These persons attend specified training, receive an identification badge, and may be deployed to assist at shelters, Alternative Care Facilities and

Alternative Care Sites (ACF/ACS), medication distribution sites, and in some cases, hospitals.

4.7.5 Medical Examiner's Office/Coroners

During a disaster involving deaths, it will be important that a local and/or state mass fatality plan be followed. This plan should be developed in advance of the incident and be a joint effort involving the medical examiner/coroner, public safety, public health, and hospital representatives. Hospitals should be familiar with this plan and ensure their procedures for managing the deceased (including mass fatalities, decedent family support) are consistent with expected practices set forth in the plan and coordinated with the medical examiner/coroner's office and law enforcement.

4.7.6 Behavioral/Mental Health Specialists

The psychological effects following a disaster will have immediate and long-term consequences over a wide segment of the affected community, including hospital staff and community responders. Hospitals must have a comprehensive response plan that addresses these issues, using qualified staff members and outside expertise where needed. Pediatric and adult age groups will seek assistance as will those with special needs. Medications for anxiety and other expected psychological reactions should be available for use if needed.

Effective planning should address providing short- and long-term behavioral health and pastoral assistance both to the patients and their families and to hospital staff members and their families. How behavioral assistance will be provided to incident management personnel and the behavioral/mental health specialists themselves must also be addressed.

4.7.7 Local Emergency Management Agency

For many hospitals, the local Emergency Management Agency (EMA) is another important response partner. Because the local EMA has primary responsibility for coordinating the community's all-hazards preparedness efforts as well as the actual response to an emergency, it is important that those responsible for hospital preparedness become familiar with the personnel in the local emergency management office and how the agency operates during an emergency. It is the local EMA which, at the direction of local municipal officials (elected or appointed), makes local disaster declarations and requests for state and federal disaster declarations, as well as requests for response assistance beyond existing resources and mutual aid agreements. These declarations help to ensure that needed assistance and coordination occurs at the local level and available funding is authorized for use. Local declarations are usually required to allow state and federal declarations to be made. These declarations will be employed to provide needed response guidance and allow directed variations in daily government operation and financial management practices. It is important that hospitals understand the implications of disaster and public health declarations and the impact such a declaration may have on their response and recovery activities.

4.7.8 State Response Teams

Some states have developed and are prepared to deploy “Strike Teams” representing various clinical and nonclinical disciplines to assist local communities encountering a disaster or public health emergency. These teams will not typically be immediately available but arrive 12–48 hours after the request is made by the local Emergency Operations Center (EOC) to the state EOC. Their assignments may include working at a hospital that requested staff supplementation or at special healthcare delivery sites established because of the incident. Thus, it is important that hospital planning address inclusion of this type of outside support in their incident command structure and response operations. The logistical support these team personnel will require (housing, transportation, et al.) should be coordinated with the local EOC.

4.7.9 Federal Response Teams

The federal government has created a number of specialty teams for deployment at the request of a governor. These teams can assist an impacted community when the available local and state medical resources are insufficient to meet the identified or forecasted needs. Among these teams are:

- ***Disaster Medical Assistance Teams*** – medical teams or professionals and paraprofessionals capable of providing critical and primary care
- ***Disaster Mortuary Teams*** – medical examiners, pathologists, and funeral directors trained and equipped to assist the medical examiner/coroner with recovery, identification, and processing of the deceased
- ***National Medical Burn Teams*** – burn-care specialists sent to be integrated into existing burn-care operations within a facility
- ***National Pharmacy Response Teams and National Nurse Response Teams*** – pharmacists and nurses sent to assist in mass dispensing of medications during disasters or mass vaccination campaigns

These teams can only be requested by the state EOC on behalf of the local EOC. Once on site (usually within 24–48 hours), they may supplement hospital personnel or work in external healthcare facilities set up to supplement the healthcare system. Hospital planning should address the need to effectively integrate these personnel once they arrive and provide appropriate orientation, credentialing and privileging, supervision, and patient assignments. The housing, transportation, and other non–work-related support these personnel require should be coordinated with the local EOC.

4.7.10 American Red Cross

Although not a governmental agency, the American Red Cross (ARC) was chartered by Congress to “carry on a system of national and international relief in times of peace and calamity.” The ARC provides a variety of disaster related services ranging from providing food and water to those in need to setting up and operating community shelters and helping victims in need of clothing and other household goods. Hospitals should be familiar with the disaster response

capabilities and leaders of their local and state ARC chapter and address how these resources can be utilized if needed.

4.7.11 Media

Good working relationships with members of the media before an incident should be a priority. The media will play a vital role, not only in reporting on a disaster but also by providing public education and risk communication information to the public on behalf of the response community. The information given to the public must be well-coordinated, timely, and accurate in order to avoid confusion, anger, and loss of the public trust.

During an incident, the hospital public information officer (PIO) or designee must work closely with other hospital and response agency PIOs to develop “one message, many voices.” To better achieve this purpose, a Joint Information System (JIS) designed to gather, prepare, and disseminate information to the public should be operated from a designated physical or virtual work location known as the Joint Information Center (JIC). A Lead PIO, operating within the parameters of the JIS, will facilitate interagency coordination and integration for developing and delivering organized, integrated, and coordinated messages and support for decision-makers. The JIS also includes plans, protocols, and structures used to provide information to the public. It encompasses all public information related to the incident. A qualified hospital representative should be designated to participate when a JIS is established. Whether physically present in the JIC or participating virtually, the hospital’s representative should be part of a unified process designed to address risk communication and public education efforts in a collective and collaborative manner.

As part of the planning process, hospitals (either individually or as a collaborative group) should attempt to pre-script risk communication messages for likely incidents and have them ready for use when needed. Where appropriate, these messages should be developed with public health and other response community members. Inviting the media to attend designated planning meetings or exercises helps promote good communication and a common understanding of the roles and responsibilities of all parties in an emergency.

4.8 Government Partners: Local/Tribal, State, and Federal

Hospitals cannot plan, train, or respond effectively without a fundamental understanding of who will be their response partners, what is the community response system design, and what are the rules and guidelines they will be expected to meet.

4.8.1 Emergency Management Assistance Compact

The Emergency Management Assistance Compact (EMAC) was enacted by Congress in 1996 to maximize interstate coordination of resources during a disaster. The legislation (Public Law 104-321), enacted by most states, outlines the legal authority, operational guidance, and financial considerations for requesting and receiving emergency assistance from other states. EMAC is

implemented as a means of expediting the delivery of needed resources, usually from states closest to the affected area. Thus, EMAC may be implemented by the State EOC to find needed personnel and other resources requested by hospitals.

4.8.2 Regional Hospital Coordination Centers

Growing numbers of communities are developing a regional concept to coordinate hospital information-sharing and medically related resource management during a crisis. Sometimes called Regional Hospital Coordination Centers (RHCC), they are staffed by trained personnel (often senior or midlevel hospital personnel or administrators from the local/state hospital association) and operate from a well equipped area within a designated hospital (not in the Hospital Command Center), separate private facility, or local EOC. Their role and responsibilities should be well-defined and closely integrated with ESF8 – Health and Medical Services, in the local EOC.

4.8.3 Local Emergency Operations Center

At the local/tribal level, the emergency management agency serves as the coordinator for emergency preparedness and response. Operating under the NIMS, each community's response will be coordinated at a local Emergency Operations Center (EOC). The operation of the local EOC will be structured in the standard Incident Command System format, which is the foundation for NIMS (functions include Command, Operations, Planning, Logistics, and Finance/ Administration as described in Chapter 2 of this Guidebook). Within the Operations Section or as a Liaison Officer (it varies from EOC to EOC), there will be a link to the Emergency Support Functions (ESFs). A list of the federal ESFs can be found in the National Response Plan (NRP). Each ESF is directed by a specific lead agency as outlined in the community Emergency Operations Plan. It is important for a hospital to become familiar with the structure of their community's EOC along with the operational procedures and decision-making processes that will be utilized in a crisis.

The Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) is an important piece of federal legislation that provides guidance for what the federal government can provide to local communities, including hospitals, when a federal disaster has been declared. For the Stafford Act to apply, a federal disaster declaration must be made by the President of the United States. This declaration will have been preceded by the state and local governments making their own respective disaster or public health emergency declarations. Once enacted, response agencies, including hospitals in select cases, become eligible to receive disaster response and recovery assistance including federal funding.

The local Emergency Operations Center is coordinated by the local emergency manager and serves as the hub of local coordination and incident management during an emergency. Most communities have adopted the emergency support function (ESF) outlined in NIMS for coordinating their local EOC operations. In some cases, as part of a way of optimizing multiagency coordination, a part of

the local EOC will be established to serve as Multi Agency Coordination Center (MAC). Hence, it is important that hospitals familiarize themselves with the roles and responsibilities of the various ESFs (or an alternative system design being used), the coordinating agency, and their key contact information.

When their information or resource needs cannot be met through normal daily practices, hospitals should contact their local EMA. Depending on the severity of the incident, the EMA Director will make the decision whether to activate the local EOC. Once the local EOC is operational, hospitals will usually make their resource requests to ESF 8 – Health and Medical Services (normally coordinated by the local public health department) unless the Regional Hospital Coordination Center is performing this role and coordinating with the local EOC.

In addition to submitting information and requests to the local EOC, hospitals should expect to be asked to submit periodic situation reports and Incident Action Plans (IAPs). A hospital's IAP is a written document that provides the hospital's objectives, anticipated obstacles, and needed resources for a specified time period (see Chapter 6, Section 6.6). The IAP, which will also be requested by other community response agencies, will be used by local EOC personnel to facilitate their overall response coordination and decision making.

4.8.4 State Emergency Operations Center

Complementing the local EOC are other levels of EOCs within a given state. These may include county, region, and/or state level EOCs, all in support of the local incident or emergency as required. Usually these are coordinated by emergency management agencies. The state EOC is activated at the direction of the governor to ensure that a community impacted by a disaster receives needed information and assistance. When the state is unable to meet these requests, they are forwarded to the federal government, which operates under the comprehensive guidance provided by the NRP. Again, it will be important that hospitals be familiar with the impact state declarations can have on their operations and recovery efforts.

The state EOC will also serve as a liaison with the federal government to ensure that local needs are being conveyed to and addressed by federal officials during and after the incident.

4.9 Community Strategies for Expanding Emergency Healthcare Delivery

In a disaster, the hospital may not be the only part of the healthcare system able to see ill or injured patients. Physician offices and free-standing emergency centers and clinics may also continue to operate using normal, expanded, or reduced office hours. Close communication and collaboration with these facilities will be important, to ensure that only critical patients are seen at the hospital; less acute and routine care patients are seen at these alternative facilities.

Standardizing the assessment and care being given at these facilities with what is being done at the hospital is important, not only to the quality of patient care

but also to public trust and confidence. This communication will most often be coordinated by the public health department.

Depending on the type and extent of a disaster, local, state, or federal authorities may bolster the local/regional healthcare system capability by establishing specialized patient care and/or family assistance centers and/or providing staffing at select hospitals. These sites may include:

Off-Site Facility Integration

- Intended to divert patient volume away from emergency departments
- May be run by hospital or corporate partners
- Limited to assessment and basic medical care capability
- May provide family reunification services
- May provide some behavioral/mental health services

Acute Care Center or Neighborhood Emergency Health Clinic (ACC/NEHC)

- A secondary site for primary medical care
- Established to divert patient volume from emergency departments
- Will include triage and treatment functions and may include hospital bed capability while patients await transfer to a hospital
- Usually staffed by hospitals, Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), and/or Medical Reserve Corps (MRC) personnel, or regional, state, or federal response teams

Screening Facility

- Performs primary triage to determine who needs further evaluation and medical care
- Usually located away from a hospital, but may be on a hospital campus
- May be staffed by hospital, public health, EMS, or ESAR-VHP, or MRC personnel

Family Assistance Center (FAC)

- Provides victim and decedent information and behavioral/mental health support to families/friends
- May be located near incident scene
- Usually coordinated and staffed by the American Red Cross or local public health department in conjunction with other local and state authorities and faith-based organizations
- Works closely with hospitals and medical examiner's office to obtain patient information
- May require standby medical assistance and may identify some persons with medical problems who will require evaluation at an Acute Care Center or hospital

Mass Prophylaxis/Vaccination Point of Distribution (POD)

- Distributes medications and vaccinations in addition to risk communication and public education information during a public health emergency (can also be used as site for food and water distribution in non–medical-related disasters
- Usually coordinated by the local public health department with assistance from other local agencies and organizations
- Likely to be operational 24 hours a day until objectives are met
- Depending on the size of the community, multiple sites may be operational
- May need to send victims to hospitals for additional medical evaluation and care

Federal Medical Station (FMS)

- Provides primary care and hospital-like care for short periods
- Used for the first time in 2005, in response to Hurricane Katrina
- Staffed by federal healthcare personnel from public health–commissioned service corps and federalized volunteers.

National Disaster Medical System (NDMS)

- A Division of U.S. Department of Health and Human Services
- Coordinates more than 2,000 hospitals who volunteer to take patients requiring admission when the local/state healthcare system is overwhelmed by surge needs or compromised in normal capability (e.g., by flooding)
- Transfer coordination done in conjunction with local and state EOC and/or Regional Hospital Coordination Center (RHCC)

4.10 Education, Training, and Exercises

4.10.1 Fundamental Requirements

Several fundamental steps will have to be undertaken for HICS to be successfully integrated into a hospital.

- Securing administrative support from the Chief Executive Officer and other senior level administrators is imperative.
- Implementation of HICS must be viewed as a high priority for the organization and the importance and value of the implementation realized by all staff.
- An individual with authority and respect within the hospital must be assigned to be in charge of implementation according to an outlined plan.
- The importance of emergency preparedness should be included at employee orientation and recurring training. Adequate time should be allocated to acquaint each employee with what the hospital is doing to be prepared, their role in an emergency, and the importance of self and family preparedness planning.

- Training requirements should meet established national standards while at the same time promoting the hospital's integration into a community-based response.
- Training must be provided and will require a cadre of qualified instructors who are familiar with the HICS as well as the hospital EOP. The training should be creative and use multiple presentation formats and methods of instruction to maximize interest and participation.

Not everyone will need to have the same training. The NIMS Compliance Guidance for Hospitals (Appendix I) should be consulted to assist with identifying the training to be presented and who should complete each level of training. It will also be important that training benchmarks be established that can help evaluate the progress being made on implementation.

4.10.2 Methods of Instruction

The personnel who will be taking the required training will primarily be adult learners of varying ages, backgrounds, and education. Instructional methods should be chosen with these factors in mind, along with the need to be cost-effective and maximize availability.

The instructional materials included with HICS have been designed for classroom use by instructors with the recommended background and instructional familiarization on HICS. The instructional time required can vary depending on what learning objectives have been established by the instructor.

The curriculum can also be adapted to computer-based learning. This format allows 24/7 use by any employee and can be stopped and started to accommodate the staff member's learning pace and schedule.

In providing instruction on incident command to hospital staff it is important that the NIMS compliance requirements set forth by the NIMS Integration Center (NIC) be met. Therefore, the HICS educational materials presented in this Guidebook have been devised to include the objectives for the various Emergency Management Institute courses wherever possible.

In addition, staff members can take the required courses directly by going to the Web site http://www.training.fema.gov/emiweb and selecting the course(s) they wish to complete. The required courses are outlined in the NIMS compliance requirements for hospitals and vary according to the command positions. Generally they include:

- Independent Study (IS) 100 - Introduction to ICS or IS100 HC- Introduction to Incident Command System for Health Care Personnel
- IS 200 - Basic ICS or IS 200 HC - Basic Incident Command for Healthcare Personnel
- IS 700 - NIMS, An Introduction
- IS 800 - National Response Plan, An Introduction

As an alternative to their online courses, the Emergency Management Institute (EMI) has developed other worthwhile courses such as “Healthcare Leadership” that can be taken either at their campus in Emmitsburg, Maryland, or at their Noble Hospital training facility in Aniston, Alabama.

Individual states may offer classroom or Internet-based education for hospital personnel. Thus, the hospital’s Emergency Management Program Manager should check with the local emergency management agency director or state hospital association to learn more about these offerings.

Beyond the federal and state educational offerings, various courses may be offered in the community. One- and two-day classes may be sponsored by a single hospital or a consortium of hospitals. In other cases, instruction may be provided by contractors hired to present a specified curriculum. For those persons within a hospital looking for higher level instruction on emergency preparedness, the local college or university may have on-campus or Intranet-based coursework of interest.

The hospital’s educational program on emergency preparedness should not only include individual instruction but group learning through seminars and tabletop exercises. These would be in addition to the hospital’s commitment to meeting their accrediting body’s (e.g., JCAHO) exercise requirements.

Whenever possible, courses or classes completed by staff members should involve self-evaluation and award CME or CEU credit as an incentive to encourage participation. Accurate records should be maintained on the emergency preparedness training completed by all hospital personnel, especially those expected to assume a leadership role during an incident. Copies of each employee's completed training and educational credits should be kept in a central location at the health care facility.

CHAPTER 5

The Hospital Incident Command System

LEARNING OBJECTIVES

After completing this chapter the reader will be able to:

- **Discuss incident command staff identification**
- **Discuss the importance of building an incident command staff**
- **Describe the function and design of the Job Action Sheet (JAS)**
- **Describe the purpose and how to use the Incident Response Guide**
- **Discuss the importance of integration with unified command, and the healthcare system**
- **Discuss issues related to managing simultaneous events**
- **Describe the role, responsibility, and command considerations for the following:**
  - **Command**
  - **Operations Section**
  - **Planning Section**
  - **Logistics Section**
  - **Finance/Administration Section**

5.1 Incident Management Team Overview

5.1.1 The Incident Management Team Charts

HICS incident management team charts depict the hospital command functions that have been identified and represent how authority and responsibility are distributed within the incident management team. Figure 4 represents how incident management personnel may be organized in relation to each other just below the Section Chief level.

