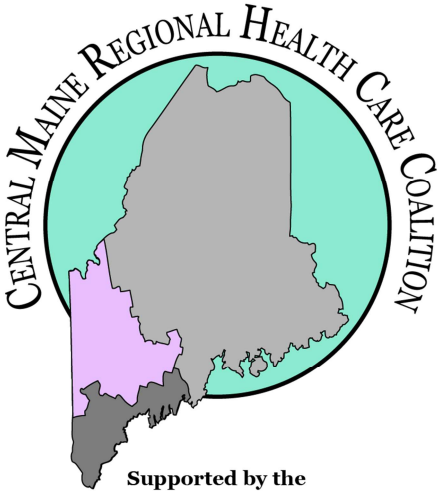


Central Maine Regional Health Care Coalition

All Hazards Emergency Operations Plan

November 2016

Central Maine Regional Resource Center
A Maine CDC Partner

Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Approval and Implementation Document

Central Maine Regional Health Care Coalition
All Hazards Emergency Operations Plan

This Plan is hereby approved for implementation.
This Plan supersedes any and all previous editions.

Date Emergency Operations Plan Approved: April 6, 2016

APPROVAL OF EMERGENCY OPERATIONS PLAN: The Plan is adopted with a review by coalition membership and approval by the Coalition Steering Committee.

Central Maine Regional Health Care Coalition
All Hazards Emergency Operations Plan
Record of Changes to Base Plan

Date of Revision	Recommended Change	Revision Number	Initials
09/22/16	Updated name of coalition to Central Maine Regional Health Care Coalition (CMRHCC), updated Hazards Vulnerability Analysis results, updated name of coalition response team to Health Care Coalition Assistance Team	001	kag

Central Maine Regional Health Care Coalition
All Hazards Emergency Operations Plan
Record of Distribution

To Whom: Person/Title/Agency	Method of Delivery	Date
Coalition Participants	Email, web-site	04/06/2016
Coalition Participants	Email, web-site	11/22/2016

SECTION I BASE PLAN 5

INTRODUCTION **5**
PURPOSE **5**
SCOPE **5**
ROLES AND RESPONSIBILITIES **6**
SITUATION OVERVIEW **9**
MITIGATION OVERVIEW **12**
PLANNING ASSUMPTIONS **12**
CONCEPT OF OPERATIONS **14**
ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES **23**
DIRECTION, CONTROL, AND COORDINATION **27**
INFORMATION COLLECTION AND DISSEMINATION **27**
COMMUNICATIONS **29**
ADMINISTRATION, FINANCE, AND LOGISTICS **29**
PLAN DEVELOPMENT AND MAINTENANCE **30**
AUTHORITIES AND REFERENCES **31**

SECTION II ANNEXES: RECORD OF REVISION 35

FUNCTIONAL ANNEXES **35**
COMMUNICATIONS PLAN 35
MEDICAL SURGE 35
RESPONDER HEALTH AND SAFETY 35
VOLUNTEER MANAGEMENT 35
HAZARD SPECIFIC ANNEXES **35**
EBOLA RESPONSE PLAN ..... **ERROR! BOOKMARK NOT DEFINED.**
SUPPORT ANNEXES **35**

APPENDIX 36

A. LIST OF ACRONYMS **37**
B. HCCAT ICS FORM 207 ..... **39**
C. RESOURCE REQUEST FORM **41**
D. VOLUNTEER REQUEST FORM **46**
E. IMPORTANT CONTACT INFORMATION **57**
F. HELPFUL LINKS **60**

SECTION III. ANNEXES LISTING 61

Section I Base Plan

Introduction

This plan describes the roles and responsibilities of the Central Maine Regional Health Care Coalition (CMRHCC) in responding to a health care emergency primarily within central Maine including the counties of Androscoggin, Franklin, Kennebec, and Oxford. The coalition can further support response in other regions of the state if needed. When effectively implemented, the health care coalition provides the mechanisms for individual health care organizations to coordinate information sharing and other response capabilities using efficient response processes and procedures. Further, this plan describes how key preparedness and response activities are coordinated with medical resources, health care services and other preparedness and response partners.

Purpose

The CMRHCC All Hazards Emergency Operations Plan (EOP) establishes and describes the emergency response framework which will guide the CMRHCC as it activates to protect the health, safety and well-being of Maine residents and visitors in areas impacted by a natural or manmade health emergency or disaster. Functional Annexes describe how the basic emergency functions will be managed. Hazard Specific Annexes describe management functions that are unique to specific hazards.