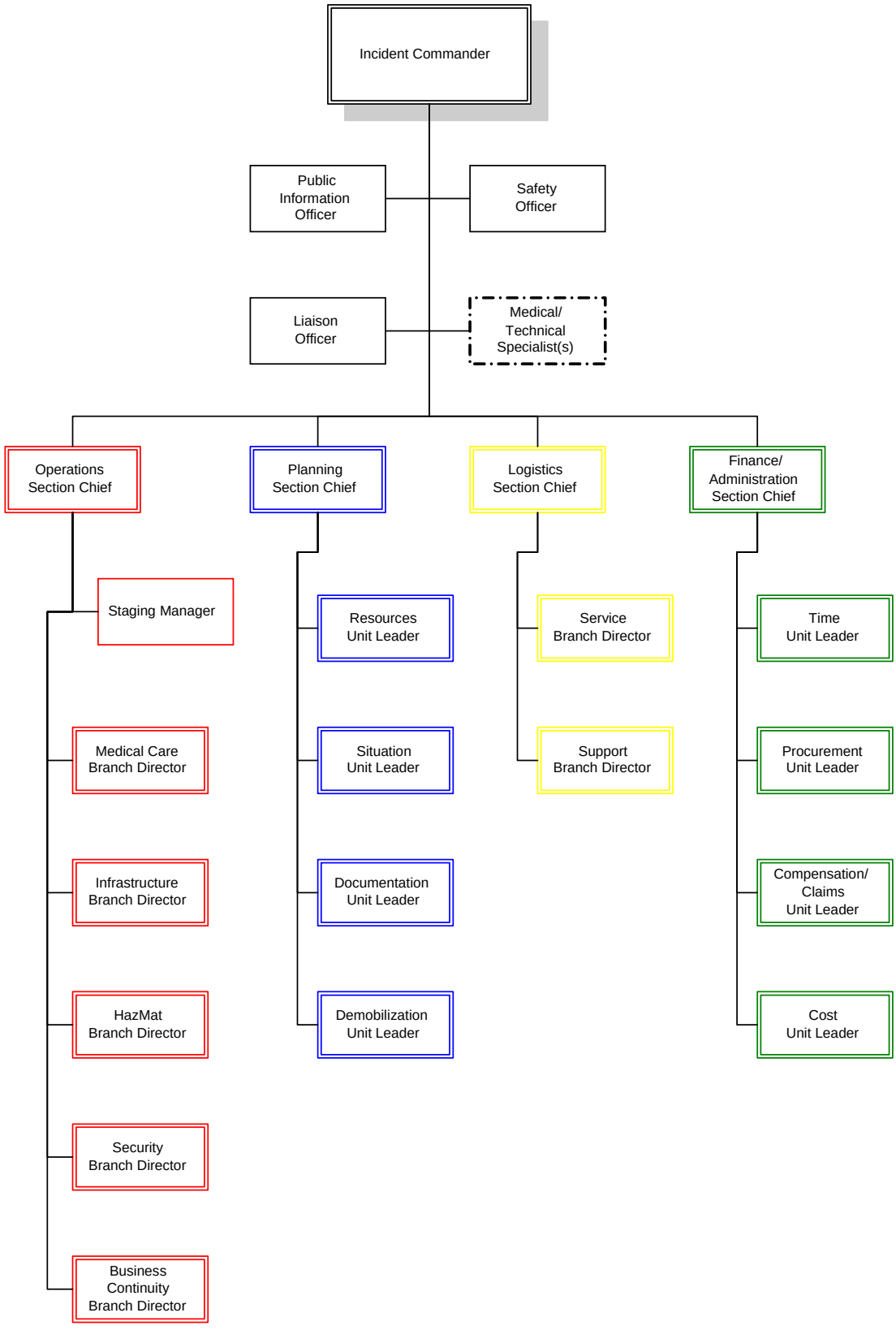

Fig. 4. Organization of Incident Management Personnel Just Below Section Chief.

The charts identify the critical functions that have been pre identified for each type of incident. In no way do the incident management team charts intend to suggest that every position will be activated for each and every incident or event. Rather, in keeping with the principle of efficiency, which is particularly important during an emergency, HICS positions are assigned to personnel only as indicated by an assessment of the scope and magnitude of the particular situation. Additional information on HICS charts can be found in Appendix B: "HICS Incident Management Team Chart."

5.2 Command

The activities at the Hospital Command Center (HCC) are directed by the Incident Commander, who has overall responsibility for all activities within the Hospital Command Center (HCC). The Incident Commander may appoint other Command Staff personnel to assist:

- The ***Public Information Officer*** (PIO) will be responsible for coordinating information sharing inside and outside the facility.
- The ***Safety Officer*** will monitor hospital response operations to identify and correct unsafe practices.
- The ***Liaison Officer*** will be the hospital link to outside agencies. In some cases one Liaison Officer may be at the HCC while a second one is assigned to represent the hospital at the local EOC or field incident command post.
- ***Medical/Technical Specialists*** are persons with specialized expertise in areas such as the infectious disease, legal affairs, risk management, and medical ethics who may be asked to provide the Incident Command staff with needed advice and coordination assistance.

Depending on the situation, the Operations, Planning, Logistics, and Finance/Administration Sections may be activated and qualified personnel assigned to serve as Section Chiefs and other subordinate positions. When personnel are assigned to the various command positions they should receive a briefing and their names should be written on the incident anagement Team chart and announced over radio and/or overhead page system as outlined in the EOP. It will be important that qualified Deputy Chiefs be appointed to assist the Section Chiefs and serve in their absence from the HCC when necessary.

5.3 Operations Section

Many incidents that likely will occur involve injured or ill patients. The Operations Section will be responsible for managing the tactical objectives outlined by the Incident Commander. This section is typically the largest in terms of resources to marshal and coordinate. To maintain a manageable span of control and streamline the organizational management, Branches, Divisions, and Units are implemented as needed. The degree to which command positions are activated depends on the situational needs and the availability of qualified command officers. Figure 5 represents how authority and responsibility is distributed within

the Operations Section. Examples of how the incident management team might be built out are included for each of the internal and external scenarios (see Appendix H: “Working with Scenarios, Incident Planning Guides, and Incident Response Guides”).

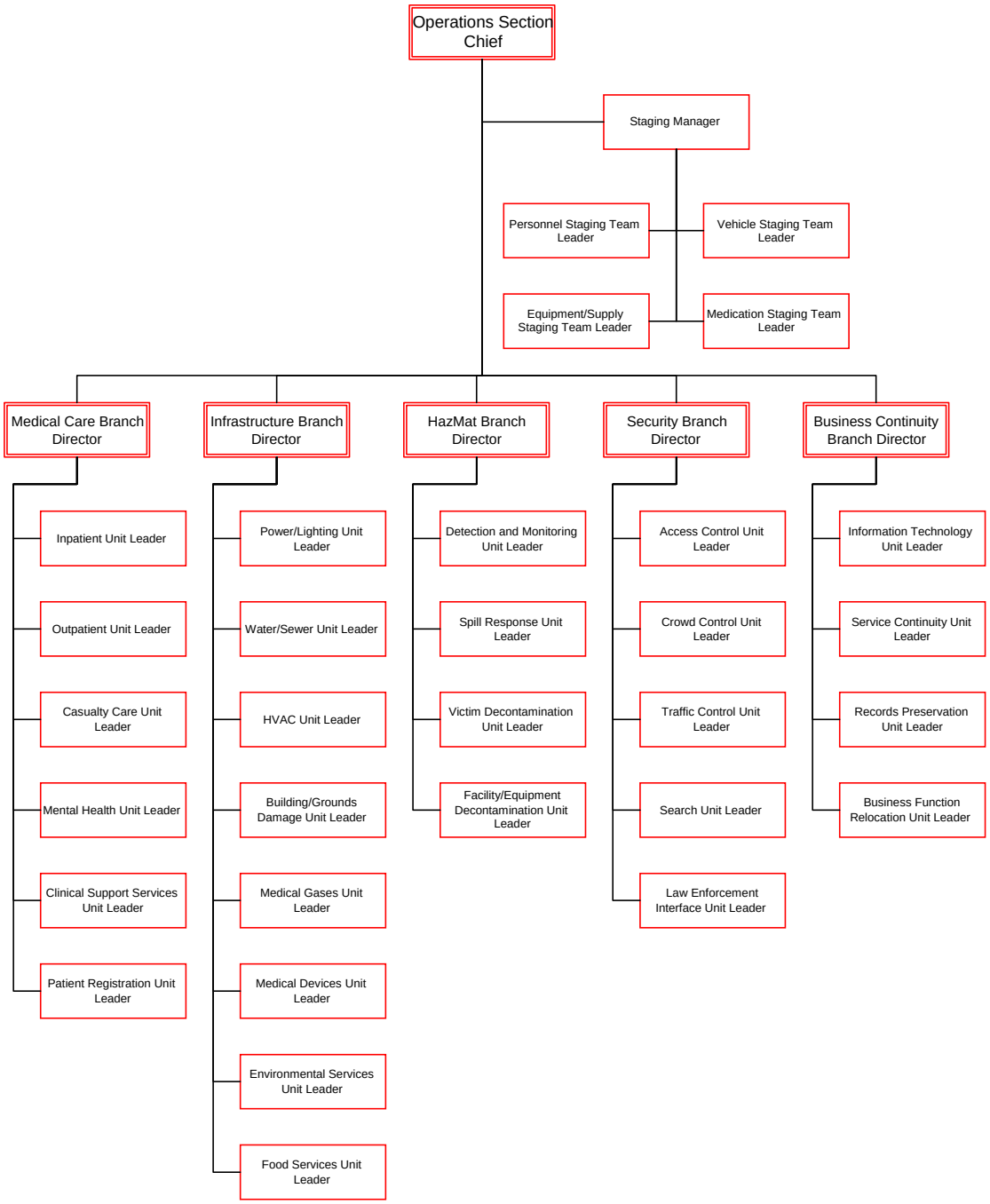

Fig. 5. Distribution of Authority and Responsibility within Operations Section.

Infrastructure Branch, Security Branch, and Business Continuity Branch have been included in the Operations Section because each of these areas, like the

Medical Care Branch, provides services that are essential for maintaining hospital operations, not simply logistical support. The facilities personnel are operating to ensure the utility needs for the incident are being met; security personnel are maintaining order; and the information technology personnel are keeping the computerized system operational for information-sharing among various areas of the hospital. In some types of internal emergencies (e.g., child abduction, water outage, or computer system going down) the function of one or more of these areas becomes an essential part of restoring normal operations.

The HazMat Branch would not be operationalized for most incidents. However, it would become critical to managing incidents when a hazardous material is involved (either internal or external).

HICS, like NIMS, allows for the deployment and supervision of single resources, task forces, and strike teams. A single resource is an asset such as a stretcher or medicine cart. A *Task Force* is a combination of like resources (e.g., eight ICU–trained RNs, two ICU technicians, and an ICU station secretary) that have been assembled and given a specific assignment under the direction of a supervisor. A *Strike Team* is an assembly of the same kind and type of resources (e.g., eight ICU RNs),) that operate under a common supervisor. The Operation Section Chief or Medical Care Branch Director will be responsible for determining the need for these assignment combinations and issue specific mission objectives. Once those objectives are met, the team will be given a new assignment or deactivated.

The Staging Manager will be located in a central location (Staging Area) large enough to allow for the collection of personnel, vehicles, equipment/supplies, and medications. His or her responsibility is centered on deploying available assets in the Staging Area to areas in the hospitals that have requested a particular resource. Thus, the Staging Manager will work closely with the *Logistics Section* to learn what is needed and ensure that the requested item(s) are sent to the correct location as soon as possible. In turn, the Logistics Section will work to obtain those needed items and direct that they be delivered to the Staging Area as outlined in the EOP and/or at the request of the Staging Manager. In situations where the number of staged items is too great or they need to be kept in separate locations, a team leader is assigned to coordinate each type of item being staged (Personnel Staging Team Leader, Vehicle Staging Team Leader, Equipment/Supply Staging Team Leader, and Medication Staging Team Leader).

5.3.1 Department Level Command

Providing leadership at the individual department level will be another important part of the hospital's overall response. The EOP should address the role and responsibility of each department for the various scenarios identified from the hazard analysis. The leadership in each department should be identified in the department plan along with 24 hours/7 days a week contact information. In addition, the following should be maintained available for immediate access:

- Job Action Sheet
- Identification vest (or other preferred method)

- Radio/phone
- Appropriate HICS forms
- Predesignated resources (e.g., phonebook, procedures manual)

Those in charge should provide staff with periodic briefings to allay fears and anxiety and promote commitment to the tasks at hand. Management issues that cannot be resolved within the department should be reported to another authority according to the EOP.

It will also be important that each hospital department or unit have ready access to the necessary equipment and supplies needed to response to various internal emergencies such as loss of power, lighting, and water. The items include but are not limited to:

- Flashlights and chemical lightsticks
- Bottled water
- RESTROOM CLOSED signs
- Chemical or standard portable toilets/toilet paper
- Handwashing foam/disinfectant wipes
- Evacuation chairs/sleds

Deployment of needed equipment should be effectively managed and replacement needs should be reported to the Hospital Command Center. Once the situation is over, arrangements should be made for the items to be replaced and put back into a ready state.

5.3.2 Patient Care Operations

Many of the incidents that a hospital will encounter are likely to involve ill or injured victims. The Medical Care Branch is responsible for addressing the provision of acute and continuous care of the incident victims as well as those already in the hospital for medical care. The Casualty Care Unit Leader will usually be located in the Emergency Department but can appoint additional command personnel to coordinate triage and treatment activities if needed. These activities should be conducted in accordance with the hospital's mass casualty annex to the hospital EOP. It will be important that patients arriving at the hospital are quickly and correctly triaged to a definitive treatment location and medical care is not delayed waiting in a treatment area. The Triage Officers treatment priority should be plainly identified on a disaster tag or band. It will also be important that a quick but reliable patient registration process is implemented to avoid delays in patient care or confusion over patient location.

Patients contaminated by hazardous material should be received by properly trained and protected personnel (see HazMat Branch below) using a standardized and well practiced decontamination procedure before they are allowed into the main hospital. In this situation, only lifesaving interventions should be rendered during decontamination, with definitive care provided in the hospital. Inpatient services (Inpatient Unit), Outpatient services (Outpatient Unit),

and clinical support services (Clinical Support Services Unit) will also be coordinated by the Medical Care Branch.

To meet surge capacity needs, the Incident Command Staff should refer to the surge capacity annex in the EOP. A well-written plan will provide guidance for phases of implementation as more personnel and treatment areas can be operationalized.

The Medical Care Branch Director will work with the Logistics Branch to ensure needed personnel, equipment, medication, and supplies are requested, and with the Staging Manager to ensure their delivery to needed areas. Making prudent decisions will be crucial when needed resources are in short supply. Guidance will come from the HCC, who will coordinate the request for needed items through the local EOC. It is also important that the medical care being rendered is uniform across the healthcare system. The local public health department or RHCC will provide guidance for area hospitals in this regard. Additional standardization will occur when all area HCCs talk with one another on a regular basis via facilitated teleconferences or face-to-face meetings.

5.3.3 Infrastructure Operations

Complementing the efforts to meet the medical care needs of the patients and protecting the staff will be the maintenance of overall facility operations. This responsibility primarily rests with the Infrastructure Branch in the Operations Section. Their responsibilities include maintaining the normal operational capability of the facility including power and lighting (Power/Lighting Unit), water and sewer (Water/Sewer Unit), HVAC (HVAC Unit), medical gases (Medical Gases Unit), medical devices (Medical Devices Unit), and building/grounds (Building/Grounds Damage Unit), increasing that capacity when patient surge requirements dictate; and identifying and fixing utility service-delivery failures. The acquisition of equipment parts or outside contractors will be coordinated with the Support Branch.

Maintaining and repairing information technology equipment is managed by the Business Continuity Branch with logistical support coming from the IT/IS Unit Leader in the Service Branch in the Logistics Section.

If an incident occurs with resulting damage to the hospital, the Infrastructure Branch Director will assign an assessment strike team or the Incident Commander may assign that responsibility along with remediating the problems.

5.3.4 Business Continuity Operations

The function of the Business Continuity Branch is to assist impacted areas with ensuring that critical business functions are maintained, restored, or augmented to meet the designated Recovery Time Objective (RTO) and recovery strategies outlined in the areas' business continuity and business resumption plans. The Business Continuity Operations Branch will:

- Facilitate the acquisition of and access to essential recovery resources, including business records (e.g., patient medical records, purchasing contracts)
- Support the Infrastructure and Security Branches with needed movement or relocation to alternate business operation sites
- Coordinate with the Logistics Section Communications Unit Leader, IT/IS Unit Leader, and the impacted area to restore business functions and review technology requirements
- Assist other branches and impacted areas with the restoring and resuming of normal operations

5.3.5 Security Operations

Lock-Down vs. Restricted Visitation

A significant number of actions will need to be taken early into an incident. Among the most important decisions will be what access restrictions into the facility and hospital campus will be implemented.

Each incident will have its own security-related issues. In the past, no consideration was given to the hospital being a secondary or especially a primary target for a harm event. Hospitals cannot afford that passive approach any longer. “Gang violence,” employee or patient-related violence, and terrorism are pressing reasons why hospital security must be taken seriously and comprehensive planning and training conducted.

The decision to restrict access must be made early into the event by the Incident Commander in conjunction with other senior personnel such as the Security Branch Director. If access is to be restricted, then implementing the decision should immediately be carried out according to the EOP. Announcing the security restrictions to the staff and public should be immediate, followed by assigned personnel rerouting pedestrian and vehicular traffic and doors being locked, either manually or electronically (Access Control Unit). Locked doors should ideally be monitored to ensure no compromise occurs. Internal and external signage indicating the doors are NOT to be opened (and, where appropriate, redirecting would-be entrants) should be posted as soon as possible. Such signage can be created in advance and stored, ideally, by doors for rapid deployment. It is crucial to involve life-safety engineers/personnel in planning and response to ensure adequate egress in the event of a fire or other internal emergency.

Heightened surveillance procedures may need to be implemented including inspecting suspect packages; closer scrutiny of personnel at checkpoints, including verification that each individual, including staff, is wearing a proper identification badge; and assigning properly protected personnel at patient arrival points, including the decontamination sector if activated (Crowd Control Unit). Certain areas such as the emergency department, pharmacy, and HCC should receive enhanced security support. Steps may need to include restricting staff

entry into certain areas because of security concerns, unsafe conditions, or because no additional staff is required.

Supplemental Security Staffing

Supplemental personnel may be needed to assist the on-duty Security staff, depending on the type and length of the incident. This need may be met by calling personnel in from home, reassigning other non-Security personnel to select tasks, and requesting help from local law enforcement (Law Enforcement Interface Unit). Planning should address when law enforcement will be able to assist and how they will be integrated into facility operations and the HICS. Their deployment assignments and pertinent response procedures, including rules of engagement, should be discussed upon their arrival along with what support they will require (e.g., personal protective equipment, phone access). In addition to using local law enforcement to supplement staffing shortfalls, consideration should be given to having a contingency contract(s) with local or national private security firms to provide trained personnel during an emergency. Planning should address the deployment, supervision, and needed support for these personnel along with associated utilization expenses.

Traffic Control

Depending on the situation, victims will likely be arriving by private autos accompanied by quickly escalating numbers of family and friends. The media will also be arriving at some point and requesting special parking locations for their outside interviewing and “live shots.” The gravity of the situation may warrant inspecting all of these vehicles as they enter the campus; this will require additional personnel and the equipment needed to do the inspection (Traffic Control Unit). For hospitals sharing campuses with other healthcare facilities, the decision-making associated with campus security should be done in a collaborative manner and employ optimal communication practices.

Traffic patterns may need to be revised to optimize EMS and other emergency vehicle arrivals. The area in front of the emergency department should be kept clear along with areas assigned for decontamination. All available parking areas should be opened and consideration given to suspending gate-entry systems and fee payments.

Planning should address situations such as abandoned vehicles, including those with possible chemical contamination, and how they should be removed from outside the emergency department and other critical locations. It should also be anticipated that law enforcement may request vehicle information (tag number, make and model of the car, and location) for the patients being seen.

As time goes on, vendor deliveries may need special inspections, alternative routing, or cancellation. The implications of all of these actions should not be taken lightly and will require careful planning and coordination.

Personal Belongings Management

Routine daily procedures for managing patients’ personal belongings may need to be modified. The arrival of a large number of patients may present challenges

in rapidly and accurately cataloguing and securing belongings. Contaminated patient belongings will require special care to avoid cross-contamination as well as to preserve the chain of custody if the incident was deliberate. Thus, it is important that incident plans comprehensively address how all patient belongings will be secured as well as the process for determining when and how they will be returned to the rightful owner (Security Branch).