Scope

The EOP describes how the CMRHCC will respond to disasters that cause severe illness, injury and/or fatalities that affect participating health care organizations and the local jurisdiction, the region, and/or state that may be sufficient to overwhelm health care capabilities. The EOP provides an overview of the CMRHCC and regional partner roles and responsibilities before, during and after emergencies in order to protect and restore the health of residents and visitors of central Maine. Every attempt is made to assure that this EOP is compatible with Federal and State emergency response plans.

Roles and Responsibilities

1. CMRHCC

CMRHCC's primary role and responsibilities include:

- Facilitating information sharing among participating health care organizations and with jurisdictional authorities to promote common situational awareness.
- Facilitating resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members, and supporting the request and receipt of assistance from local, State, and Federal authorities.
- Facilitating the coordination of incident response actions for the participating health care organizations so incident objectives, strategy, and tactics are consistent for the health care response.
- Facilitating the interface between the Health Care Coalition (HCC) and relevant jurisdictional authorities to establish effective support for health care system resiliency and medical surge.

2. Maine Center for Disease Control and Prevention (Maine CDC)

The Maine CDC is the lead state agency responsible for preparing for and responding to public health emergencies resulting from natural disasters that impact the public's health, disease investigations and contact tracing for infectious disease outbreaks and laboratory testing of biological, technological, and chemical terrorism agents.

A. Public Health District Liaisons (includes Tribal Liaisons)

The District and Tribal Liaisons serve as the arm of the Maine CDC at the District and Tribal level. They participate in planning, response and recovery at the district level, coordinating with the Regional Resources Centers (RRCs), county Emergency Management Agencies (EMA) and other local agencies. They facilitate communication between the state and local agencies.

B. Public Health Nursing

Public Health Nurses are responsible for helping to monitor the health status of residents in their regions, diagnosing and investigating health problems and health hazards, providing medical countermeasure dispensing at Strategic National Stockpile (SNS), Point of Dispensing (POD) sites.

C. Health and Environmental Testing Laboratory (HETL)

The Health and Environmental Testing Laboratory is responsible for rapidly identifying, tracking, and containing outbreaks through isolating, identifying, analyzing and monitoring any biological, chemical, or radiological hazards which are capable of causing harm.

D. Environmental Health

The Division of Environmental Health is responsible for ensuring the safety and security of public drinking water systems, responding to food-borne illnesses, ensuring the safety of radiological devices and materials, environmental toxicology response and monitoring occupational disease reporting.

E. Infectious Disease Epidemiology

The Infectious Disease Epidemiology Program is responsible for containing the spread of infectious diseases, conducting trace investigations and contact investigations, implementing non-pharmaceutical interventions such as isolation and quarantine and expert consultation to members of the public and health care practitioners.

F. Disaster Behavioral Health (DBH)

The Maine CDC Disaster Behavioral Health Response Team is responsible for providing direct mental and behavioral health support and services to victims and response personnel during and after a disaster or emergency. DBHRT also provides mental/behavioral health support to families impacted by a disaster or emergency through the activation of a Family Assistance Centers (FAC), which are managed jointly with the American Red Cross, Medical Examiners, religious leaders and others to help families during times of crisis.

G. Volunteer Management

The volunteer management program provides the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support health care organizations with medical preparedness and response to incidents and events.

3. Central Maine Regional Resource Center (CMRRC)

CMRRC is responsible for coordinating and leading the CMRHCC in planning for, responding to and recovering from a regional health care disaster. The CMRRC is the primary hub for facilitating regional HCC response and recovery operations including facilitating communications, providing medical surge support, coordinating regional medical equipment and supplies, and providing and receiving health care situational awareness and information with the Maine CDC during a disaster or emergency.

4. County Emergency Management Agencies (CEMAs)

Local emergency management activities are coordinated regionally by EMAs, as applicable, in the CMRHCC's four counties. County Directors provide support to cities and towns in Androscoggin, Franklin, Kennebec, and Oxford Counties as well as leadership in preparedness, response, recovery and mitigation to their local business and volunteer partners. CEMAs are integral in providing mutual aid and support to CMRHCC with deploying resources during an emergency.

5. Maine Emergency Management Agency (MEMA)

MEMA is responsible for coordinating the mitigation (risk reduction) preparedness, response and recovery from emergencies and disasters such as floods, hurricanes, earthquakes or hazardous materials spills. MEMA also provides guidance and assistance to county and local governments, businesses and nonprofit organizations in their efforts to provide protection to citizens and property, and increase resiliency in the face of disaster. MEMA uses strategies such as planning, training, exercise and public education to carry out its mission.