Chain of Custody Considerations

For suspicious incidents, specific chain-of-custody procedures must be followed. The EOP should outline a fundamental strategy of basic objectives and steps. These procedures ideally will address everything from handling a patient's personal effects to packaging and transfer of laboratory specimens. Local law enforcement should be consulted when developing these procedures to ensure the outlined steps are consistent with accepted practice. During an incident it will be important for the Security Branch to identify what procedures are to be employed and to quickly disseminate easily understood instructions

5.3.6 HazMat Branch

In situations involving a hazardous material release (internal or external) the Incident Commander may choose to activate the Hazardous Materials Branch (HazMat Branch) per the EOP. The HazMat Branch will have the personnel and equipment to address agent identification (Detection and Monitoring Unit), spill response (Spill Response Unit), victim decontamination (Victim Decontamination), and decontamination of equipment and the facility (Facility/Equipment Decontamination Unit). It is important that the PPE and decontamination procedures employed complement whenever possible those used by other hospitals and the fire department. In addition, having a designated decon area that can be quickly established and suitable in size and flow to accommodate patient processing needs is vital. Procedures should be available for staff donning and doffing PPE and decontamination of ambulatory, non-ambulatory, and patients with special needs.

5.3.7 Additional Branch Options

Unique situations, usually involving internal emergencies, may occur that require the creation of additional Operational Branches. For example, a Special Operations Branch might be created to address the specific needs of an incident that are not being met by the standard HICS, such as a pending tornado which could require a defensive action to protect the personnel response (e.g., internal shelter-in-place operation or evacuation). Other examples include evacuation, sheltering in place, and a working fire in the facility. The Incident Commander will appoint a qualified individual to be the Special Operations Branch Director. This individual would exercise command over the unique response activities associated with the situation, working with other command officers as appropriate to meet the mission objectives.

5.4 Planning Section

As outlined in NIMS, the Planning Section will "collect, evaluate, and disseminate incident situation information and intelligence to Incident Command." They will also be responsible for preparing status reports, displaying various types of information, and developing the Incident Action Plan (IAP). The effectiveness of the Planning Section has a direct impact on the availability of information needed for the critical, strategic decision-making done by the Incident Commander and the other General Staff positions. There are three principle sections in the Planning Section, each of which is directed by a Unit Leader (Fig. 6).

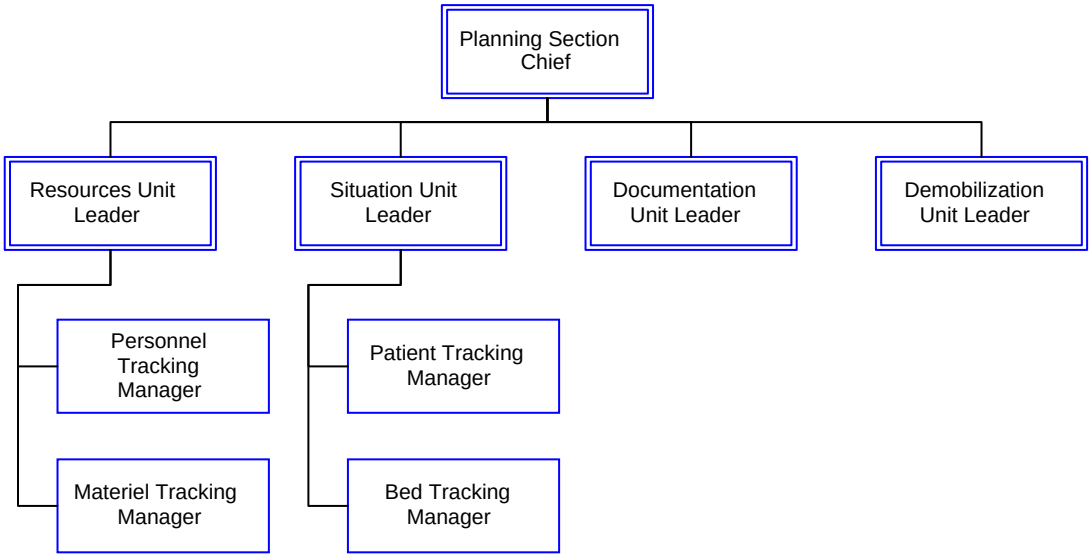

Fig. 6. Distribution of Authority and Responsibility within Planning Section.

The Situation Unit Leader will be responsible for writing and maintaining incident updates based on internal and external events, including those related to patient tracking (Patient Tracking Manager) and bed tracking (Bed Tracking Manager). A Patient Tracking Manager may be appointed to assist with staying current with patient location assignments and making this information available to HCC personnel as well as with the local EOC and other appropriate external agencies through the Liaison Officer.

The Resource Unit Leader tracks the status of personnel (Personnel Tracking Manager) and material resources (Materials Tracking Manager) that are being utilized in various locations of the hospital. A Personnel Tracking and Materials Tracking Manager may be appointed to assist when necessary. The Documentation Unit Leader completes action plans and other support documents and archives them. The Demobilization Unit Leader is responsible for developing and revising the demobilization plan.

5.4.1 Documentation

Multiple types of information should be documented during an incident. This information may originate from the incident scene, in one of the hospital's

operating service areas, or from the Hospital Command Center. The Planning Section will take the lead in coordinating documentation efforts. The Documentation Unit Leader will work with other members of the incident management team to document the incident.

Multiple methods of documentation will likely be used during an incident. Written documentation will be the primary method of information recording. Each Incident Command position is tasked with maintaining their own log of issues, actions, and outcomes. Some personnel experienced in serving in Incident Command roles have found it helpful to dictate information into a portable recording device and later go back and transcribe the information. Actual recording of the information may be done on paper or, more commonly, on computers using standard word-processing, database, or spreadsheet programs. Among the advantages of computer-based documentation is the easy readability, filing capability, and the ability to immediately transmit the information to other locations. Growing numbers of emergency management software vendors are developing information management programs specifically for hospitals.

Video and audio recordings may be used during meetings and provide the additional opportunity for others not present to see or hear what was said. The continuous recording of phone lines or even the HCC operation itself can be helpful in reconstructing information received and actions taken during an incident.

The effective use of designated incident management forms will be another important part of incident management. Twenty (20) specific forms have been included for use as part of HICS (see Appendix D: “Using the HICS Forms”). Each form is intended to assist hospitals in identifying the various types of information to record and archive during an incident. The forms are of two principal types:

- FEMA has created a set of standardized forms that all responders would be asked to maintain, depending on the incident. Many of these forms have been modified for hospital use.
- Special forms have also been created for use by hospitals and have been adapted into HICS.

The various HICS forms for documentation needed during an incident are found in Appendix D. Among the most important information to be collected and recorded will be:

- Details about the actual incident as they are learned (e.g., fire, plane crash, widespread illness) (HICS 201)
- Organizational assignments (HICS 203)
- Critical problems encountered and incident command actions taken (HICS 202, HICS 213)
- Patient location (HICS 254)
- Resources on hand and requests for supplementation (HICS 256, HICS 257)

- Personnel time and accountability (HICS 252, HICS 253)
- Internal and external communications (HICS 205)
- Facility status (HICS 251)

It will be important that the forms being used are completed accurately, with all the required data. Certain forms are designed to be used to reflect a chronology of decisions while others are used for reporting information or making resource requests. Each form is accompanied by instructions on the purpose of the form, who should complete it, how it should be completed.

Once completed, the forms should be duplicated and distributed according to the directions provided. It is important that the author(s) write legibly and neatly. As an alternative to photocopying a completed form, preprinting the forms using a non–carbon paper format with multiple copies could be a practical solution.

It will be important that each command position is familiar with the forms they are responsible for completing as well as with the established reporting timeframes. For information that is to be repeatedly collected (e.g., patient data, resource availability information), announcing the predetermined deadlines for submission will help ensure that the information is received on time from each reporting area.

As the situation unfolds, archiving the information being collected, particularly in the Hospital Command Center, is important. The Planning Section is generally responsible for maintaining a complete file on all incident management information. When necessary, duplicate copies may be made for security reasons.

Archiving

The Planning Section (Documentation Unit Leader) will be responsible for maintaining a continual record of the hospital's IAPs and other incident management forms so that Incident Command personnel can refer back to them if needed. At the termination of the incident, all of the collated IAPs will be used to help outline the hospital's response activities and decision-making processes.

Sharing Information with Outside Agencies

Depending on the nature of the incident and its longevity, the local EOC or Regional Hospital Coordination Center may request hospitals to submit their IAPs at designated times. This information will help community emergency response officials better understand the issues the hospitals are confronting and what future assistance may be required. Other information such as patient data, resource availability (e.g., personnel, equipment/supplies, medications etc.) and response cost information may also be requested from the local and/or state EOC. In some communities information being shared with local and state EOCs maybe transmitted via specially designed emergency response software programs while others may use fax machines or phone reporting. It is important that hospital command personnel are familiar with the expected reporting methodologies and redundant systems are in place in case of technical problems being encountered.

5.5 Logistics Section

For the hospital to respond effectively to the demands associated with a disaster, support requirements will be coordinated by the Logistics Section. These responsibilities include acquiring resources from internal and external sources using standard and emergency acquisition procedures and requests to the local EOC) or the RHCC. Each resource request from an area in the hospital should be reported to the Logistics Section using pre identified ordering procedures outlined in the EOP. When requesting resources from outside sources it will be important that the hospital specify exactly what their need is and not try to identify how that need can be met: that will be done at the local EOC or RHCC. In addition, it is important for the hospital to know how the requests are to be made (electronically, fax, phone) The Logistics Section can be subdivided into two branches as the situation warrants The Service Branch will be responsible for supporting communication (Communications Unit), IT/IS resource needs (IT/IS Unit), and food services for staff (Staff Food & Water Unit). The Support Branch will be responsible for coordinating resources needs for employee health and behavioral/mental health (Employee Health & Well-Being Unit), family care (Family Care Unit), acquiring needed supplies (Supply Unit), supporting infrastructure operations (Facility Unit), coordinating internal and external transportation (Transportation Unit), and acquiring and credentialing additional personnel (Labor Pool & Credentialing Unit). When activated, each Unit would have a Unit Leader providing command and control. Figure 7 represents how authority and responsibility is distributed within the Logistics Section.

5.6 Finance/Administration Section

The costs associated with the response must be accounted for from the outset of the incident. These costs can come from multiple sources such as overtime; loss of revenue-generating activities; and repair, replacement, and/or rebuild expenses. Daily financial reporting requirements are likely to be modified and, in select situations, new requirements outlined by state and federal officials.

Preplanning efforts should identify what state and federal financial aid documents must be completed for receiving reimbursement. In addition to patient costs being tracked, vendor expenses, mutual aid financial remuneration, and personnel claims must also be accounted for and processed. The Finance/ Administration Section coordinates personnel time (Time Unit), orders items and initiates contracts (Procurement Unit), and arranges personnel-related payments and Workers' Compensation (Compensation/Claims Unit) and tracking of response and recovery costs and payment of invoices (Cost Unit).

Figure 8 represents how authority and responsibility are distributed within the Finance/Administration Section.

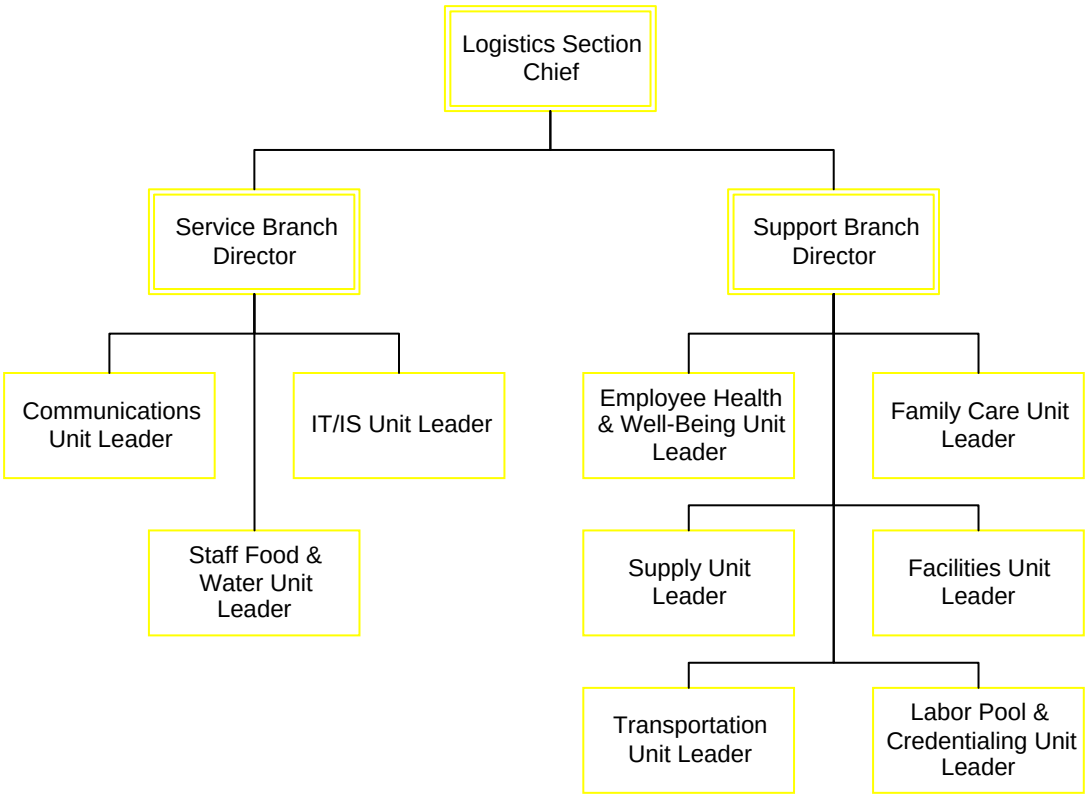

Fig. 7. Distribution of Authority and Responsibility within Logistics Section.

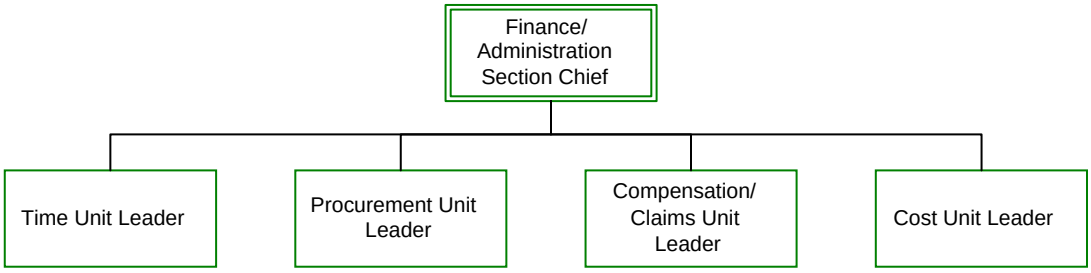

Fig. 8. Distribution of Authority and Responsibility within Finance/Administration Section.

5.7 Additional Incident Command Principles and Practices

5.7.1 Incident Command Staff Identification

All personnel assigned to an incident command role should wear identification that correctly communicates his or her role. Many hospitals use a vest for this purpose. Each vest should clearly identify the HICS position title on the front and back in both normal and low-light conditions. The vests may also be color-coded to the HICS incident management team chart (grey/black – Command Staff; red – Operations; blue – Planning; yellow – Logistics; and green – Finance/ Administration). They should contain large pockets for holding a portable radio, tablet, pens, markers, and a Job Action Sheet (JAS). The vests should be readily

available from a secure location and regularly checked to make sure they have the required items

5.7.2 Building Incident Command Staff Depth

Real-world experience from the 2004 outbreak of Severe Acute Respiratory Syndrome (SARS) in Canada and the U.S. Gulf Coast hurricanes in 2005 has reinforced the need for a hospital to be able to support three to five persons trained for each command position in case a prolonged response is required. Appendix F: “Potential Candidates for HICS Command Positions” includes a suggested list of hospital personnel who might serve in each command position.

No JAS has been written for a Deputy Chief position. Rather, the individual assuming this role will assist the Section Chief by performing delegated job activities or tasks as outlined by that JAS.

In addition to training adequate numbers of their own staff, hospital planning should address the incorporation of other qualified personnel from corporation member hospitals or headquarters (if applicable), and nonaffiliated local or regional hospital or state/federal response teams.

Training and exercises should be used as a means of preparing personnel to competently and confidently assume one or more roles based on situational need and available resources. Completion of the specified NIMS courses, either online or more traditionally in the classroom, should help to prepare those persons likely to assume command roles. For or more information on available training see Appendix I: “NIMS Compliance Guidance for Hospitals.”

5.7.3 Job Action Sheets

The Job Action Sheet (JAS) is an incident management tool designed to familiarize the user with critical aspects of the command position he or she is assuming. Information provided on a JAS includes a radio identification title, purpose, to whom they report, and critical action considerations. These tasks are intended to “prompt” the incident management team members to take needed actions related to their roles and responsibilities. The Job Action Sheets included with HICS have been extensively revised and include more action steps listed by time periods; a new Demobilization and System Recovery time period has also been added. The JAS format allows for personnel to document each action undertaken and record decision timeframes. The new JAS also graphically depicts the position within the incident management team and highlights reporting relationships. Appendix C: “Using the Job Actions Sheets” provides the JASs that have been developed for HICS and instructions for how hospitals can develop additional JASs if needed.

5.7.4 Incident Response Guides

To assist the incident command staff to optimally react to the situation they are confronting, Incident Response Guides (IRGs; see Appendix H: “Working with the Scenarios, Incident Planning Guides, and Incident Response Guides”) have

been devised for fourteen (14) external and thirteen (13) internal scenarios. Each IRG lists fundamental decision considerations specific to managing that situation by timeframe. The IRGs are intended to complement the hospital EOP and provide a primer that will provide some directional assistance and a means of initially documenting the actions undertaken.

5.7.5 Integration of HICS with Unified Command

It is imperative that those in charge of a hospital response to any disaster or untoward event realize that their facility will not be responding alone. Depending on the nature and extent of the incident, it is likely that a wide variety of agencies will be engaged to some degree in the response effort. (Chapter 4, Sections 4.7 and 4.8 provide further discussion of hospital relationships with external partners.)

Early in an incident, the hospital must be effectively integrated into the community response, including the overall incident command structure. This integration actually starts before the incident occurs, through the hospital's regular participation in community preparedness meetings, training, and exercises. It is at these sessions that the groundwork is laid for mutual understanding of roles and responsibilities, incident management principles, resource allocation, and effective communication and information-sharing practices.

Depending on the situation, the incident may be managed overall by a single agency. For example, at the scene of a multiple vehicle accident, the fire department is in charge and other response agencies support the overall response; or in a prison riot, the police are in charge until order is restored. However, there will be situations where instead of the *single agency command* model, a *unified command* approach will be used. Unified command will be used when more than one responding agency for the incident is present or the situation crosses political jurisdictions. This approach will have senior leadership from identified agencies who are co-located and make decisions together as they analyze available information and establish a common set of objectives and strategies for a single Incident Action Plan. This command model does not change any feature of HICS. It does allow for all agencies with responsibility for the incident, including the hospital, to participate in the decision-making process. This participation usually will take place at the local EOC.

5.7.6 Integration with Healthcare Systems

Hospitals that are part of a corporate or not-for-profit integrated healthcare system must also coordinate their planning and response activities with the appropriate administrative section(s) of the parent organization. This effort may be fostered by having a system emergency planning committee(s) composed of representatives from each facility and affiliate organizations. They should meet on a regular basis (in person, via teleconference, or virtually) to discuss plans and procedures and rehearse their collective response during training and exercises.

When HICS is employed at the senior level of a healthcare system, information and resource management becomes easier to coordinate. To ensure overall system preparedness and response effectiveness, the organization will need to involve representatives from all of the member hospitals and affiliate organizations that are part of the healthcare system in any meetings, training, and exercises. Using standardized terminology and response policies and procedures enhances the ability of all members of the system to support one another during a crisis.

5.7.7 Managing Simultaneous Events

Hospitals normally confront the consequences of one incident at a time, but there are occasions when that is not the case. For example, an earthquake may result in injured victims seeking medical care while at the same time the structural integrity of the facility or infrastructure services may also be compromised; or, a hurricane may strike during a large-scale infectious disease outbreak.

Depending on the situation, the remediation of the problem may require assistance from municipal resources such as Public Safety or Public Works. This request would be coordinated through the Liaison Officer. If contractor assistance is needed, that request will be coordinated through the appropriate Logistics Section Branch Director (e.g., carpenters and masons would be coordinated through the Support Branch).

If an Incident Commander is faced with multiple facilities on the hospital campus being impacted, consideration should be given to establishing an Area Command. This concept would have each involved facility having its own Incident Command structure that reports to a unified Area Command structure. The Area Command structure would include all but the Operations Section because those activities are best coordinated at each building.

CHAPTER 6

Life Cycle of an Incident

LEARNING OBJECTIVES

After completing this chapter the reader will be able to:

- **Discuss critical planning and response elements for the following:**
  - **Alert and notification**
  - **Situation assessment and monitoring**
  - **EOP Implementation**
  - **Establishing the HCC**
  - **Building the ICS structure**
  - **Incident action planning**
  - **Communications and coordination**
  - **Staff health and safety**
  - **Operational considerations**
  - **Legal and ethical considerations**
  - **Demobilization**
  - **System recovery**
  - **Response evaluation and organizational learning**

6.1 Alert and Notification

The hospital response to an incident begins with recognition that an untoward incident could happen (advance warning) or has happened (post-incident warning) that may disrupt normal business operations. Advance warning information may come from several sources, including police intelligence being disseminated through a well-defined transfer plan, EMS or local EMA notification that a special event or mass-gathering activity is being held, or a weather forecast advising possible threatening conditions.

A hospital may receive three principle notifications: The *Advisory* is given when no system response is needed but the potential for a response exists. An *Alert* is given when a response is likely or imminent and should prompt an elevated level of response preparedness. An *Activation* is given when a response is required.

These notifications will usually be received from the local Public Health Department or emergency management office.

Hospitals often receive little or no warning of an incident. Their first indication something has happened may be the situational assessment: the EMS radio providing preliminary incident details, TV or radio presenting a “breaking news story,” major utility loss, or early-arriving victims sharing information on what happened. Information from fire/EMS personnel may be sketchy at first but increases as their situational assessment progresses. Important information to obtain as soon as possible should include but not be limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons on buses)
- Estimated time of arrival of first-arriving EMS units

Regardless of the method or timing of the incident notification, it is important that hospital staff who receive this alert know the plan for protecting themselves and their co-workers (including access to personal protective equipment, if indicated), and that they notify key personnel in a timely manner. This information-sharing strategy should take into account an incident happening either during or after normal business hours and avoid using a single communications infrastructure. Personnel pager (including two-way pagers allowing for text messaging back and forth), cell phone, e-mail/personal digital assistant (PDA), and home-phone contact information should be kept secure but readily available for on duty supervisory personnel and telecommunication specialists to access when needed. This contact information should be continuously updated so these notification methods will work when an incident occurs. After-hours contact procedures should take into account the need to telephone personnel, because many persons will not hear their pagers while asleep.

For some incidents, such as an infectious disease outbreak, it may be the hospital that first recognizes something untoward has happened (e.g., large numbers of patients with flu-like symptoms, particularly at an unusual time of year). In this case, it is important that not only appropriate internal notifications but also external contacts are made quickly. External agencies to notify depend on the event-specific circumstances but could include police, fire/EMS, public health, other hospitals, law enforcement, and/or emergency management. Proper planning will ensure staff has needed information on how and when these personnel should be notified including after hours or on weekends and holidays.

Many of the instances that require partial or full activation of the Hospital Command Center (HCC) will be to manage emergencies, but there are non emergent situations in which activation of the HCC and use of the Hospital Incident Command System is valuable. Examples of such situations include moving patients into a new part of the facility, weather-related emergencies such

as snow storms, or mass-gathering events being held in the community. The HICS should be developed to the extent necessary to manage the anticipated situations that could occur.

6.2 Situation Assessment and Monitoring

Incident Command personnel will receive periodic external situation updates via several means. EMS will provide incident reports by radio or cell phone, and reports from personnel arriving at the facility with transported patients will also be an important source of needed information. Some EMS agencies are using wireless transfer of incident information. Talking to the patients can be helpful in learning what happened and what else should be expected. Arriving law enforcement may be able to provide scene- or situation-related information. Periodic updates may be received from personnel assigned to ESF 8 – Health and Medical Services at the local EOC or from staff at the Regional Hospital Coordination Center (RHCC).

When needed situation information is not being received from other responders, hospitals should be aggressive in making contact with the Incident Command Post at the scene, by contacting the dispatch center or local Emergency Operations Center or the RHCC (if operational). Although it is tempting to send a hospital member to an incident scene to report back information, the practice is often proven unreliable because of problems related to reaching the scene and relaying the information via already busy or dysfunctional cellular phone lines or crowded radio channels.

While external situation reports are important, so are updates on what is transpiring within the facility. The Incident Commander should be receiving periodic, personal updates from command staff members on a regularly announced basis and emergently as the situation warrants. Tours of key areas within the facility should be limited but can be worthwhile in allowing command officers to get a personal feel for what is happening; if a command officer leaves the Hospital Command Center (HCC) a temporary acting officer should be appointed to ensure continuity of command. When available, viewing surveillance cameras or video cameras positioned to observe critical areas can also provide useful information. An alternative is to have videotapes taken of critical areas and replay them in the HCC. Watching the news footage shown on local and national TV can also be useful in getting a sense of what's happening at the scene or what is being reported as happening at the hospital.

6.3 Emergency Operations Plan Implementation

After the alert and notification of personnel is done, the next critical step is to determine the appropriate response actions, based on available information. Among the critical initial actions to be considered are partial or full activation of the HCC and revision of clinical care practices in the emergency department and other operational areas in the hospital.

The situational assessment details initially provided often lack some or all of the information that may be desired to easily determine what correct next step should

be initiated. The individual making the decision will nonetheless have to react to what is known and, coupled with his or her experience in similar situations or advice from others, make a decision whether to implement a partial or full activation of the Emergency Operations Plan (EOP) or to maintain normal operations (perhaps with just a heightened response by an single area of the hospital). Critical to making the correct decision will be the answers to the questions: What happened? What is the likely impact on the facility? and Can that impact be managed through daily operations and management practices?

It is important that the hospital EOP identify who has decision-making authority along with what criteria should be used to assist those in charge with making these early decisions. Key decision-makers typically include the hospital administrator on call, nursing supervisor, and senior emergency department physician and/or nurse on duty. New incident response guides (IRGs) have been included with this manual (Appendix H) to suggest to hospitals some critical decision-making actions they might consider for responding to internal and external scenarios hospitals may confront. The hospital IRGs should be easily accessed for use, including being reduced to pocket-size format or even converted to PDA use. Depending on their content detail and formatting, they could also be used as a means of assisting with documentation of the actions being taken.

Once the decision regarding the appropriate hospital response level has been made by those in charge, this information should be shared immediately and effectively with other key hospital staff, whether in the facility, off-site, at meetings, or at home. These timely notification efforts should be well designed, coordinated, and rehearsed using redundant strategies such as overhead announcements, pagers, e-mails, and phone messages to ensure those being alerted receive the message.

Implementation of the EOP should result in the immediate opening of the HCC and the operationalizing of individual command work stations, implementation of information management procedures, and setting up of needed communication technology, along with making available the incident command kits prepared for each position being activated.

6.4 Establishing the Hospital Command Center

The effectiveness of a hospital's incident management team is greatly enhanced when they have access to a location prepared for them to convene and coordinate response activities, resources, and information, that is, a Hospital Command Center (HCC).

6.4.1 Design Features

HCC location and design should reflect the following characteristics:

- *Accessibility* – the area can be easily reached from any area of the hospital 24 hours a day/seven days a week and is not in the middle of critical hospital operations or public access area.

- *Flexibility* – sufficient space, equipment, furniture, supplies, and technology to accommodate any size incident management team, based on the scope and requirements of the incident.
- *Sustainability* – infrastructure support for emergency operations 24/7 without interruption.
- *Security* – protection of the facility, occupants, communications systems and equipment, and sensitive information.
- *Survivability* – ability to withstand effects of local hazards or have a fully capable alternative HCC location.
- *Interoperability* – technological capability to exchange routine and time-sensitive information with other HCCs or emergency operations centers.

Space should ideally be designated for:

- *Main operations room* for coordination among incident management team members. This area would be clearly identified as to where each command position is to be located, via table tents or overhead signage.
- *Command positions with* usable space and easy access to the command tools identified on their JAS.
- *Enclosed nearby conference room* for private meetings or executive briefings.
- *Communications area* for radio, telephone, and support equipment.
- *Electronic and written displays* for providing needed decision-making information.
- *Storage closet* for plans, reference manuals, resource directories, maps, supplies, and the like, and for command kits when not in use.

6.4.2 Equipment and Supplies

To ensure that the incident management team is able to communicate and receive information effectively both with the rest of the hospital organization as well and with external agencies and the greater community, the HCC should be equipped with redundant communication capabilities.

- *Voice systems* include telephones land, cellular and satellite lines, and amateur and commercial two-way radio
- *Data systems* include computers with modems on analog lines, computers on a local or wide area network (LAN or WAN), and computers with wireless cards.
- *Equipment for receiving public broadcasts* is necessary, including multiple televisions or a large screen capable of showing multiple channels simultaneously and AM/FM and weather radios.
- *Equipment for visual display of incident information* is also critical and includes large projection screens, whiteboards, maps, charts, and chart pads on easels.

Finally, in addition to preprinted HICS forms and general office supplies, a fax machine and photocopier are basic equipment in the HCC.

6.4.3 Staffing

The number of staff in the HCC will expand and contract according to the course of the incident. The Incident Commander determines the level of staffing of the incident management team. Generally, this would minimally include the Command and General Staffs. Other staff would be accommodated in the HCC if space is available; otherwise, nearby or adjacent rooms should be used. (Each Section's teams would not be stationed in the HCC but instead would be cohorted in nearby space or operate from their normal offices.) In addition, Medical/Technical Specialists and external agency representatives may be located in the HCC or in a nearby auxiliary site as space allows. Finally, it is important that administrative support staff be available to assist senior command personnel with documentation and communication activities, thereby freeing them to address critical issues.

6.4.4 Alternative Hospital Command Center

In the eventuality that the primary HCC is not accessible or usable, an alternate site must be available. Planning consideration should be given to where this alternative site would be located and how it could be quickly set up for use. Consideration should be given to other areas in the hospital or nearby buildings on campus. Some hospitals have developed a "Plug and Play" approach, which includes storing each HCC command position's materials (e.g., vest, Emergency Operations Plan, paper, pens, laptop computer) in heavy-duty roller boxes that can be relocated to a secondary site in an emergency. When the primary HCC is activated, the boxes are brought out from storage and the needed materials removed for use; the same practice would occur at the alternative HCC. Separate boxes are used for storage of radios and other portable technology.

6.4.5 Activating the Incident Command System

When the decision has been made to activate the HICS, the Incident Commander should determine the initial management objectives and priorities. Based on this assessment and in accordance with the EOP, additional command staff should be activated to assume designated command positions.

The incident management positions being activated may initially have to be filled by in-house mid-level staff until more senior personnel arrive. After hours, or for small- or medium-size hospitals, some individuals may have to simultaneously perform several roles throughout the entire response or until additional assistance arrives. The functional needs of the hospital response should drive which incident management positions are filled by the Incident Commander.

6.5 Building the Incident Command System Structure

Only those personnel who have completed the required incident command training specified by the federal government (National Incident Management

System [NIMS]) and other hospital or corporate requirements should be appointed to command positions activated in the response. Some individuals, by virtue of their background and training, might be capable of performing in more than one position. Appendix E: “HEICS to HICS: Some Suggested Implementation Steps” contains a suggested list of administrative positions who might serve in each incident command role. It is vital that each hospital maintain a sufficient cadre of trained personnel to ensure the capability to operate for extended periods of time (e.g., days and weeks).

A list of the qualified personnel should be maintained and immediately available in the HCC for the Incident Commander to use. An alternative system would be to assign teams of personnel, with each team taking an “on call” time period; if an incident occurred on their duty day, they would be the first response team members activated. The other teams would fill in positions that are vacant because of illness or vacation and be the second-shift and relief teams.

The Incident Commander should ensure that HICS General Staff receive an initial incident briefing (see Appendix D: HICS Forms - ICS 201). The briefing will provide an overview of the general hospital response priorities and preliminary problems being addressed as well as answers to any initial questions or concerns. It is also necessary to provide updated operational briefings at regular intervals.

In most cases, the Incident Commander will be well-served to ensure the command staff positions of Public Information Officer and Safety Officer are immediately appointed, along with the general staff positions of Operations Section Chief and Logistics Section Chief. The Liaison Officer (Command Staff) and Planning Section and Finance/Administration Section Chiefs (General Staff) should be appointed as the situation warrants and available resources allow. If the situation requires specialized expertise, a Medical/Technical Specialist(s) may be assigned. These would include experts in clinical areas such as infectious disease and radiation or chemical emergencies, or nonclinical expertise such as risk management, legal affairs, and hospital administration. These individuals are used to primarily provide situational assessment assistance and response recommendations to the Incident Commander.

Along with the development of the incident command organization at the HCC, other operational areas (emergency department, operating room, registration, etc.) should follow the EOP and develop their area’s incident command staff using available trained personnel for each position.

As the incident management positions are activated, a written record is crucial to document who is assuming what role. This information should be posted in the HCC for everyone to see, using an LCD projector or wall charts. Noting the officers’ names and contact information is particularly important. In addition, the appropriate organization assignment forms should be maintained (see Appendix D; HICS Forms 203 and 207) and widely distributed through all appropriate means (e.g., print format, e-mail, etc.).

In some cases, the Incident Commander may not be the Chief Executive Officer (CEO) for the hospital. That individual may be away or assume other duties according to the EOP (e.g., represent the hospital at the local Emergency Operations Center). The Incident Commander must ensure that the CEO and other senior administrators (including the Board of Directors) who are not directly involved in managing the incident are kept properly informed and consulted when needed.

6.6 Incident Action Planning

6.6.1 Purpose

The HICS is intended to ensure that a concept of operations (how the system operates in a coordinated manner) is the foundation for guiding the response, regardless of the nature of the problem being encountered. Critical to the concept of operations is management by objectives. Incident Response Guides (IRGs) should be available to assist the incident management team through the early stages of the response. Complementing the IRG is the Incident Action Plan (IAP), a document that is intended to help the incident command staff establish and communicate response objectives, identify response needs, and resolve obstacles associated with meeting the objectives. As the principle means of standardized communication of important information, it is also a useful tool for successful transition of operational activities to HCC relief staff.

6.6.2 Planning Cycle

The Incident Commander will identify the response sections that will be expected to submit an IAP. Each section chief will be given an electronic or manual form to complete (see Appendix D; Forms-ICS 202H) with the assistance of others in their section as necessary. The completed form should be submitted to the Planning Section Chief by the announced deadline. The Planning Section will assimilate the forms received into a single hospital IAP and present it to the Incident Commander. In turn, the Incident Commander will make any modifications deemed appropriate and then brief the Command staff on the document at a planning meeting.

During that meeting, the IAP will be modified as needed, based on discussion by the meeting participants. The IAP will be initially developed as soon as possible after the HCC is operational. This IAP will provide preliminary guidance for the response effort for a defined operational period. The Incident Commander or, at his or her direction, the Planning Section Chief will then establish announced times when subsequent IAPs are to be submitted. Generally, the deadline should be a minimum of two hours before the end of the work shift. This should allow the Planning Section time to develop the composite hospital IAP that will be used by the Incident Commander to brief the oncoming Command staff.

Another critical part of successfully managing an incident will be conducting various meetings involving key personnel. These meetings will generally be of three types (Barbera, Macintyre, et al. *Emergency Management Principles and Practices for Healthcare Systems.* Veterans Health Administration: June 2006):

- *Planning meetings,* in which the Command and General Staff decide upon response objectives, strategies, tactics, and response assignments (in some situations where the development of tactical objectives and delineation of actual tactics is too complex to accomplish during the planning meeting, a special Tactics meeting can be held before the planning meeting)
- *Operations briefings,* to impart information to all parts of the hospital Command Staff and discuss critical issues
- *Management meetings,* which begin the next planning cycle and include reassessing and revising management objectives on the basis of information received throughout the operational period

Each of the meetings should be well-facilitated; participants' comments should be brief and on topic. The decisions reached should be recorded on appropriate documents and shared with other command personnel and hospital staff as appropriate.

6.6.3 Forms

The suggested forms to compose the IAP are found in Appendix D: "Using the HICS Forms." They can be revised if a hospital chooses, but the current formats follow the NIMS–suggested content requirements. The electronic version can immediately be transferred to the HCC via the Internet and allows for rapid revisions to be made if necessary; print versions should be available for use when computers are not available.

6.7 Communications and Coordination

6.7.1 Internal

Gathering information from and sharing information with the hospital staff is critical to successfully managing the incident. Internal communication will usually be accomplished using the following strategies and technologies when available:

- Obtaining information from different departments submitting via the phone, intranet, e-mail, or fax (see Appendix D: "HICS Forms," Incident Message Form HICS 213)
- Using radios assigned to specific areas with assigned channels (see Appendix D: "HICS Forms," Incident Communications Log HICS 205)
- Staff completion and return of designated forms downloaded from the Internet or provided in print format
- Sending out regular situation updates and/or response guidance via the radio, Internet, print material, or face–to-face meetings

Two-way pagers and personal communication devices/digital assistants are increasingly being used to relay information between multiple parties and can be a means to confirm message receipt when necessary. Teleconferencing and video conferencing have also proven useful for communication and should be used when available.

Depending on the circumstances surrounding the incident, conducting a "town hall meeting" with the hospital staff before or during a shift can be useful. Involving key command personnel and medical/technical specialists can help ensure that correct information is being given to the staff, rumors are dispelled, and worries assuaged through personal contact.

Hospitals that are part of a healthcare corporation or system must give early notification to the appropriate company officials and update them periodically as needed. Close communication with the other system hospitals should be undertaken as outlined in the hospital and organizational EOP.

Keeping the patients and visitors properly informed is another important communication requirement. Providing them with insight on what happened and what the hospital is doing to address these issues can be done via overhead page announcements, personal reassurance from the staff, using the hospital television channel (if available) to provide the news, information updates strategically posted throughout the facility, and print material put on individual meal trays.

6.7.2 External

Communication will also occur with a number of external response partners. If situations unfold without initial notification from police, fire, or EMS, they must be called when appropriate (e.g., patient with chemical contamination, child abduction) and apprised of what is happening and any assistance requests.

Periodic information-sharing and joint decision-making should occur among all the hospitals receiving victims. In some communities situation information is provided according to a communication plan via the radio (e.g., VHF, UHF), telephone (including satellite phones when land lines or cellular service isn't available), and the Internet, using predetermined forms or tables. Each of these technologies has limitations and hence system redundancy is important to ensure that functional communication capabilities exist.