6. Office of the Chief Medical Examiner (OCME)

The OCME is responsible for the investigation of sudden, unexpected and violent deaths resulting from mass fatality incidents and for implementing the state's mass fatality plan in accordance with Title 22, Chapter 711, MEDICAL EXAMINER ACT.

7. Hospitals

Hospitals are responsible for providing definitive care to individuals resulting from a disaster or other medical emergency. Hospital emergency operation activities include preparing for medical surge incidents as well as activating and staffing alternative care sites and extended care sites.

8. Federally Qualified Health Centers (FQHC)

Local FQHCs provide outpatient medical surge support to regional health care facilities during disasters or emergencies.

9. Maine Emergency Medical Services (Maine EMS)

Maine EMS is responsible for providing rules, data collection, and treatment protocols for the transporting and non-transporting EMS agencies and pre-hospital care providers. Maine EMS works closely with CMRHCC participating health care organizations, as well as Emergency Medical Dispatchers, on pre-hospital treatment and transport, medical surge, and mass casualty response operations.

10. Long-term Care/Assisted Living/Residential Care

Long-term Care, Assisted Living and Residential Care are all fairly interchangeable terms. One difference being the level of care provided to the residents as medical (ex. Long-term Care) versus nonmedical (ex. Residential Care). Assistance provided during a disaster will vary depending on the level of medical care available at each facility and may range from rapidly accepting transfers of patients from damaged hospitals to serving the needs of the community by supporting community-dwelling elderly that may suffer from disrupted support systems.

11. Home Health

Partner home care agencies provide support to regional health care facilities during disaster or emergencies through the delivery of skilled nursing, therapy and social work services to individuals able to shelter in place within their own homes.

12. Northeastern and Southern Maine Regional Resource Centers

The coordination between the three regional HCCs is integral to forming a common operating picture across the entire state and to providing support to one another. The Northeastern and Southern Maine Regional Resource Centers can facilitate the sharing of information collected from its member organizations and provide support to actions taking place in the central Maine region. Likewise, if an incident were to occur in either other region, the CMRHCC and CMRRC will provide information sharing and assistance as needed.

Situation Overview

Maine is a large, rural state, with a land mass of over 30,800 square miles, making it almost as large as the other 5 New England states combined. Maine has a population of 1.33 million residents and a limited sub-state public health infrastructure. Maine is also home to nearly 16,000,000 overnight visitors annually and nearly 19,000,000 day visitors annually. The majority of this influx of populous occupies the central and southern part of the State. Within Maine's large geographic area and relatively low population are Maine's 39 hospitals (3 are trauma centers) and a broad array of health care providers including 151 FQHCs, other health centers and private practitioners. Maine EMS is regulated by the Maine Bureau of Emergency Medical Services which provides rules, data collection, and treatment protocols for the 273 transporting and non-transporting EMS agencies and the roughly 5,500 pre-hospital care providers.

The geographical area served by CMRHCC includes four Maine counties (Androscoggin, Franklin, Kennebec, and Oxford) and all municipalities within including one additional facility (Bridgton Hospital) in Cumberland County. CMRHCC strives to improve an all-

hazard medical response in the central Maine region through effective communication, planning, coordinated exercises, and collaboration between regional health care organizations, emergency responders, local/regional emergency management directors, public health and other emergency response planners.

In order to protect the health and well-being of the residents of central Maine, it is imperative to identify the potential hazards that pose the greatest risk to the health and well-being of these residents and to assess the current level of mitigation and preparedness for responding to and recovering from those hazards should they occur. The Hazards Vulnerability Analysis (HVA) is the method by which these potential hazards are identified. The hazards identified in the HVA as posing the current greatest risk to the health and well-being of the public will inform CMRHCC in planning, mitigation, response and recovery activities.

CMRHCC updates their regional HVA yearly taking into consideration many factors including corrective actions identified in previous After Action Reports (AARs). The instrument used for the HVA was a modification of the Kaiser Permanente Hospital Hazards Vulnerability Assessment tool. The instrument was modified by Maine CDC Public Health Emergency Preparedness (PHEP) staff making it applicable to a regional health care coalition and public health. The instrument categorizes the hazards into 4 basic categories: natural occurring events, technological events, human-related events, and events involving hazardous materials.