When available, amateur radio can also be used for communication. Many communities have found their local amateur radio operators to be reliable, skillful, and possessing very dependable communication equipment. However, amateur radio, like most public safety radios, is typically not secure, and thus messages may be overheard by unintended recipients such as the media and the public.

Teleconferencing is another useful tool for hospitals to consider. A successful teleconference will typically require the following:

- Timely notification of all of the hospitals that a teleconference will be held, the time for the call, and the correct call-in number
- A facilitator from one of the hospitals or a respected outsider who will keep to the agenda and focus the discussion
- Meeting rules, such as the reporting order and content, announced at the outset

- One spokesperson per hospital participating, although others may listen to what is being said
- Pertinent comments being concisely made by the participants
- Announced time for next teleconference, if one is to be held

Hospitals will also continue to communicate with other external partners as the situation unfolds. Maintaining a regularly updated resource directory of external agencies and vendors (Appendix D; see Hospital Resource Directory – HICS 258) will assist in rapidly identifying contact information.

Information received from the outset of the incident should be followed by updated operational briefings based on a set timeline or on an as-needed basis. ESF 8–Health and Medical Services will be periodically requesting updated information; they will also be a primary point of contact for each hospital when some type of resource is needed (e.g., medications, staffing, transportation). The local EOC may ask the hospital to submit certain reports at designated times. Among the information requested will be an IAP and patient-tracking form. Effective preplanning should identify the forms to be completed and indicate the likely timeline for reporting.

In some communities, the RHCC could be another response partner to which hospitals might be providing information and which they might contact for assistance. When activated, the RHCC will usually focus on the hospital's medical care operations, and the local EOC will assist with the nonmedical issues. To be effective, there will need to be close coordination between the local EOC and RHCC.

Other agencies and important personnel will contact the hospital. The Liaison Officer is the hospital's principal contact with all outside agencies and will normally be the conduit for two-way communication between the HCC and local EOC. Additional staff support may be utilized to ensure that the information flows in a timely, effective, and accurate manner.

6.8 Staff Health and Safety

Of paramount importance is maintaining the health and safety of the staff, regardless of the nature of the incident, including adherence to mandatory personal protective equipment (PPE) and safety procedures. The Safety Officer will be primarily responsible for evaluating the ongoing situation and, with assistance from the Incident Command staff and others, for identifying and resolving health and safety matters.

Only authorized personnel who have received necessary training and medical clearance should wear personal protective equipment (PPE) for a chemical, biological, or radiation-related incident. Training should be consistent with state and federal guidance and include periodic refresher training to ensure continued competence. Appropriate sizes and quantities of PPE should be available for use as needed. These items should be properly maintained in a safe, secure, and

environmentally controlled storage location close to where they most likely will be needed.

Persons wearing PPE will have to be watched closely for signs of illness, injury, and fatigue. In addition, it will be important that personnel have the proper PPE to wear during an incident and they are monitored to ensure that the equipment is being worn correctly. Proper personnel and equipment decontamination, disinfection, or disposal will be important to minimize cross contamination and comply with state and federal regulations. . The Safety Officer should work closely with the Operations Section, in particular the Medical Care Branch Director and HazMat Branch Director, to ensure the staff has frequent rest periods, a rehabilitation sector is established, and medical surveillance (such as observing for signs and symptoms of fatigue and heat exhaustion, emotional stress, and pulse and blood pressure measurements) is conducted. The Infrastructure Branch Director and Support Branch Director will take the lead in ensuring needed equipment and supplies are available and that facility cleanliness is maintained. They will also work with the Safety Officer to ensure proper disposal of hazardous waste materials by authorized contractors.

As soon as possible during a contagious biological event, staff should be given health and safety instructions on the proper precautions to be undertaken, in collaboration with Infection Control specialists. If infectivity or route of infection is not yet established, full airborne precautions (including respirators) should be used. The Safety Officer should work with Medical/Technical Specialists, such as an infectious disease or occupational health physician or nurse, to determine what information is needed, and protective measures for the staff are required... Instructions should be transmitted to the staff and patients in several forms (intranet, print format, pager messages, et al.) and be regularly updated as more information becomes available.

The hospital EOP should include an annex that addresses mass prophylaxis/ medication distribution to the staff if the situation warrants. This comprehensive plan should include issues such as medication and vaccination distribution to on- and off-duty staff (and, as appropriate, their families), adverse-outcome reporting, medication acquisition using standard vendor lists, documentation and tracking, and working with local public health officials to procure additional medications if necessary from the state and federal government.

The Incident Command staff will have to maintain close vigilance as the situation unfolds for signs of fatigue and psychological stress. The Logistics Section, primarily the Staff Support Branch Director, will be responsible for addressing staff issues in conjunction with the Operations Section. Personnel showing signs of illness or stress must be cared for properly or additional adverse impact on other staff members is likely. The Employee Health & Well-Being Unit Leader will provide leadership in this effort. Maintaining reasonable work periods with periodic days off (Planning Section) and ensuring the availability of healthy nutrition (Service Branch) must be a priority.

The Incident Commander's efforts to provide timely, accurate, and candid information updates will also be important to maintaining the staff's willingness to work under difficult or dangerous conditions. It will be important that staff members who do become ill or injured are cared for immediately and effectively by the Employee Health & Well-Being Unit. Workers' compensation issues will be addressed jointly with the Compensation/Claims Unit Leader in the Finance/Administration Section.

6.9 Operational Considerations

Many of the most common untoward incidents that hospitals face are short-lived, lasting only several hours. However, the SARS outbreak in 2004 and the results of the Gulf Coast hurricanes in 2005 reinforce the importance of hospitals being prepared for the possibility that the response operations may go on for days, weeks, or possibly longer.

6.9.1 Issues

Numerous issues related to extended operations must be addressed in hospital planning. Among them are:

Personnel

- Loss of staff who become victims of the event
- Lack of adequate staff
- Longer work shifts
- Staff fatigue leading to slower delivery of, or compromise in, patient care
- Loss of staff who evacuate or become victims of the event
- Absenteeism
- Fear
- Concerns for family or personal situations
- Need for time off to assess and manage their home situations
- Integration of outside relief personnel into daily operations and incident command structure

Patient Care

- Lack of needed staff/expertise
- Lack of needed beds, equipment, medications, and supplies
- Need to alter the standard of care (austere care)
- Documentation demands while caring for greater than normal patient volume

Equipment and Supplies

- Lack of needed equipment and supplies
- More than normal type and quantities needed
- Moving cumbersome/heavy items up/down stairs when elevators not working

- Repair and replacement issues
- Staff not being familiar with borrowed equipment

Behavioral/Mental Health

- Increased acute and long-term demand for limited behavioral health resources
- Natural fear, anxiety, and apprehension among patients, family, and staff
- Rumors
- Preventing post traumatic stress disorder

Security

- Implementing and sustaining enhanced security measures
- Staff and visitor compliance with security procedures being used
- Increased risk of patient or visitor violence from impatience or dissatisfaction with service delivery
- Parking needing to be controlled and supplemented
- Controlling media access

Infrastructure Support

- Meeting and sustaining increased demand on various clinical and nonclinical services
- Recovery of utility services to the hospital; operating under reduced capability in the interim
- Unavailability or delay in receiving needed assistance (fuel, repairs, replacement parts, medical gases, et al.)
- Increased need for food/water supplies and meal preparation
- Normal and hazardous waste pick-up
- Clean-up from damage

Information Sharing

- Need to keep patients, family members, and staff informed of the situation
- Establishing, maintaining, integrating, and interpreting multiple databases, files, and reports
- Meeting information management need when daily IT/IS service is compromised
- Responding to multiple information requests (local, state, and federal)

Media Relations

- Requests for information, interviews with staff and patients, and filming
- Family making media statements
- Efforts of unscrupulous media trying to infiltrate a secure facility
- Need for risk communication to inform the public on pertinent health-related issues

- Integrating efforts with other hospital, public health, and community public information officers

6.9.2 Planning

It will be important for the Planning Section in particular to address these issues, in part through utilization of the Incident Action Plan. These planning efforts should also be coordinated where appropriate with others such as corporate headquarters, other area hospitals, and the local EOC.

Although responding to the incident is a priority, maintaining appropriate delivery of everyday inpatient and outpatient services is also important and must be simultaneously addressed. This may be done by continuing everyday management practices (using separate managers from those involved in the incident management) or having the HCC be responsible for coordination. Based on the situation (initial and ongoing) decisions will need to be made on operational issues such as canceling elective admissions, non-emergent surgery and other nonessential scheduled activities (e.g., meetings, medical rounds, special events). Clinic and physician office hours may need to be expanded, reduced, or temporarily cancelled. Pre-incident planning efforts should address the decision making process to be employed and the procedures to be followed for all of these situations.

Although planning for the relief of hospital staff must be a priority, it is also important that planning for rotation of HCC personnel is effectively developed and executed. A vital part of short- and long-range planning is documentation being completed when required.

6.10 Legal and Ethical Considerations

The response requirements of a particular disaster may require the hospital to address a number of important medicolegal issues. For example:

- A surging patient volume that exceeds available resources could result in the decision to have a “graceful or managed degradation of care.” The preservation of essential functions to achieve the organization’s goals becomes the guiding principle, as opposed to altered standards of care. This results in a shift to providing care and allocating scarce equipment, supplies, and personnel in a way that saves the largest number of lives, in contrast to the traditional focus on saving individuals (Barbera, Macintyre, et al. *Emergency Management Principles and Practices for Healthcare Systems.* Veterans Health Administration: June 2006).
- Patient information will be requested by family members, various governmental (e.g., public health) or nongovernmental (e.g., American Red Cross) agencies, and the media. Trained Public Information Officers should be available and promptly disseminate relevant information approved for release.
- Adherence to modified HIPAA and EMTALA requirements during a declared local, state, and/or federal disaster.

- Compliance with Environmental Protection Agency directives pertaining to environmental protection.
- Normal scope-of-practice guidelines may need to be revised to accommodate unusual demand with limited resources.
- The arrival of solicited and unsolicited volunteers necessitates a plan that includes credentialing, privileging, utilization, and supervision.
- Responsibility for a patient who dies from naturally occurring disease and or accidental injury vs. illness or injury related to terrorism.
- A deliberate act of harm or terrorism will require that a chain of custody be established for such things as personal effects and laboratory specimens.
- Investigative medication procedures normally followed may need to be revised or abandoned.

The Emergency Management Committee should consider retaining the hospital attorney, a medical ethicist, and a risk manager to provide guidance in preplanning these issues and should address their availability to provide advice if needed during an actual incident.

6.11 Demobilization

In any type of incident, there will come a point when the worst impact has been encountered and consideration should turn to demobilization. The time frame for this activity may vary by situation, but planning for demobilization should actually begin from the outset of the response. The Planning Section, in particular the Demobilization Unit Leader, is tasked with developing preliminary plans for when and how demobilization is to occur. The ultimate decision as to when to move from response mode to demobilization will be made by the Incident Commander.

The criteria to implement demobilization will vary incident by incident, but fundamental considerations will be:

- The number of incoming patients is declining to a manageable level using normal staffing patterns and resources
- There is no secondary rise in patient volume expected
- Other responders are beginning their demobilization
- Other critical community infrastructure returns to normal operations

It will be important that the Incident Commander consult not only with Command Staff and Section Chiefs but also with external decision-makers, such as other hospitals and the local EOC, before making a final decision.

Depending on the situation, not all areas of the hospital may be able to begin demobilization at the same time. Thus, planning will need to address not only when the demobilization process is to begin but also how it will be implemented.

When the demobilization decision has been made, it should be communicated in a timely and effective manner to the hospital staff and appropriate external agencies as well (fire/EMS, police, public health, et al.) by the Liaison Officer.

Select information may need to be shared with the patients and their families. The PIO should also determine the need to share information with the general public, particularly in situations where hospital operations have been curtailed and will now be resumed.

6.12 System Recovery

A hospital's return to normal operations will be multifaceted and progressive. Incident planning will have to take into account that patient care activities will be ongoing but the ramped-up methods to accommodate a surge will be dismantled as patient care activities allow. Improvised patient care areas will be returned to their prior state. Extra equipment, supplies, and medications will return to the pre-incident "just-in-time inventory levels" as soon as the opportunity permits.

The supplemental staffing levels required during the response may continue to be maintained longer for certain patient care and support service areas than for others. However, eventually even these areas will return to their normal or "new normal" operational levels. It is important that the hospital personnel formally debrief the response with any individual or group that was used to bolster the hospital response. Further, suitable expressions of appreciation should be offered, such as a recognition gift (a certificate or an item with the hospital name on it), a party in their honor, or a simple letter of appreciation. These small gestures will have great importance both to hospital staff and volunteers.

Recovery efforts will also have to address various other personnel issues. Personnel who wore PPE should complete medical surveillance forms that become part of their personnel/employee health record; they should also receive an appropriate health debriefing covering signs/symptoms to watch for and responsive actions to subsequent health effects.

The staff members who become ill or injured while on duty will have financial, psychological, and medical-care issues that can be coordinated by the Compensation/Claims Unit. The possibility of a line-of-duty death occurring should be addressed by a specific annex to the EOP and be implemented through the combined efforts of Logistics Section, Finance/Administration Section, Operations Section, the Safety Officer, and the Public Information Officer. The wide impact a staff member illness and death can have on the rest of the staff cannot be underestimated and must be given proper attention for the duration of an incident. Failure to do so can lead to lack of confidence in the Incident Command personnel and other feelings that will run counter to what is needed for the hospital to succeed in meeting their mission in the midst of chaos. Behavioral/mental health support will be a critical ingredient not only to working through these issues but also to avoiding others.

Experience has shown that the intensity of the response, perceived dangers related to doing the job, and family concerns may lead to staff absenteeism or even resignation during or following the incident. Although there is no guaranteed strategy to avoid these problems, regular, effective, and candid communication with the staff while also providing for their health and safety during an incident

are critical to minimizing their occurrence. The importance of planning for family care and support during these types of emergency situations should be emphasized prior to an incident as part of the hospital's overall preparedness efforts. Planning guidance is available from FEMA and the American Red Cross.

During and especially following the termination of the response, formal and informal recognition of individual and hospital unit efforts will be important in maintaining their ongoing commitment and will help with the emotional recovery from what happened. The Support Branch will play an important response coordination role for all matters pertaining to staff and family support. Psychological debriefing should be provided for hospital staff and volunteers, as determined by the Staff Support Branch Director.

The degree to which the physical plant will have to be restored will vary by incident. At a minimum, all patient-care areas and equipment will have to be thoroughly cleaned. Depending on the area involved, this effort may be time-consuming and costly. The Facilities Unit Leader will primarily be responsible for coordination of this activity, along with the Medical Care and Infrastructure Branches. The actual clean-up work may be done using normal environmental services personnel or, to reduce recovery time, general hospital staff when they are available or contractors when needed.

For hazardous material or biological-related incidents, clean-up efforts may require special cleaning agents and procedures to be used; some situations may even require special contractors to do the work. Hazardous waste, including the collected runoff from decontamination operations, should be disposed of properly by licensed, bonded, and insured contractors. Supervision of the clean-up of contaminated areas should be coordinated by the HazMat Branch and the Infrastructure Branch with logistical support coming from the Support Branch.

For legal reasons and/or the reassurance of the staff, patients, and the general public, it may be important to have a health inspector or other qualified professional conduct a survey of the facility and confirm that it is clean and safe.

The costs associated with a hospital response to any disaster can be enormous and potentially become the "disaster within the disaster." This is especially true if documentation is not collected properly and submitted within deadlines set by the local, state, and federal government. From the outset of the response, the Finance/Administration Section has the responsibility to track the various costs associated with the hospital's response. The primary costs to be closely tracked include personnel, patient care, resources, equipment repair and replacement, and facility operations. The tracking of these costs should be done according to daily practices and/or special procedures as outlined in the EOP.

In some cases, normal reimbursement methods will be used and third-party insurance companies invoiced for all the patient care services rendered. However, in some situations involving state or federally declared disasters, hospitals may be eligible to recover additional response monies not otherwise being reimbursed. To be considered for reimbursement, hospitals will have to submit special applications that require detailed explanations and accurate

records. Thus, hospitals should be familiar with what forms must be used, the degree of detail required, to whom the completed forms must be sent, and reporting deadlines. Ideally, this knowledge should be obtained prior to an incident to best ensure that all recordkeeping will optimize the chance for restitution to be made.

Normally, hospitals enjoy the trust of the communities they serve. However, this trust may be shaken when the hospital's performance during a disaster is not up to public expectation. In addition, there may be concerns about a hospital's capability for providing patient care if there has been noticeable damage or if the cleanliness and safety of the facility has been compromised by the perceived presence of a hazardous material or dangerous pathogen. It is important that the hospital remain responsive to these issues and through the Public Information Officer and others in the hospital, be proactive to allay fears and, if necessary, rebuild the public trust.

6.13 Response Evaluation and Organizational Learning

During an incident all personnel will be occupied with performing their assigned roles. One of the most important Recovery activities will be capturing what lessons were learned from these individual and collective response efforts. Several strategies will be needed for codifying this information.

During the incident, at times determined by the Incident Commander or individual Command Staff, a quick "time out" can be taken to quickly assess what is going well and what is not. On the basis of the information being shared, adjustments can be made to the command structure or the policy and procedures being used. Any formal changes being made must be then transmitted to other hospital personnel and external agencies as necessary.

Following the termination of the response, a series of debriefing meetings or "hot washes" should be held at various levels to provide those attending with the chance to hear what happened and share an opinion on what worked well and what needs to be changed. These comments should be formally recorded and reflected as part of the After Action Report (AAR) process for the incident. The format for the AAR process should be decided and a principal author(s) assigned to write a draft report for submission to the Emergency Management Committee and other groups identified by the Incident Commander or hospital administrator. After a final draft with accompanying improvement recommend-ations is approved, the emergency preparedness committee should make the needed revisions in the Emergency Operations Plan or annex and ensure the staff receives needed training on the changes.

Hospitals should also be prepared to participate in the community AAR process, which may include conducting both closed meetings and public hearings. These meetings may be among single disciplines (e.g., meetings involving just the hospitals or the healthcare community) or more widely inclusive of all the response community at the local, state, and federal levels. It is important for hospitals to regularly participate in these meetings, not only to share their own

opinions on the response and system improvements, but also to ensure hospital interests are being represented and their needs met.

Depending on the incident, hospitals may be asked to have representatives speak at local, state, or even federal conferences and forums. Making these presentations is an important way for hospitals throughout the rest of the United States to learn from the experience. However, experience has shown that, depending on the situation, the volume of invitations can be daunting and requires careful selection. Developing a standardized presentation will reduce the time requirement and diversify who can make the presentation.

In addition to formal public presentations on the experience, publication in professional journals is another opportunity that can be helpful for the recovery of the author and the education of the readers. The Internet is increasingly being used to disseminate original writings and to host chat rooms to discuss various response-related issues.

GLOSSARY OF TERMS AND ACRONYMS[1]

Terms

Action plans: Written or verbal plans that reflect the overall incident goal (control objectives) and incident strategy, objectives for the designated operational period, specific tactical actions and assignments, and supporting information for the designated operational period. They provide designated personnel with knowledge of the objectives to be achieved and the strategy and steps to be used for achievement, hence improving coordination across different levels of government and intrastate jurisdictional borders. Actions plans not only provide direction, but also provide a metric for measuring achievement of objectives and overall system performance. (*Adapted from SEMS*)[2]

Activate (emergency management definition): To begin the process of mobilizing a response team, or to set in motion an emergency response or recovery plan, process, or procedure for an exercise or for an actual hazard incident.