The Definition of Risk is operationalized in the instrument as follows:
Relative Threat = Probability of the event x Severity of the event
Severity = Magnitude – Mitigation

The HVA scores do not measure how well prepared CMRHCC is for each type of event, only the need for such preparation based on the likely probability, the expected severity of the event accounting for the projected magnitude, and the current level of mitigation.

During the April 2016 HVA, CMRHCC identified the following top five hazards for the central Maine region:

1. Cyber Attack
2. Ice Storm
3. Major Hazmat Incident
4. Supply Disruption
5. Heavy Snow, Blizzard (severe weather)

CMRHCC does not prepare specifically for individual hazards, but has adopted an all-hazards approach that focuses on the development of capabilities necessary to respond and recover from to any hazard. The Office of the Assistant of the Assistant Secretary for Preparedness and Response (ASPR) identified eight capabilities as the basis for health care system, Health Care Coalition, and health care organization preparedness. CMRHCC has

adopted the further development of these eight capabilities as their goals to increase regional preparedness to respond to all hazards:

1. **Healthcare System Preparedness**
   Develop, refine or sustain our health care coalition; coordinate health care planning to prepare the health care system for a disaster; identify and prioritize essential health care assets and services; determine gaps in health care preparedness in our region and identify resources for mitigation of the gaps; coordinate training to assist health care responders to develop the necessary skills in order to respond; improve health care response capabilities through coordinated exercise and evaluation; coordinate planning for at-risk individuals and those with special medical needs.

2. **Healthcare System Recovery**
   Develop recovery processes for the health care delivery system; assist health care organizations to implement Continuity of Operations (COOP).

3. **Emergency Operations Coordination**
   Facilitate health care organization multi-agency representation and coordination with emergency operations; assess and notify stakeholders of health care delivery status; support health care response efforts through coordination of resources; demobilize and evaluate health care operations.

4. **Fatality Management**
   Coordinate surges of deaths and human remains at health care organizations with community fatality management operations; coordinate surges of concerned citizens with community agencies responsible for family assistance; coordinate mental/behavioral support at the health care organization level.

5. **Information Sharing**
   Provide health care situational awareness that contributes to the incident common operational picture; develop, refine, sustain, and regularly test redundant, interoperable communication systems.

6. **Medical Surge**
   Assist with the coordination of the health care organization response during incidents that require medical surge through preparedness activities and multi-agency coordination during response; coordinate integrated health care surge operations with pre-hospital Emergency Medical Services; assist health care organizations with surge capacity and capability; develop Crisis Standards of Care guidance; provide assistance to health care organizations regarding plan for evacuation and shelter in place.

7. **Responder Safety and Health**
   Assist health care organizations with additional pharmaceutical protection for health care workers; provide assistance to health care organizations with access to additional Personal Protective Equipment (PPE).

8. Volunteer Management

Participate with volunteer planning processes to determine the need for volunteers in health care organizations; volunteer notification for health care response needs; organization and assignment of volunteers; coordination of the demobilization of volunteers.

Mitigation Overview

Mitigation activities eliminate hazards and/or reduce the effects of hazards that do occur.

Following any actual emergency, disaster, or exercise, the CMRHCC will prepare an AAR documenting the details of the event or exercise, noting actions taken, resources expended, economic and human impact, and the lessons learned as a result of the disaster, specifically what went well, and areas in need of improvement.

As an outgrowth of the AAR, an Incident Improvement Plan will be created identifying the corrective actions to be undertaken to mitigate the impact should the hazard reoccur in the future and plans needing to be updated accordingly. Training exercises will be planned and implemented with stakeholders to test the soundness of selected updated components of the updated plans.

Planning Assumptions

CMRHCC will use the National Incident Management System (NIMS) as a basis for supporting, responding to, and managing activities.

Emergencies, disasters, and planned events such as marathons affecting CMRHCC organizations will be managed at the lowest possible geographic, organizational, and jurisdictional level using the Incident Management System, and will be conducted at the lowest activation level to effectively and efficiently handle the situation. Organizations are encouraged to use NIMS when managing planned events in order to apply structure to the components addressed in NIMS.

Emergencies and disaster events may:

- Require significant communications and information sharing across jurisdictions and between the public and private sectors, as well as media management.
- Involve single or multiple geographic areas.
- Involve multiple varied hazards or threats on a local, regional, state, or national level.

- Involve widespread illness, casualties, fatalities, disruption of life sustaining systems, damage to essential health services and critical infrastructure and other impacts to the environment which will have an impact on statewide economic, physical and social infrastructures.
- Disrupt sanitation services and facilities, result in loss of power and require massing of people in shelters which can increase the potential for disease and injury.
- Produce urgent needs for mental health crisis counseling for victims and emergency responders.
- Overwhelm the capacity and capabilities of local and tribal governments or state agencies.
- Require short-notice asset coordination and response timelines.
- Require collaboration with non-traditional health partners (ex. massage therapist, medical interpreter, dental hygienist, nutritionist, lactation consultant, etc.).
- Require deployment of medical and lay volunteers.
- Require response operations including sustained incident management operations and support activities for an extended period of time as the emergency or disaster situation dictates.
- Require the evacuation of a facility to an alternate care site.
- Require the activation of an alternative care site.
- Disrupt the ability to provide day to day essential services.

This EOP reflects the additional assumptions and considerations below:

- The highest priorities of any incident management system are always life/safety for staff, responders, and the public health and safety of the public.
- Medical standards of care may be adjusted in a major incident or catastrophe where there are scarce resources, such as an influenza pandemic.
- Participating organizations maintain their respective decision-making sovereignty during incident response, except in unusual circumstances that warrant the implementation of local or state health authorities (e.g., enactment of isolation or quarantine).
- Participating organizations determine individually how they will respond to an incident and whether they will activate any emergency response procedures. The Coalition does not supplant this responsibility.
- The HCC response organization may convene (often virtually) representatives from its member organizations to discuss response issues.
- Decisions made by the Coalition during incident response are made on a consensus basis or are recommendations only.
- HCC partners will work together for a common good despite day-to-day competition, especially if a fair platform with transparent decision-making is provided for this functional relationship.
- Support from the administrative leadership of each participating organization can be achieved with proper attention to the design and function of the Coalition.

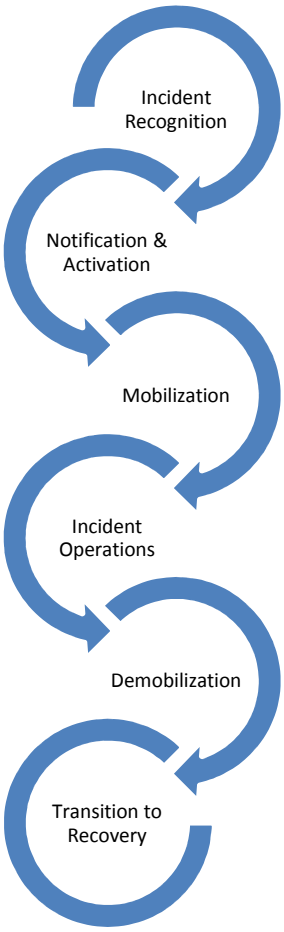
- The use of NIMS-consistent concepts and procedures will promote integration with public sector response efforts; NIMS consistency is also required to be eligible for Federal funding.

Not all emergencies or disasters will require full activation of this plan. The degree of involvement of CMRHCC in a given emergency or disaster event will depend largely upon the impact on the organizations within central Maine. This EOP is intended to be flexible to adapt and conform to the circumstances of a particular situation. Other factors that may also affect the degree of CMRHCC involvement include:

- Requests for assistance.
- The type or location of the incident or event.
- The severity and magnitude of the incident or event.