Activation: A notification category that provides urgent information about an unusual occurrence or threat of occurrence, and orders or recommends that the notified entity activate its emergency response (usually via its emergency operations plan). An activation may be partial (stipulating the components of the EOP to activate, or some other indication of the level of commitment to be made by the notified entity) or full (stipulating full activation of the notified entity's EOP). It usually includes actionable information directing the notified entity on initial actions for mobilization, deployment, and/or response (See "alert" and "advisory" for contrast between the other notification categories).

Advisory: A notification category that provides urgent information about an unusual occurrence or threat of an occurrence, but no activation of the notified entity is ordered or expected at that time. An advisory can be used for notification that something has occurred or is anticipated, and provide actionable information for notified personnel even though the response entity is not being activated. For example, a weather advisory that includes recom-

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[1] This glossary of terms and acronyms is largely based on the Emergency Management Glossary of Terms and Emergency Management Acronyms listings in *Emergency Management Principles and Practices for Healthcare Systems*, by the Institute for Crisis, Disaster, and Risk Management at George Washington University for the Veterans Health Administration. Terminology is defined for the purposes of emergency management education, and therefore uses an emergency response and recovery context. Where appropriate, terminology definitions from NIMS are cited. Definitions not referenced are products of substantive research and development efforts by the authors themselves during the current or prior academic initiatives. References that are recurrently cited have their full citations listed at the end of this document.

[2] Standardized Emergency Management System (SEMS) Guidelines, Part I. System Description Section A (Draft 12/23/94), p. 5, available at:http://www.oes.ca.gov/Operational/OESHome.nsf/a0f8bd0ee918bc3588256bd400532608/b4943535210895448825 6c2a0071e038?OpenDocument, accessed April 24, 2006.

mended actions for individuals. (See “alert” and “activation” for contrast between the other notification categories.)

After Action Report (AAR): The document that describes the incident response and findings related to system response performance (see AAR process).

After Action Report (AAR) process: A focused, post-incident or post-exercise activity to capture objective observations, both positive as well as negative, related to response system performance. Its product is commonly referred to as “lessons learned,” but a comprehensive process goes beyond the collection of “lessons learned” to accomplish objective improvements in procedures, assignments, equipment, training, and personnel to attain true organizational learning. This term “AAR process” is used to describe the activity related to developing and conducting the After-Action Review, including meetings and documentation review and developing the after action report.

Agency: A division of government with a specific function, or a nongovernmental organization (e.g., private contractor, business, etc.) that offers a particular kind of assistance. In ICS, agencies are defined as jurisdictional (having statutory responsibility for incident mitigation) or assisting and/or cooperating (providing resources and/or assistance). (*FIRESCOPE California*) [3]

Agency Representative: A person assigned by a primary, assisting, or cooperating Federal, State, local, or tribal government agency or private entity that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency. (*NIMS*)

Alert: A notification category between “advisory” and “activation” that provides urgent information and indicates that system action may be necessary. An alert can be used for initial notification that incident activation is likely, and for ongoing notification throughout an incident to convey incident information and directed or recommended actions (see “advisory” and “activation” for contrast between the other notification categories).

All-hazards: A descriptor that denotes a specific strategy for managing activities in an emergency management program. Throughout the four phases of EM, management structure, processes and procedures are developed so they are applicable to every significant identified hazard. The remaining hazard specific interventions are layered on top of the basic components as indicated and presented through “incident” annexes in the emergency operations plan (EOP). For example, the procedures for notifying appropriate personnel during EOP activation would use the same process across all hazard types, even though the types of personnel notified and mobilized may vary by hazard.

American Red Cross: The American Red Cross is a humanitarian organization, led by volunteers, that provides relief to victims of disasters and helps people

[3] FIRESCOPE California: Glossary of Terms ICS-010-1 Incident Command System Publication October 15, 1999, available at: http://www.nimsonline.com/firescope_forms/ICS%20010-1.pdf, accessed November 15, 2005.

prevent, prepare for, and respond to emergencies. It does this through services that are consistent with its Congressional Charter and the Principles of the International Red Cross Movement. *(FEMA State and Local Guide 101)*

***Approach, All-Hazards**:* A strategy (see "All-hazards) that addresses the commonalities of incident identification, assessment, and response to natural, technological, and intentional hazards. It provides a common emergency operations plan for use in response to and recovery from all emergencies and disasters.

Area Command (***Unified Area Command***): An organization established (1) to oversee the management of multiple incidents that are each being handled by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command has the responsibility to set overall strategy and priorities, allocate critical resources according to priorities, ensure that incidents are properly managed, and ensure that objectives are met and strategies followed. Area Command becomes Unified Area Command when incidents are multijurisdictional. Area Command may be established at an emergency operations center facility or at some location other than an incident command post. (*NIMS*)

Assessment: The evaluation and interpretation of measurements and other information to provide a basis for decision-making. (*NIMS)*

Assignments: Tasks given to resources to perform within a given operational period that are based on operational objectives defined in the Incident Action Plan (IAP). *(NIMS)*

Assistant: Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications, and responsibility subordinate to the primary positions. Assistants may also be assigned to unit leaders. (*NIMS)*

Assumptions (management definition): Statements of conditions accepted as true and that have influence over the development of a system. In emergency management, assumptions provide context, requirements and situational realities that must be addressed in system planning and development, and/or system operations. When these assumptions are extended to specific operations, they may require re-validation for the specific incident.

Branch: The organizational level having functional or geographical responsibility for major aspects of incident operations. A branch is organizationally situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area. *(NIMS)*

Business Continuity Program: An ongoing process supported by senior management and funded to ensure that the necessary steps are taken to identify the impact of potential losses, maintain viable recovery strategies and

recovery plans, and ensure continuity of services through personnel training, plan testing and maintenance. *(NFPA 1600, 2004)*

Capability, Surge: The ability to manage patients requiring unusual or very specialized medical evaluation and care. Surge requirements span the range of specialized medical and health services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed (e.g., pediatric care provided at non-pediatric facilities or burn care services at a non-burn center). Surge capability also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the medical care facility.

Capacity, Surge: The ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations.

Case: A person in the population identified as having a particular disease, health disorder, or condition under investigation *(HHS)*[4]

Casualty: Any human accessing health or medical services, including mental health services and medical forensics/mortuary care (for fatalities), as a result of a hazard impact.

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority. (*NIMS*)

Chief: The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, and Finance/Administration.

Chief Executive Officer: A common title for the senior-most decision maker (other than a board of directors or equivalent) in private and non-governmental organizations.

Command: The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority. (*NIMS*)

Command Staff: In an incident management organization, the Command Staff consists of the Incident Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed. *(NIMS*)

Communications: A focused process that is a narrow but vital component of Information Management, referring only to the method(s) of conveying information.

Communications Unit: An organizational unit in the Logistics Section responsible for providing communication services at an incident or an EOC. A

[4] U.S. Department of Health and Human Services Terrorism and Other Public Health Emergencies: A Reference Guide for the Media Glossary, available at: http://www.hhs.gov/emergency/mediaguide/PDF/#appendices, accessed November 21, 2005.

Communications Unit may also be a facility (e.g., a trailer or mobile van) used to support an Incident Communications Center. *(NIMS)*

Community: A political entity which has the authority to adopt and enforce laws and ordinances for the area under its jurisdiction. In most cases, the community is an incorporated town, city, township, village, or unincorporated area of a county. However, each State defines its own political subdivisions and forms of government. (*FEMA State and Local Guide 101*)

Concept of Operations*:* A description of how components of a system operate in a coordinated manner through successive stages of a response and recovery.

Contamination: The undesirable deposition of a chemical, biological, or radiological material on the surface of structures, areas, objects, or people. *(FEMA State and Local Guide 101)*

Credentialing: Credentialing involves providing documentation that can authenticate and verify the certification and identity of designated incident command staff and emergency responders. This system helps ensure that personnel representing various jurisdictional levels and functional disciplines possess a minimum common level of training, currency, experience, physical and medical fitness, and capability for the incident management or emergency responder position they are tasked to fill. (*NIMS*)[5]

Cyber (or Information) Security: Actions taken for the purpose of reducing information system risk, specifically, reducing the probability that a threat will succeed in exploiting critical Automated Information System infrastructure vulnerabilities using electronic, radio frequency or computer-based means.

Damage Assessment: An appraisal or determination of the effects of the disaster on human, physical, economic, and natural resources. *(NFPA 1600, 2004)*

Decontamination (Decon): The reduction or removal of a chemical, biological, or radiological material from the surface of a structure, area, object, or person. *(FEMA State and Local Guide 101)*

Demobilization: The ICS/IMS phase that begins the transition of Management, Operations, and Support functions and elements from the incident activities back to normal operations or to their baseline standby state as their operational objectives are attained.

Deputy: A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Directors. (*NIMS*)

[5] Credentialing the Nation's Emergency Responders: Working Group Guidelines – Draft Version 1.6 (November 2005), NIMS Integration Center, Federal Emergency Management Agency, Washington D.C.

Disaster *(emergency management application)*: A hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to rapidly & effectively respond. Despite a stepped up capacity and capability (call-back procedures, mutual aid, etc.) and change from routine management methods to an incident command/management process, the outcome is lower than expected compared to a smaller scale or lower magnitude impact (See "emergency" for important contrast between the two terms).
Disaster as a term is not defined in the NIMS Glossary. "Major Disaster" is defined in relation to Stafford Act (*see also*) assistance.

Disaster:
(General) – Accidental or uncontrollable events, actual or threatened, that are concentrated in time and space, in which a society undergoes severe danger and incurs such losses to its members and physical appurtenances that the social structure is disrupted and the fulfillment of all or some of the essential functions of the society is prevented.

(Facility Specific) – Any internal or external emergency incident generated by a force, or an event occurring on or off campus, that endangers the well-being and safety of medical center patients, visitors, staff, property or records. (*VA Emergency Management Guidebook 2005*)

Dispatch: The ordered movement of a resource or resources to an assigned operational mission or an administrative move from one location to another. (*NIMS*)

Division: The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section. (*NIMS*)

Emergency *(emergency management application)*: A Hazard impact causing adverse physical, social, psychological, economic or political effects that challenges the ability to rapidly & effectively respond. It requires a stepped up capacity and capability (call-back procedures, mutual aid, etc.) to meet the expected outcome, and commonly requires change from routine management methods to an incident command/management process in order to achieve the expected outcome (See "disaster" for important contrast between the two terms).

Emergency: Absent a Presidentially declared emergency, any incident(s), human-caused or natural, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States. (*NIMS*)

Emergency Assistance: Assistance which may be made available under an emergency declaration. In general, Federal support to State and local efforts to save lives, protect property and public health and safety, and lessen or avert the threat of a catastrophe. Federal emergency assistance may take the form of coordinating all disaster relief assistance (including voluntary assistance) provided by Federal agencies, private organizations, and State and local governments. Or , the Federal government may provide technical and advisory assistance to affected State and local governments for: the performance of essential community services; issuance of warnings of risks or hazards; public health and safety information, including dissemination of such information; provision of health and safety measures; management, control, and reduction of immediate threats to public health and safety; debris removal; temporary housing; and distribution of medicine, food, and other consumable supplies. (*Stafford Act*)

Emergency Management: Organized analysis, planning, decision making, and assignment of available resources to mitigate (lessen the effect of or prevent) prepare for, respond to, and recover from the effects of all hazards. The goal of emergency management is to save lives, prevent injuries, and protect property and the environment if an emergency occurs. (*FEMA 1995, I-6*).[6]

Emergency Management Assistance Compact (EMAC): A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement. *(EMAC web site)*[7]

Emergency Management Committee (EMC): A committee established by an organization that has the responsibility for Emergency Management Program (EMP) oversight within the organization. As such, the committee would normally have the responsibility to ensure the overall preparation, implementation, evaluation and currency of the EMP. (*Adapted from the VHA Emergency Management Guidebook 2005*)

Emergency Management Program (EMP): A program that implements the organization's mission, vision, management framework, and strategic goals and objectives related to emergencies and disasters. It uses a comprehensive approach to emergency management as a conceptual framework, combining mitigation, preparedness, response, and recovery into a fully integrated set of activities. The "program" applies to all departments and organizational units within the organization that have roles in responding to a potential emergency. *(Adapted from NFPA 1600, 2004 and the VHA Guidebook, 2004)*

Emergency Operations Center (EOC):

- The physical location at which the coordination of information and resources to support domestic incident management activities normally takes place.

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[6] FEMA. Introduction to Emergency Management (1995). Emergency Management Institute, Emmitsburg, MD.

[7] Emergency Management Assistance Compact, available at: http://www.emacweb.org/, accessed February 16, 2006.

An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, county, city, tribal), or some combination thereof. (*NIMS*)

- An emergency operations center (EOC) is a location from which centralized emergency management can be performed during response and recovery. The use of EOCs is a standard practice in emergency management, and is one type of multiagency coordinating entity. Local governments should have designated EOCs. The physical size, staffing, and equipping of a local government EOC will depend on the size and complexity of the local government and the emergency operations it can expect to manage. The level of EOC staffing will also vary with the specific emergency situation. A local government's EOC facility should be capable of serving as the central point for:
  - Coordination of all the jurisdiction's emergency operations.
  - Information gathering and dissemination.
  - Coordination with other local governments and the operational area. *(SEMS)*[8]

Emergency Operations Plan (EOP):

- The "response" plan that an entity (organization, jurisdiction, State, etc.) maintains for responding to any hazard event. It provides action guidance for management and emergency response personnel during the response phase of Comprehensive Emergency Management.
- An all-hazards document that specifies actions to be taken in the event of an emergency or disaster event; identifies authorities, relationships, and the actions to be taken by whom, what, when, and where, based on predetermined assumptions, objectives, and existing capabilities. (*From the FEMA Higher Education Project*)
- The "steady-state" plan maintained by various jurisdictional levels for responding to a wide variety of potential hazards. (*NIMS*)

Emergency Management Phases*:* The time and function-based divisions within comprehensive emergency management: mitigation, preparedness, response, and recovery.

Emergency Preparedness: Activities and measures designed or undertaken to prepare for or minimize the effects of a hazard upon the civilian population, to deal with the immediate emergency conditions which would be created by the hazard, and to effectuate emergency repairs to, or the emergency restoration of, vital utilities and facilities destroyed or damaged by the hazard. (*Stafford Act*)

[8] Standardized Emergency Management System, Section C. Local Government Level, available at:http://www.oes.ca.gov/Operational/OESHome.nsf/0/B4943535210895448825 6C2A0071E038?OpenDocument, accessed November 21, 2005.

Emergency Program Manager (EPM)*:* The person who has the day-to-day responsibility for emergency management programs and activities. The role is one of coordinating all aspects of a jurisdiction's mitigation, preparedness, response, and recovery capabilities. The individual primarily responsible for developing, implementing and maintaining a healthcare organization's emergency management program. The individual who has been specifically charged with the development and coordination of the EMP.

Emergency Services: The preparation for and the carrying out of functions, other than those for which military forces are primarily responsible, to prevent, minimize and repair injury and damage resulting from disasters, together with all other activities necessary or incidental to the preparation for and carrying out of the foregoing functions. These functions include, but are not limited to, fire fighting services, police services, medical and health services, rescue, engineering, warning services, communications, radiological, chemical and other special weapons defense, evacuation of persons from stricken areas, emergency welfare services, emergency transportation, emergency resource management, existing or properly assigned functions of plant protections, temporary restoration of public utility services, emergency sheltering, and other functions related to civilian protection. These functions also include the administration of approved regional, state and federal disaster recovery and assistance programs. (*Arlington County, Virginia, EOP and CEMP*)[9]

Emergency Support Function (ESF): A grouping of government and certain private-sector capabilities into an organizational structure to provide support, resources, and services. *(NRP)*[10] ESF 8 - Health and Medical Services is the principal ESF with which hospitals will coordinate activities.

Entity: A governmental agency or jurisdiction, private or public company, partnership, nonprofit organization, or other organization that has disaster/emergency management and continuity of operations responsibilities. *(NFPA 1600, 2005)*

Essential Functions: Functions required to be performed by statute, Executive Order, or otherwise deemed essential by the heads of principal organizational elements to meet mission requirements. (*VHA Emergency Management Guidebook 2005*)

Evacuation: Organized, phased, and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas. (*NIMS*)

Evaluation *(emergency management application)*: A systematic assessment process that leads to judgments and decisions about plans, programs or

[9] Emergency Operations Plan and Comprehensive Emergency Management Program, Arlington, VA, May 2005, available at: http://www.arlingtonva.us/Departments/EmergencyManagement/pdf/EOP.pdf, accessed April 24, 2006.
[10] National Response Plan (NRP), p. 10., available at www.dhs.gov.

policies *(adapted from Schalock, 2001)*.[11] "Informal" evaluation is also recognized as an ongoing and important activity of an emergency management program. It can be "formalized" by objective documentation of the assessment activity and its findings.

***Event**:* This term has multiple definitions depending upon the context:

- A planned, non-emergency activity. ICS can be used as the management system for a wide range of events, e.g., parades, concerts, or sporting events. (*NIMS*)
- A future activity that will include the activation of an ICS organization *(ICS 300, Unit 4)*
- An event can be used to differentiate "any unusual activity" from an "incident," where an EOP and its response system are activated and ICS is implemented.

Executive: The Executive is the administrator, chief executive officer, or designee of the agency or political subdivision that has responsibility for the incident. The title may also be applied to "executives" from the private and non-governmental sectors (see "chief executive officer"). Executive and "agency administrator" are commonly considered to be synonymous terms. *(Adapted from ICS for Executives)*[12]

***Exposure** (risk & emergency management application)*: The condition of being subjected to a source of risk.

Finance/Administration: The ICS functional area that addresses the financial, administrative, and legal/regulatory issues for the incident management system. It monitors costs related to the incident, and provides accounting, procurement, time recording, cost analyses, and overall fiscal guidance.

First Receivers: Employees at a hospital engaged in decontamination and treatment of victims who have been contaminated by a hazardous substance(s) during an emergency incident. The incident occurs at a site other than the hospital. These employees are a subset of first responders. *(OSHA)*[13] Because the personnel are located remote from the hazardous materials event site and are receiving live victims, their HazMat exposure may be less than that of HazMat first responders at the incident site.

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[11] Schalock, R. L. (2001). Outcome-based Evaluation. New York, Kluwer Academic/Plenum Publishers. p.6.

[12] National Wildfire Coordinating Group. Incident Command System, National Training Curriculum Module 17*:* ICS for Executives Instructor Guide, October 1994: pp.17-5 to 17-7. Available at: http://www.nwcg.gov/pms/forms/ics_cours/ics_courses.htm#I-402, accessed January 20, 2006.

[13] OSHA. Best Practices for Hospital Based First Receivers (2004), Appendix B: Acronyms and Definitions, page B-2, available at: http://www.osha.gov/dts/osta/bestpractices/firstreceivers_hospital.html, accessed February 28, 2006.

Function:

- Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs. (*NIMS*)
- In the Incident Command System, refers to the five major activities (Command, Operations, Plans/Information, Logistics, and Finance/ Administration). The term function is also used when describing the activity involved (e.g., the planning function). Intelligence is not considered a separate function under ICS.

General Staff: A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief. (*NIMS*)

Goal *(emergency management application)*: A description of the end state – where the organization wants to be at the end of the activity, program, or other entity for which the goal was defined.