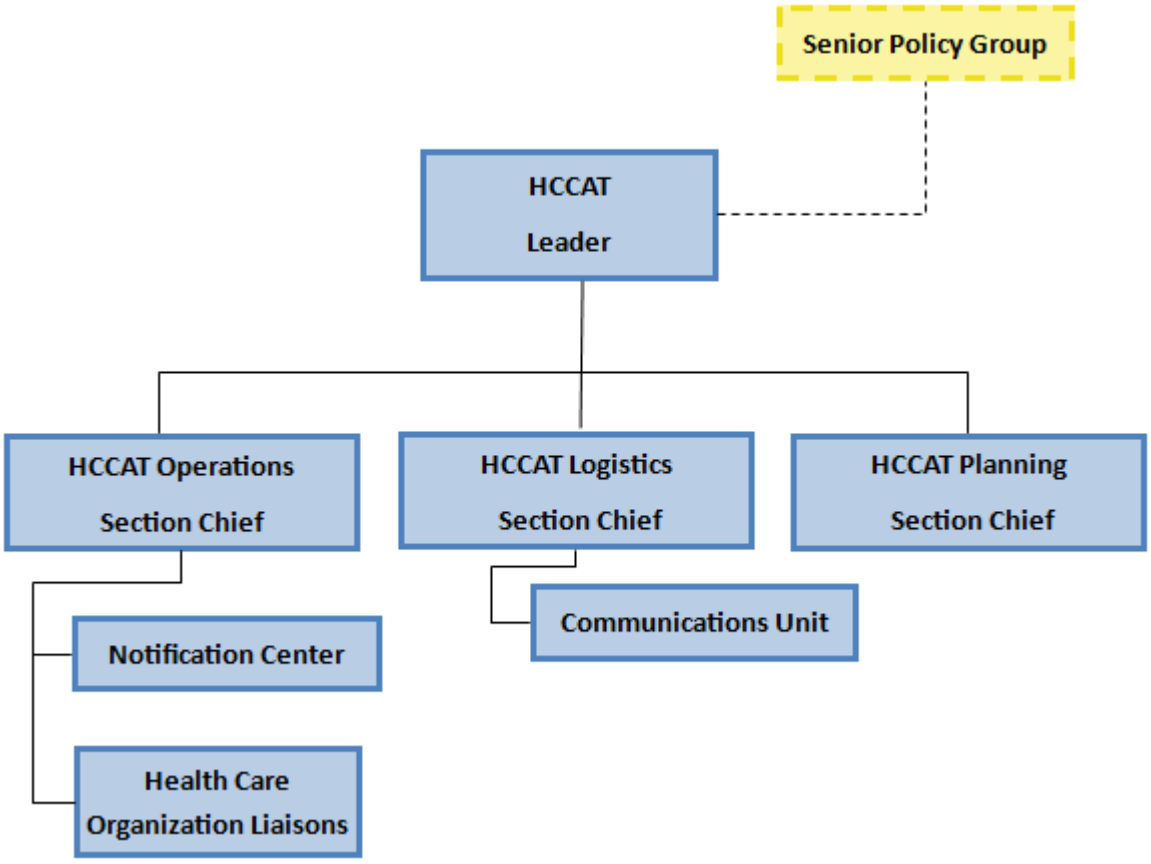
Concept of Operations

The following general stages of emergency response and recovery provide the basis for the Concept of Operations (CONOPS) for CMRHCC and will be used to describe critical actions that CMRHCC will take during an emergency:



Health Care Coalition Assistance Team

ICS-based models have been validated in the management of many types of complex activities under emergency and non-emergency conditions. NIMS does not specify any one structure for managing Multiagency Coordination System (MAC) activities; therefore, the CMRHCC has chosen to manage a complex coalition response with the use of an Health Care Coalition Assistance Team (HCCAT). It is important to understand that using ICS in a MAC does not mean that the EOC-like function (i.e., the HCCAT) is managing the incident itself. The HCCAT supports the incident managers, whether the incident is based regionally or supporting a member organization. Using an ICS-based structure also ensures consistency with NIMS and with the organizing strategy used by most health care organizations for their own EOPs. The Hospital Incident Command System (HICS), which has been adopted by many health care organizations for incident response, is based on ICS. While the ICS-based model employs the traditional Incident Management Team (IMT) structure (see below), the responsibilities and processes addressed in the HCCAT may be somewhat simplified. For example, because the Administration/ Finance Section may have minimal responsibility in a Health care Coalition response, it may be subsumed as a supporting function within the Planning or Logistics Sections (this is consistent with NIMS guidance).



Depending on the level of activation, positions will be filled with members of the CMRRC and volunteers of member organizations that are not directly affected by an emergency, essentially forming a health care specific incident management team. NIMS allows for the expansion and contraction of the IMT structure as the emergency deems necessary. If a Senior Policy Group is required it will be comprised of the members of the current Coalition Steering Committee (CSC) as provided for in the CMRHCC bylaws. In many situations, the HCCAT functions can be performed by a minimal number of staff.

During emergency response, personnel staffing HCCAT are still employed by their "home" organization and often are responsible for some element of their home organization's response. Therefore, HCCAT staffing must be as lean and efficient as possible. This may mean enabling HCCAT staff to conduct response tasks remotely rather than from one centralized location. In addition, personnel from the most affected organizations should be able to rapidly transfer Coalition duties to other qualified personnel.

Stage 1: Incident Recognition

This is the interval when an organization determines whether emergency response actions are needed. The incident recognition process identifies an anomaly (either independently or through communication with others), develops a rapid situation assessment, and determines whether a response by the organization may be necessary. An "incident" exists for the CMRHCC whenever an actual or potential need arises to provide emergency-related support to health care organizations.