Group: Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section. (*NIMS*) See "division."

Hazard:

- A potential or actual force, physical condition, or agent with the ability to cause human injury, illness and/or death, and significant damage to property, the environment, critical infrastructure, agriculture and business operations, and other types of harm or loss.
- Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome. (*NIMS*)

Hazard Vulnerability Analysis (HVA)/Assessment: A systematic approach to identifying all hazards that may affect an organization and/or its community, assessing the risk (probability of hazard occurrence and the consequence for the organization) associated with each hazard, and analyzing the findings to create a prioritized comparison of hazard vulnerabilities. The consequence, or "vulnerability," is related to both the impact on organizational function and the likely service demands created by the hazard impact. A hazard vulnerability assessment is the outcome of the HVA process.

Hazardous Material (HazMat): Any material which is explosive, flammable, poisonous, corrosive, reactive, or radioactive (or any combination), and requires special care in handling because of the hazards posed to public health, safety, and/or the environment. (*FIRESCOPE 1994*)

HazMat: The common acronym for "hazardous materials."

HazMat Team: Term used to describe a team of highly skilled professionals who specialize in dealing with hazardous material incidents.

Health Insurance Portability and Accountability Act (HIPAA): Public Law 104-191 (August 21, 1996) addresses many aspects of healthcare practice and medical records. This federal act most notably addresses the privacy of personal health information, and directs the development of specific parameters as to how personal health information may be shared.

Healthcare system: A system that may include one or several healthcare facilities that provides patient evaluation and medical interventions (for illness and injury) and/or preventive medicine/health services (see healthcare facility, see "system").

Homeland Security Presidential Directive-5 (HSPD-5): A Presidential directive issued February 28, 2003 on the subject of "Management of Domestic Incidents." The purpose is to "enhance the ability of the United States to manage domestic incidents by establishing a single, comprehensive national incident management system."[14]

Hospital Command Center (HCC)*:* A designated location in the hospital prepared to convene and coordinate response activities, resources, and information during an emergency or disaster.

Hospital Incident Command System (HICS)*:* The Hospital Incident Command System (HICS) is a management system based on NIMS that consists of a flexible organization structure and time-proven management principles. The system includes defined responsibilities and reporting channels and uses common language to promote internal and external communication and integration with community responders. HICS can be utilized for emergency incidents or for planned events.

Hotwash: A systems performance review that is generally less formal and detailed than the After-Action Report (AAR) meeting, and occurs in close proximity to the end of the incident or exercise. Preparation for a hot wash is commonly less extensive than for an AAR meeting. The results of the hot wash may serve as a starting point for a later, more formal AAR meeting. It should never be considered the endpoint to an after-action report process for an incident or exercise, or replace formal AAR meetings.

Improvement Plan (IP)*:* The Improvement Plan is the means by which the lessons learned from the exercise are turned into concrete, measurable steps that result in improved response capabilities. It specifically details what actions will be taken to address each recommendation presented in the draft AAR, who or what entity will be responsible for taking the action, and the timeline for completion. An initial IP should be developed at the debriefing while all key command staff are together. *(U.S. Department of Homeland Security, Office of*

[14] Available at: http://www.whitehouse.gov/news/releases/2003/12/20031217-6.html, accessed February 16, 2006.

Domestic Preparedness, Homeland Security Exercise and Evaluation Program, Volume II: Exercise Evaluation and Improvement, October 2003)

Incident: (multiple definitions)

- An unexpected occurrence that requires immediate response actions through an ICS organization. (*ICS 300, Unit 4*)
- Activity resulting from an actual or impending hazard impact, that requires action by emergency personnel to prevent or minimize loss of life or damage to property and/or natural resources. For organizations other than public safety agencies, this action is generally beyond the normal everyday actions of the organization. The emergency action is managed through the Incident Command System.
- An occurrence or event, natural or human-caused that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response. (*NIMS*)
- **"**Under the ICS concept, an incident is an occurrence, either human-caused or by natural phenomena, that requires action by emergency service personnel to prevent or minimize loss of life or damage to property and/or natural resources." (FEMA *Disaster Dictionary* 2001, 62-63, citing National Wildfire Coordinating Group, Incident Command System, National Training Curriculum, *ICS Glossary* (*PMS 202, NFES #2432), October 1994*)

Incident Action Plan (IAP):

- An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods. (*NIMS*) See also "Action Plans."
- The document in ICS/IMS that guides the response for that operational period. It contains the overall incident objectives and strategy, general tactical actions and supporting information to enable successful completion of objectives. The IAP may be oral or written. When written, the IAP may have a number of supportive plans and information as attachments (e.g., traffic plan, safety plan, communications plan, and maps). There is only one "incident action plan" at an incident, all other "action plans" are subsets of the IAP and their titles should be qualified accordingly (for example, the water purification action plan).

Incident Command Post (ICP): A facility established close to the incident scene (or elsewhere for a diffuse incident or one with multiple scenes), which serves as a base location for managing "field operations" – all activities within the defined scope of the "incident." Located within the ICP are designated representatives of the major response agencies for that incident, filling designated positions in

the incident management team. The ICP location is designated by the Incident Commander. If the ICP and EOC are co-located in the same building, their personnel and procedures should remain physically separated and functionally distinct.

Incident Command System (***ICS***):

- A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations. (*NIMS*)
- A standardized on-scene emergency management concept specifically designed to allow its users to adopt an integrated organizational structure equal to the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. (*NWCG 1994*)

Incident Commander (***IC***): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. (*NIMS*)

Incident Management System (IMS):

- See Incident Command System. This term is preferred over “Incident Command System” (ICS) by many disciplines involved in emergency response.
- In disaster/emergency management applications, the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to an incident. (*NFPA 1600, 2004)*

Incident Management Team (IMT):

- The IC and appropriate Command and General Staff personnel assigned to the incident. (*NIMS*)
- The management unit that directly manages the incident response, and defines the scope of the “incident.” The IMT provides guidance to responders by establishing Incident-specific goals, strategy and objectives, and oversees the development of incident tactics and tactical strategy by the incident operations chief.

Incident Objectives: Statements of guidance and direction necessary for selecting appropriate strategy(s) and the tactical direction of resources. Incident

objectives are based on realistic expectations of what can be accomplished have been effectively deployed (sic). Incident objectives must be achievable and measurable, yet flexible enough to allow strategic and tactical alternatives. (*NIMS*)

Incident Response: The term used to indicate the management and operational actions conducted to address an impending hazard threat and/or actual hazard impact. It connotes a condition that is larger or more complex than the usual organizational actions, and that is usually accomplished by activating the organization's Emergency Operations Plan. Incident response requires a management system (usually the Incident Command System under NIMS) that is commonly different than everyday management and everyday response, even in an everyday "emergency" organization such as fire or police.

Information Management: The processes of the collection, analysis, formatting and transmission of data and information during an incident.

Joint Information Center (JIC): A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should collocate at the JIC. (*NIMS*)

Joint Information System (JIS): Integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, timely information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; developing, recommending, and executing public information plans and strategies on behalf of the IC; advising the IC concerning public affairs issues that could affect a response effort; and controlling rumors and inaccurate information that could undermine public confidence in the emergency response effort. (*NIMS*)

Jurisdiction: (multiple definitions are used and each is context dependent):

- A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., city, county, tribal, State, or Federal boundary lines) or functional (e.g., law enforcement, public health). (*NIMS*)
- A political subdivision (federal, state, county, parish, and/or municipality) with the responsibility for ensuring public safety, health and welfare within its legal authorities and geographic boundaries.

Liaison *(Verb)*: A form of communication for establishing and maintaining mutual understanding and cooperation. (*NIMS*)

Liaison *(Noun)*: In ICS, it is a position(s) assigned to establish and maintain direct coordination and information exchange with agencies and organizations outside of the specific incident's ICS/IMS structure. (*NIMS*)

Liaison Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies. (*NIMS*)

Life-safety: In emergency response, this indicates safety issues that are important in preventing injury or death for exposed responders or victims during an incident.

Line of Duty Death*:* The death of any hospital personnel while on duty and in the performance of their job or assigned role.

Local Government: A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under State law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal organization, or in Alaska a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. (*HSPD-5 definition*)[15]

Logistics: Providing resources and other services to support incident management. Logistics Section: The [ICS] section responsible for providing facilities, services, and material support for the incident. (*NIMS*)

Management *(general)*: Management consists of decision-making activities undertaken by one or more individuals to direct and coordinate the activities of other people in order to achieve results that could not be accomplished by any one person acting alone. Effective management focuses on group effort, various forms of coordination, and the manner of making decisions. Management is required whenever two or more persons combine their efforts and resources to accomplish a goal that cannot be accomplished by acting alone. Coordination is necessary when the actions of group participants constitute parts of a total task. If one person acts alone to accomplish a task, no coordination may be required; but when that person delegates a part of the task to others, the individual efforts must be coordinated. (*Unknown source*)

Management *(ICS/IMS – noun)*: The IMS/ICS function related to directing and coordinating resources while establishing overall response objectives. Typically objectives are defined in a manner so that they are measurable and achievable within a defined period of time.

Management *(ICS/IMS – verb)*: The act of providing objectives, assigning resources to the objectives and delineating the parameters within which the resources are to achieve the objectives. See “management by objective” and “incident objectives” for NIMS definitions (the term “management” is not explicitly defined in NIMS).

Management by Objective:

- “A management approach that involves a four-step process for achieving the incident goal. The… approach includes the following: establishing overarching objectives; developing and issuing assignments, plans, procedures, and protocols; establishing specific, measurable objectives for various incident management functional activities and directing efforts to

[15] Section 2 (10), Homeland Security Act of 2002, Pub. L. 107-296, 116 Stat. 2135 (2002).

fulfill them, in support of defined strategic objectives; and documenting results to measure performance and facilitate corrective action." (*NIMS*)

- The proactive management strategy in ICS/IMS that directs and coordinates resources across the incident command system/incident management system by:
  1. Setting overall (control) objectives for the incident and objectives for each specific operational period.
  2. Assigning resources to achieve those objectives and to provide support.
  3. Providing plans, procedures and protocols to establish parameters within which assigned resources operate.
  4. Monitor progress towards achieving the incident objectives, reassess and revise the objectives, and revise assignments as indicated.

Mass casualty incident (MCI): A casualty-creating hazard incident in which the available organizational and medical resources (both "first" and "second response"), or their management systems, are severely challenged or become insufficient to adequately meet the medical needs of the affected population. Insufficient management, response, or support capability or capacity can result in increased morbidity and mortality among the impacted population. "Mass casualty" equates to a "disaster," whereas "multiple casualty incident" equates to an "emergency."

Mission: In emergency management, an organization's primary goal and expected control objectives.

Mitigation:

- The phase of Comprehensive Emergency Management that encompasses all activities that reduce or eliminate the probability of a hazard occurrence, or eliminate or reduce the impact from the hazard if it should occur. In comprehensive emergency management, mitigation activities are undertaken during the time period prior to an imminent or actual hazard impact. Once an imminent or actual hazard impact is recognized, subsequent actions are considered response actions and are not called "mitigation" – this avoids the confusion that occurs with the HazMat discipline's use of mitigation, which applies to response actions that reduce the impact of a hazardous materials spill.
- Activities taken to eliminate or reduce the probability of the event, or reduce its severity or consequences, either prior to or following a disaster/emergency. *(NFPA 1600, 2004)*
- The activities designed to reduce or eliminate risks to persons or property or to lessen the actual or potential effects or consequences of an incident. Mitigation measures may be implemented prior to, during, or after an incident. Mitigation measures are often informed by lessons learned from prior incidents. Mitigation involves ongoing actions to reduce exposure to, probability of, or potential loss from hazards. Measures may include zoning and building codes, floodplain buyouts, and analysis of hazard- related data to determine where it is safe to build or locate temporary facilities. Mitigation

can include efforts to educate governments, businesses, and the public on measures they can take to reduce loss and injury. (*NIMS*)

Multiagency Coordination Systems: Multiagency coordination systems provide the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration, and information coordination. The components of multiagency coordination systems include facilities, equipment, emergency operation centers (EOCs), specific multiagency coordination entities, personnel, procedures, and communications. These systems assist agencies and organizations to fully integrate the subsystems of the NIMS. (*NIMS*)

Multiple Casualty Incident: A hazard impact with casualties in which the available organizational and medical resources, or their management systems, are severely challenged. A stepped up capacity and capability beyond the normal "first response," usually involving the use of ICS for expanded management, is required to adequately meet the medical needs of the affected population. "Multiple casualty incident" equate to an "emergency," whereas "Mass casualty" equates to a "disaster."

Mutual Aid: Voluntary aid and assistance by the provision of services and facilities including but not limited to: fire, police, medical and health, communications, transportation, and utilities. Mutual aid is intended to provide adequate resources, facilities, and other support to jurisdictions whenever their own resources prove to be inadequate to cope with a given situation. *(SEMS)*[16] Some authorities differentiate "mutual aid" from "cooperative assistance," where the assisting resources are compensated for their response costs. Other authorities designate this as "compensated mutual aid."

Mutual-Aid Agreement:

- Written agreement between agencies and/or jurisdictions that they will assist one another on request, by furnishing personnel, equipment, and/or expertise in a specified manner. National: Of a nationwide character, including the Federal, State, local, and tribal aspects of governance and polity. (*NIMS*)
- A pre-arranged agreement developed between two or more entities to render assistance to the parties of the agreement. *(NFPA 1600, 2004)*

National Disaster Medical System (NDMS):

- A cooperative, asset-sharing partnership between the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Homeland Security, and the Department of Defense. NDMS provides resources for meeting the continuity of care and mental health services

[16] Standardized Emergency Management System (SEMS) Guidelines, Part I, System Description (Draft 12/23/94), p. 7, available at: http://www.oes.ca.gov/Operational/OESHome.nsf/a0f8bd0ee918bc3588256bd400532608/b4943535210895448825 6c2a0071e038?OpenDocument, accessed April 24, 2006. The draft document became a part of California regulation, and so has remained marked as "draft" even though it has full regulatory effect.

requirements of the Emergency Support Function 8 in the Federal Response Plan. (*NIMS*)

- A federally coordinated initiative to augment the nation's emergency medical response capability by providing medical assets to be used during major disasters or emergencies. NDMS has three major components: Disaster Medical Assistance Teams and Clearing-Staging Units to provide triage, patient stabilization, and austere medical services at a disaster site; an evacuation capability for movement of patients from a disaster area to locations where definitive medical care can be provided; and a voluntary hospital network to provide definitive medical care. NDMS is administered by the Department of Health and Human Services/U.S. Public Health Service, in cooperation with the Department of Defense, the Department of Veterans Affairs, FEMA, State and local governments, and the private sector. (*Facts on the NDMS*)

National Incident Management System (NIMS): A system mandated by HSPD-5 that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private-sector, and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, local, and tribal capabilities, the NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the ICS; multiagency coordination systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources. (*NIMS*)

National Response Plan (NRP): The National Response Plan establishes a comprehensive all-hazards approach to enhance the ability of the United States to manage domestic incidents. The plan incorporates best practices and procedures from incident management disciplines—homeland security, emergency management, law enforcement, firefighting, public works, public health, responder and recovery worker health and safety, emergency medical services, and the private sector—and integrates them into a unified structure. It forms the basis of how the federal government coordinates with state, local, and tribal governments and the private sector during incidents.[17]

Notification: Information distributed to relevant personnel that contains important information regarding an actual or potential hazard impact and the response status of the organization. There are generally three categories of notification: alert, advisory, and activation.

Objectives, Incident: Statements of guidance and direction necessary for selecting appropriate strategy(s) and the tactical direction of resources. Incident

[17] U.S. Department of Homeland Security. National Response Plan, (web introduction), available at: http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml, accessed January 25, 2006.

objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow strategic and tactical alternatives. (*NIMS)*

Occupational Health:

- A professional discipline that focuses on the promotion and maintenance of physical and mental health in the work environment.
- The science of designing, implementing and evaluating comprehensive health and safety programs that maintain and enhance employee health, improve safety and increase productivity in the workplace.[18]

Operational period:

- A designated time interval during incident operations where organizational strategies and tactics are guided by response objectives (operational period objectives) that are specific for that time period.
- A designated time period in which tactical objectives are to be accomplished and re-evaluated. *(ICS 300)*
- The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan. Operational periods can be of various lengths, although usually not over 24 hours. (*NIMS*)

Operations: The IMS/ICS functions that develop and directly implement tactics to achieve the objectives established by Management.

Operations Section: The section responsible for all tactical incident operations. In ICS, it normally includes subordinate branches, divisions, and/or groups. (*NIMS*)

"Out the Door" Evacuation*:* The immediate removal of all occupants from the facility because of imminent or already present danger.

Patient Prioritization Assessment*:* The process of assessing hospital inpatients for early discharge, transfer, or other disposition to free the bed for disaster or more critical patients.

Personal Protective Equipment*:* Examples include protective suits, gloves, foot covering, respiratory protection, hoods, safety glasses, goggles, and face shields. *(OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances)*

Personnel Accountability: The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that ICS principles and processes are functional and that personnel are working within established incident management guidelines. (*NIMS*)

[18] Definition from: Federal Occupational Health, U.S. Department of Health and Human Services, available at: http://www.foh.dhhs.gov/Public/WhatWeDo/OHDefinition.asp, accessed May 16, 2006.

Plan: A plan is a proposed or intended method of getting from one set of circumstances to another. A plan provides guidelines and/or directives on moving from the present situation towards the achievement of one or more objectives or goals. The term "Plans" in emergency management has multiple connotations:

- ***Component plans***: of the overall emergency management program (EMP). In comprehensive emergency management, these are the Mitigation Plan, Preparedness Plan, Emergency Operations Plan (i.e., Response Plan), and Recovery Plan.
- ***Incident plans****:* plans developed during incident response (often customized from pre-plans) that guide the response actions and achieve "management by objective.*"*
- ***Planning Section****: (see below)*
- ***Pre-plans***: Guidelines that describe processes and procedures to be followed, plus other response considerations, for specific events and/or for specific geographic locations (stadiums, government facilities, special security events, etc.). These build upon the guidance in the functional annexes, and are included in the incident (i.e., hazard-specific) annexes of the EOP. Most of the guidance and accompanying considerations in the per-plan can be accomplished within the usual EOP construct. The VHA refers to these detailed pre-plans for complex events as "Standard Operating Procedures" ("SOPs").
- ***Preparedness plans***: plans that address the preparedness of organizations for emergency response and recovery; these include a training plan, exercise plan, and others. Developing, documenting and revising/refining response and recovery plans and all their components.
- ***Sub-plans***: Function-specific guidance and tools for use during emergency response and recovery. For example, the mobilization of the decontamination area may be a sub-plan to the Patient Decontamination Plan, which is a function-specific plan that guides hospital personnel in receiving and managing contaminated casualties.
- ***Supporting Plans***: the incident planning documents that support the Incident Action Plan. These include the Safety Plan, the Medical Plan, Communications Plan and others.

Planning, Incident Response: Activities that support the incident management process, including developing the incident action plan and support plans and accomplishing incident information processing. This is in contrast to preparedness planning, which is designed to ready a system for response.

Planning Meeting: A meeting held as needed prior to and throughout the duration of an incident to select specific strategies and tactics for incident control operations and for service and support planning. For larger incidents, the planning meeting is a major element in the development of the Incident Action Plan. (*NIMS*)

Planning Section: Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and

documentation of the Incident Action Plan. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident. (*NIMS*)

Point of Distribution*:* A designated area to distribute medications and vaccinations and provide risk communication and public education information during a public health emergency (can also be used as a site for food and water distribution in non-medical-related disasters).

Position Description: Position description is a written summary of the critical features of an emergency response or recovery job, including the nature of the work performed and the specific duties and responsibilities. It is intended to help assigned personnel understand their specific role and to clarify relationships between positions. The position description is augmented by position qualifications or competencies.

Preparedness:

- The phase of Comprehensive Emergency Management that encompasses actions designed to build organizational resiliency and/or organizational capacity and capabilities for response to and recovery from disasters and emergencies. *(adapted from the VHA Emergency Management Guidebook, 2005)*
- Activities, programs, and systems developed and implemented prior to a disaster/emergency that are used to support and enhance mitigation of, response to, and recovery from disasters/emergencies. *(NFPA 1600, 2004)*
- The range of deliberate, critical tasks and activities necessary to build, sustain, and improve the operational capability to prevent, protect against, respond to, and recover from domestic incidents. Preparedness is a continuous process. Preparedness involves efforts at all levels of government and between government and private-sector and nongovernmental organizations to identify threats, determine vulnerabilities, and identify required resources. Within the NIMS, preparedness is operationally focused on establishing guidelines, protocols, and standards for planning, training and exercises, personnel qualification and certification, equipment certification, and publication management. (*NIMS*)

Prevention: Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice. (*NIMS*)

Private Sector: Organizations and entities that are not part of any governmental structure. It includes for-profit and not-for-profit organizations, formal and

informal structures, commerce and industry, and private voluntary organizations. (*NIMS*)

Privileging: The process where appropriately credentialed personnel (see credentialing) are accepted into an incident to participate as an assigned resource in the response. This process may include both confirmation of a responder's credentials and a determination that an incident need exists that the responder is qualified to address. Privileging is associated with a separate process, badging, which indicates that a person has been privileged to access a specific incident or to access a specific location.

Probability: The likelihood of a specific outcome, measured by the ratio of specific outcomes to the total number of possible outcomes. Probability is expressed as a number between 0 and 1, with 0 indicating an impossible outcome and 1 indicating an outcome is certain. (*Standards 1995*)

Procedure: A series of specific activities, tasks, steps, decisions, calculations and other processes, that when undertaken in the prescribed sequence produces the described result, product or outcome. "Following" a procedure should produce repeatable results for the same input conditions. In the context of emergency management, procedures are much more tightly defined and specific to a distinct organization than the "process" that the procedure or series of procedures accomplishes.

Process: A process is a defined activity, related to planning and/or implementation, carried out to achieve the objectives of the program. A process commonly encompasses multiple procedures that are linked or coordinated to accomplish the process objectives (see Procedure).

Processes: Systems of operations that incorporate standardized procedures, methodologies, and functions necessary to provide resources effectively and efficiently. These include resource typing, resource ordering and tracking, and coordination. (*NIMS*)

Program (emergency management application): An organized collection of projects, activities and/or individual plans in an established framework that directs them toward a common goal. The term "program" implies that regular, ongoing activities are occurring. This contrasts with the term "plan," which may be a set of guidelines that are inactive until "activated."

Public Health: The art and science that addresses the protection & improvement of community health by organized community effort, including preventive medicine and sanitary & social science, or, simply put: "what we, as a society, do collectively to assure the conditions in which people can be healthy" (*Institute of Medicine: The Future of Public Health – 1988*).

Public health emergency: An occurrence or imminent threat of an illness or health condition that

(1) is believed to be caused by any of the following:

- Bioterrorism

- Appearance of a novel or previously controlled or eradicated infectious agent or biological toxin
- Natural disaster
- Chemical attack or accidental release
- Nuclear attack or accident**; and**

(2) poses a high probability of any of the following harms occurring in a large number of the affected population:

- Death
- Serious or long-term disability
- Widespread exposure to infectious or toxic agent posing significant risk of substantial future harm (*Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities*)

Public Information Officer: A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements. (*NIMS*)

Recovery*:*

- The phase of Comprehensive Emergency Management that encompasses activities and programs implemented during and after response that are designed to return the entity to its usual state or to a "new normal." For response organizations, this includes return-to-readiness activities.
- Activities and programs designed to return conditions to a level that is acceptable to the entity. *(NFPA 1600, 2004)*
- The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private- sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post-incident reporting; and development of initiatives to mitigate the effects of future incidents. (*NIMS*)

Regional Hospital Coordination Center (RHCC)*:* The Regional Hospital Coordination Center is a multi-agency coordination center that provides policy and strategic guidance for hospitals and healthcare centers within a defined region. The RHCC has no jurisdictional authority, and its function and scope is determined by the incident. Functions of the RHCC may include working with local or regional EOCs in the coordination of hospital requests and response within the region and providing guidance on resource allocation and utilization.

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an EOC. (*NIMS*)

Resources, Available: Resources assigned to an incident, checked in, and available for a mission assignment, normally located in a Staging Area. (*NIMS*)

Resource Management: A system for identifying available resources at all jurisdictional levels to enable timely and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management under the NIMS includes mutual-aid agreements; the use of special Federal, State, local, and tribal teams; and resource mobilization protocols. (*NIMS*)

Resource management involves four primary tasks:

- establishing systems for describing, inventorying, requesting, and tracking resources;
- activating these systems prior to and during an incident;
- dispatching resources prior to and during an incident; and
- deactivating or recalling resources during or after incidents. (*NIMS*)

Resources Unit: Functional unit within the Planning Section responsible for recording the status of resources committed to the incident. This unit also evaluates resources currently committed to the incident, the effects additional responding resources will have on the incident, and anticipated resource needs. (*NIMS*)

Response:

- The phase of Comprehensive Emergency Management that addresses the immediate and short-term effects of the disaster or emergency. *(Adapted from the VHA Emergency Management Guidebook 2005)* It includes activities immediately before (for an impending threat), during, and after a hazard impact to address the immediate and short-term effects of the disaster or emergency.
- In disaster/emergency management applications, activities designed to address the immediate and short-term effects of the disaster/emergency. *(NFPA 1600, 2004)*
- Activities that address the short-term, direct effects of an incident. Response includes immediate actions to save lives, protect property, and meet basic human needs. Response also includes the execution of emergency operations plans and of mitigation activities designed to limit the loss of life, personal injury, property damage, and other unfavorable outcomes. As indicated by the situation, response activities include applying intelligence and other information to lessen the effects or consequences of an incident; increased security operations; continuing investigations into nature and source of the threat; ongoing public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and specific law enforcement operations aimed at preempting, interdicting, or disrupting illegal activity, and apprehending actual perpetrators and bringing them to justice. (*NIMS*)

Risk: The expectation of loss from hazards and their impact. Risk is a function of probability (likelihood) of a hazard occurrence and the impact (consequences)

of a hazard[19] on the target of the risk assessment. It connotes a relationship between the hazard and the target's vulnerability to the hazard. Risk can be addressed by managing probability (through mitigation) and/or managing impact (through mitigation, preparedness, response and recovery).

Risk Communication: The process of providing concise, comprehensible, credible information, as needed to make effective decisions regarding risks. In emergency management/incident response, risk communication is generally considered to be providing a service to those outside of the incident command system, with the goal of influencing behavior.[20]

Risk Management: A management science that employs the findings of the Hazards Vulnerability Analysis process to make strategic and tactical decisions on how risks will be treated – whether deferred, reduced (through mitigation and preparedness activities), transferred, or avoided.[21] Risk management provides the option of accepting certain levels of risk, at least temporarily, that are considered too low for resource allocation. Conversely, it provides the decision option to commit major resources that eliminate or avoid risks that are of such high probability and/or high consequence that they threaten the very existence of an organization. Risk management, which may be considered a subsection of overall emergency management, focuses upon mitigation preparedness activities that prevent and or reduce hazard impacts, and is considered by many to be its own discipline.[22]

Safety: Safety, in the traditional sense, refers to monitoring and reducing the work-place risk of personnel casualties (injuries and deaths) to some acceptable level.

Safety Officer: A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety. Section: The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command. (*NIMS*)

Section*:* The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/ Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command. *(NIMS)*

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[19] Adapted from - Ansell, J. and F. Wharton. 1992. *Risk: Analysis, Assessment, and Management*. John Wiley & Sons. Chichester. p. 100.
[20] Adapted from: Baruch Fischhoff. Risk Perception and Risk Communication. prepared for D. Kamien (ed) The McGraw-Hill Handbook of Terrorism, August 11, 2004.
[21] Adapted from Shaw, G, Harrald J. The Identification of the Core Competencies Required of Executive Level Business Crisis and Continuity Managers. *The Electronic Journal of Homeland Security and Emergency Management. Berkeley Electronic Press,.* January 2004.
[22] Carnegie Mellon Software Engineering Institute – Risk Management Web Site, available at: http://www.sei.cmu.edu/risk/main.html, accessed August 10, 2005.

Security: Security in the traditional sense refers to monitoring and reducing the risk of human induced events that adversely affect people or property (intrusion of unauthorized personnel, theft, sabotage, assault, etc.), to some acceptable level.

Situation Analysis: The process of evaluating the severity and consequences of an incident and communicating the results. *(NFPA 1600, 2004)*

Situation assessment: An assessment produced during emergency response and recovery that combines incident geography/topography, weather, hazard, hazard impact, and resource data to provide a balanced knowledge base for decision-making. Adequate situation assessment and dissemination of a comprehensive situation assessment (through situation reports and other means) creates the "common operating picture."

Situation report (SITREP): A document that is developed and distributed during response as a means for disseminating a current situation assessment.

Span of Control: The number of individuals a supervisor is responsible for, usually expressed as the ratio of supervisors to individuals. (Under the NIMS, an appropriate span of control is between 1:3 and 1:7.) (*NIMS*)

Stafford Act: 1) The Robert T. Stafford Disaster Relief and Emergency Assistance Act, Public Law 93-288, as amended. 2) The Stafford Act provides an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage which result from disaster. The President, in response to a State Governor's request, may declare an "emergency" or "major disaster" in order to provide Federal assistance under the Act. The President, in Executive Order 12148, delegated all functions, except those in Sections 301, 401, and 409, to the Director, of FEMA. The Act provides for the appointment of a Federal Coordinating Officer who will operate in the designated area with a State Coordinating Officer for the purpose of coordinating state and local disaster assistance efforts with those of the Federal Government. (*44 CFR 206.2*)

Staging Area: Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas [where assets assigned to operations are staged]. (*NIMS*)

Strategic: Strategic elements of incident management are characterized by continuous long-term, high-level planning by organizations headed by elected or other senior officials. These elements involve the adoption of long-range goals and objectives, the setting of priorities; the establishment of budgets and other fiscal decisions, policy development, and the application of measures of performance or effectiveness. (*NIMS*)

Strategy:

- The general direction selected to accomplish incident objectives set by the IC. (*NIMS*)
- The approach to how a goal and objectives are to be achieved.

Surge capability: See "Capability, Surge."

Surge capacity: See "Capacity, Surge."

Surge, Medical*:* Describes the ability to provide adequate medical evaluation and care in events that severely challenge or exceed the normal medical infrastructure of an affected community (through numbers and/or types of patients). See "Capacity, Surge" and "Capability, Surge."

System: A clearly defined functional structure, with defined processes, that coordinates disparate parts to accomplish a common goal.

System Recovery*:* The return of a system to a normal condition.

Tactics: Tactics in incident management are specific actions, sequence of actions, procedures, tasks, assignments and schedules used to fulfill strategy and achieve objectives.

Task: A clearly defined and measurable activity accomplished by organizations or some subset thereof (sections, functions, teams, individuals and others). It is the lowest behavioral level in a job or unit that is performed for its own sake.

Task Force: Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader. (*NIMS*)

Team *(emergency management)*: A nonspecific term for a group of personnel who work as a unit (with some incorporated leadership structure) to accomplish assigned tasks within incident management. The term may also be used as a shortened meaning for "strike team" (see "strike team")

Terrorism:

- Under the Homeland Security Act of 2002, terrorism is defined as activity that involves an act dangerous to human life or potentially destructive of critical infrastructure or key resources and is a violation of the criminal laws of the United States or of any State or other subdivision of the United States in which it occurs and is intended to intimidate or coerce the civilian population or influence a government or affect the conduct of a government by mass destruction, assassination, or kidnapping. (*NIMS*)[23]
- "The unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives (FBI). **Domestic** terrorism involves groups or individuals who are based and operate entirely within the United States and U.S. territories without foreign direction and whose acts are directed at elements of the U.S. government or population." (*FEMA 2001)*[24]

[23] Homeland Security Act of 2002, Section 2 (15), Pub. L. 107-296, 116 Stat. 2135 (2002).
[24] FEMA. Guide for All-Hazard Emergency Operations Emergency Operations (1996), addendum Managing the Emergency Consequences of Terrorist Incidents (2001): 6-G-F-3; available at: http://www.fema.gov/pdf/plan/managingemerconseq.pdf, accessed April 23, 2006.

Tools: Those instruments and capabilities that allow for the professional performance of tasks, such as information systems, agreements, doctrine, capabilities, and legislative authorities. (*NIMS*)

Threat:

- An indication of possible violence, harm, or danger. *(NIMS)*
- The possibility of a hazard occurrence; something that has the potential to cause harm.

Unified Command:

- An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single IAP. (*NIMS*)
- This management structure brings together the Incident Managers of all major organizations involved in the incident, to coordinate an effective response while allowing each manager to carry out his/her own jurisdictional or discipline responsibilities. UC links the organizations responding to the incident at the leadership level, and it provides a forum for these entities to make consensus decisions. Under UC, the various jurisdictions and/or agencies and non-government responders may blend together throughout the organization to create an integrated response team. UC may be used whenever multiple jurisdictions or response agencies are involved in a response effort. UC may be established to overcome divisions from:
  - Geographic boundaries;
  - Government levels;
  - Functional and/or statutory responsibilities; or
  - Some combination of the above. (*Adapted from the U.S. Coast Guard*)[25]

Unit: The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

Volunteer*:* Multiple definitions are used, with the issue of payment for services being the factor that is important to differentiate:

- A person agreeing to provide service outside the scope of his/her employer and/or employed position, without additional or specific compensation for this voluntary commitment. This differentiates the “volunteer” from personnel who provide service as part of their job position in an assigned resource. An individual offering or providing this service is a “volunteer” even if the volunteer's time is compensated through his/her usual employer and employment rate.
- In some contexts such as ESAR-VHP, a volunteer is defined as providing service “without pay or remuneration.” (*DHHS/HRSA/ESAR-VHP*)[26]

[25] U.S. Coast Guard Incident Management Handbook; U.S. Coast Guard COMDTPUB P3120.17, April 11, 2001; pp. 8-12, available at: http://www.uscg.mil/hq/nsfweb/download/IMH/IMH-2001.pdf, accessed November 13, 2005.

- For purposes of the NIMS, a volunteer is any individual accepted to perform services by the lead agency, which has authority to accept volunteer services, when the individual performs services without promise, expectation, or receipt of compensation for services performed. See, e.g., 16 U.S.C. 742f© and 29 CFR 553.101. (*NIMS*)

Volunteer:

- ***Federalized volunteer****:* Volunteers who have been pre-approved by the federal government to provide assistance when activated and deployed.
- ***Solicited volunteer***: Volunteers with skills that could address unique or short-supply needs of the disaster response, and are individually requested by the response system (by name or by technical ability) to assist in the effort. They may be affiliated or unaffiliated volunteers.
- ***Unsolicited volunteer****:* Volunteers presenting to help at the disaster scene who were neither recruited nor affiliated with an organization. Also referred to as "nonsolicited volunteers."

Vulnerability: The likelihood of an organization being affected by a hazard, and its susceptibility to the impact and consequences (injury, death, and damage) of the hazard. *(Adapted from the VHA Emergency Management Guidebook 2005*)

Warning: Dissemination of notification message signaling imminent hazard which may include advice on protective measures. See also "alert." *(Adapted from U.N. 1992, 5*). For example, a warning is issued by the National Weather Service to let people know that a severe weather event is already occurring or is imminent, and usually provides direction on protective actions. A "warning" notification for individuals is equivalent to an "activation" notification for response systems.

[26] Healthcare Resources and Service Administration (HRSA/DHHS). Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), available at: http://www.hrsa.gov/bioterrorism/esarvhp/guidelines/, accessed January 29, 2006.

Recurrent Reference Citations

NIMS National Response Plan (NRP): http://www.dhs.gov/dhspublic/interapp/editorial/editorial_0566.xml

Federal Emergency Management Agency, FEMA, Higher Education Project (Appendix: Select Emergency Management-Related Terms and Definitions - 501KB MS Word): http://training.fema.gov/EMIWeb/edu/hazdisusems.asp

Federal Emergency Management Agency, FEMA, State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning: http://www.fema.gov/plan/gaheop.shtm

Department of Veterans Affairs. Emergency Management Program Guidebook. 2005: http://www1.va.gov/emshg/page.cfm?pg=114

NFPA 1600, Standard on Disaster/Emergency Management and Business Continuity Programs 2004 Edition: http://www.nfpa.org/assets/files/pdf/nfpa1600.pdf

Acronyms

A

AAR: After Action Report
ACC: Acute Care Center
ACF: Alternative Care Facilities
ACS: Alternative Care Sites
AHA: American Hospital Association
AHRQ: Agency for Healthcare Research and Quality
ASHE: American Society of Healthcare Engineering

C

CDC: Centers for Disease Control and Prevention
CEO: Chef Executive Officer
CFR: Code of Federal Regulations
COOP: Continuity of Operations

E

EMA: Emergency Management Agency
EMAC: Emergency Management Assistance Compact
EMI: Emergency Management Institute
EMS: Emergency Medical Services
EMSA: Emergency Medical Services Authority
EMP: Emergency Management Program
EMTALA: Emergency Medical Treatment and Active Labor Act
EOC: Emergency Operations Center
EOP: Emergency Operations Plan
EPA: Environmental Protection Agency
ESF: Emergency Support Function.

F

FAC: Family Assistance Center
FEMA: Federal Emergency Management Agency
FMS: Federal Medical Station
FPC: Federal Preparedness Circular

H

HCC: Hospital Command Center
HEICS: Hospital Emergency Incident Command System
HICS: Hospital Incident Command System
HIPAA: Health Insurance Portability and Accountability Act
HRSA: Health Resources and Services Administration
HSPD: Homeland Security Presidential Directive
HVA: Hazard Vulnerability Analysis/Assessment

I

IAP: Incident Action Plan
ICS: Incident Command System
IPG: Incident Planning Guide
IRG: Incident Response Guide
IS: Independent Study
IT/IS: Information Technology/Information Services

J

JAS: Job Action Sheet
JCAHO: Joint Commission on Accreditation of Healthcare Organizations
JIC: Joint Information Center
JIS: Joint Information System

L

LEPCs: Local Emergency Planning Committees

M

MAC: Multi Agency Coordination

N

NDMS: National Disaster Medical System
NEHC: Neighborhood Emergency Health Clinic
NIC: National Incident Management System (NIMS) Integration Center
NIMS: National Incident Management System
NRP: National Response Plan

O

OSHA: Occupational Safety and Health Administration

P

POD: Point of Distribution
PIO: Public Information Officer
PPE: Personal Protective Equipment

R

RHCC: Regional Hospital Coordination Center

S

SARS: Severe Acute Respiratory Syndrome
SEOC: State Emergency Operations Center

V

VA: U.S. Department of Veterans Affairs
VHA: Veterans Health Administration