The CMRHCC developed the following conditions that are reportable to the Central Maine Regional Resource Center:

- Health care organizations reporting lack of necessary care resources
- Health care organizations reporting high rates of absenteeism for essential staff members to the point that it is impacting normal operations
- National vendors reporting that they are unable to fill supply request/resource request on back order
- Health care organizations reporting lack of surge capacity
- An organizational emergency causing a change in normal operations (ex. diversion)
- An organizational or geographical area emergency causing the need to evacuate or initiate the organization's disaster plan (emergent notification required)

These conditions are discussed in more detail in the **Information Collection and Dissemination** section below.

Stage 2: Initial notification/activation.

Initial notification and activation occur in a relatively simultaneous fashion depending on the urgency required. "Notification" refers to the actions required to inform appropriate organizations within the response system about the onset of an incident or an important change in incident parameters. Notification conveys important details (if available) and

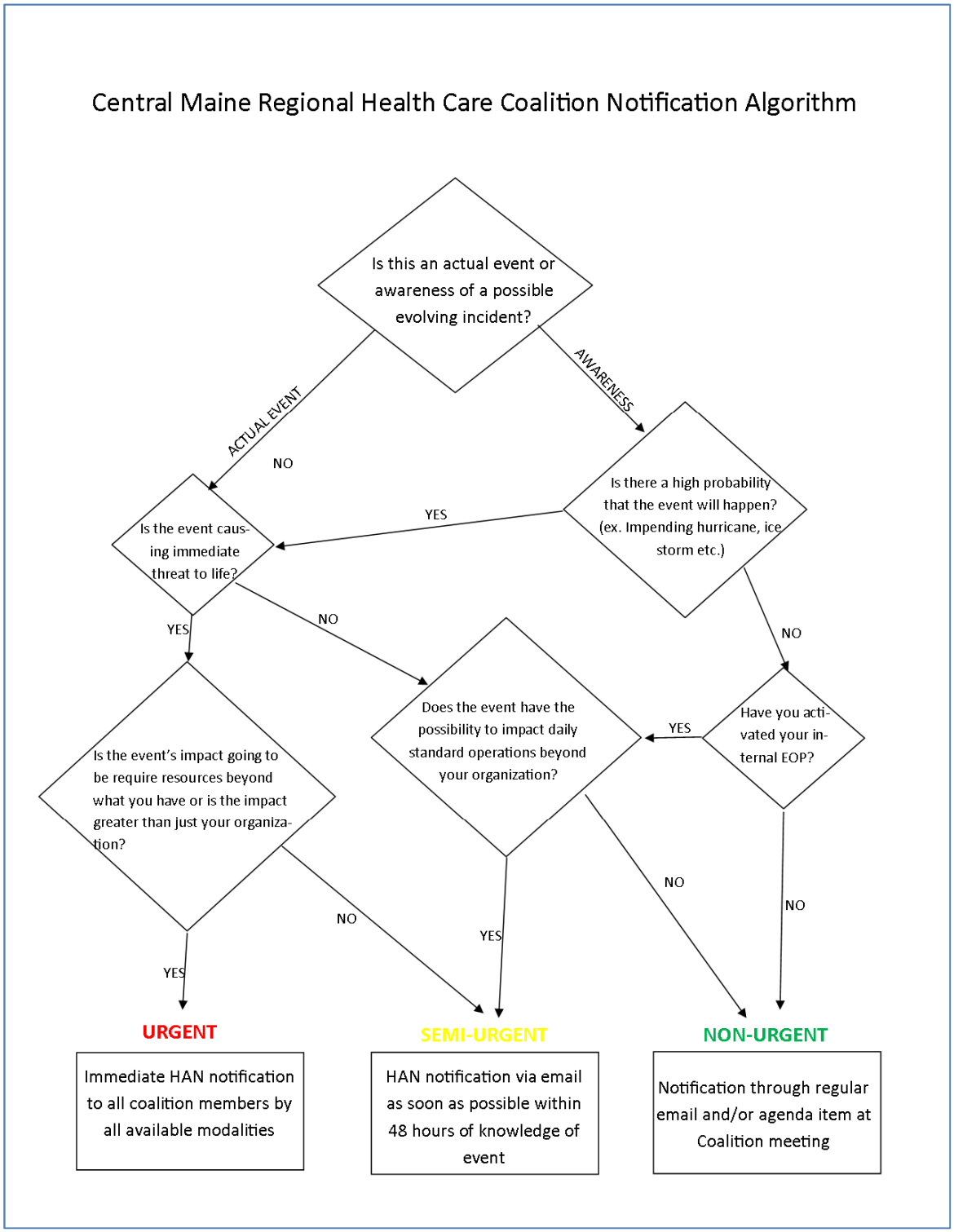
may indicate whether the notified organizations should undertake response actions. An initial notification message accomplishes the following:

- Provides urgent information about a hazard occurrence or threat of a hazard occurrence
- Commonly suggests actionable guidance for the notified entity for protective and initial response actions
- Conveys the activation decision regarding the HCCAT

Notifications can be placed in the following categories:

- **Advisory:** Provides urgent information about an unusual occurrence or threat of an occurrence, but no action by the message recipient is expected. An advisory may include actionable information for individual personnel at Coalition member organizations even though the organizations may not need to take emergency action (e.g., a weather advisory that includes travel precautions for individuals).
- **Alert:** Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. An alert may also be used to notify Coalition member organizations that the HCCAT has been activated. This category may also be used for ongoing notification during an emergency to convey urgent information and recommended actions from the HCCAT or incident command authorities.
- **Update:** Provides non-urgent incident information and suggests no urgent actions. This category is used in both emergency and non-emergency times (e.g., notification of a response action taking place at a member facility that does not require coalition support.)

Based upon what conditions are reported to the CMRRC, the following algorithm will be followed to determine the urgency and modality of notification to CMRHCC member organizations.



"Activation" refers to determining the response level for the system. As applied to the HCC, activation refers to the decision to transition from baseline operations to HCCAT operations with a designated staffing level as described in this EOP. Activation levels may be *partial or full*. It is important to note that an activation order is binding only for personnel designated to staff the HCCAT and does not require (but may request) individual member organizations to activate their emergency response procedures. Each organization determines its response actions independently based on information received through the Coalition and other sources.

Level 3: Monitoring & Assessment	This level is a monitoring and assessment phase where a specific threat, unusual event, or developing situation is actively monitored. Notification will be made to those who will need to take action as part of their everyday responsibilities. Activities will take place during working hours and will primarily be the responsibility of the CMRRC.
Level 2: Partial Activation	Partial activation is typically limited activation of the HCCAT to include the CMRRC staff. Section Chiefs with a role in the incident response are activated and required to report virtually as part of the HCCAT. Notifications will be made to the CMRHCC member organizations via the notification algorithm and conference calls will be scheduled to provide situational awareness.
Level 1: Full Activation	HCCAT member organization volunteers will be notified regarding the HCCAT full activation and a conference call will be established to assign roles and discuss incident objectives.

At Level 3 the Monitoring and Assessment phase, the CMRRC will coordinate with the available members of the CSC to assess the current situation and determine if further action is required including escalating to Level 2 or Level 1.

Stage 3: Mobilization

This refers to the transition of the HCCAT from a state of inactivity or baseline operations to the designated response level. Each Coalition member organization mobilizes its own response (based on its EOP) independent of the HCCAT activation. Coalition members are only required to make available an Organizational Liaison to interface with the HCCAT and this activity may be performed by each member organization's Liaison Officer in their activated IMT. Communications during the mobilization phase can be facilitated by the use of CMRHCC's Incident Command Communications Spreadsheet ICS 205 form located in the MEMBER area (password required) of the following web-site: www.cmrrc.org.

Stage 4: Incident Operations

This stage refers to actions that address the Health Care Coalition's response objectives following activation of the Coalition's EOP (other than mobilization and demobilization).

Actions in this stage may be divided into "initial" (or "immediate") and "on-going" categories.

Managing CMRHCC's Emergency Response

The HCCAT Leader provides oversight and maintenance of the HCCAT. *Even during minimal HCCAT activation, it is mandatory to designate an HCCAT Leader.* It is expected that other traditional ICS Command staff positions will be unassigned during most HCCAT activations. The functions of these unstaffed positions are assumed by the HCCAT Leader.

Important initial management actions include the following:

- Conduct an initial situational assessment.
- Designate the structure of the HCCAT and which positions will be staffed for the emergency. This should be documented and disseminated to Coalition member organizations, jurisdictional authorities, and other relevant response organizations (e.g., regional Health Care Coalitions). This may be accomplished using an HCCAT ICS Form 207 (attached in Appendix B). Because the HCCAT may evolve as the incident progresses, the structure should be updated with each operational period as necessary. This is critical to integrating the HCCAT with other response entities.
- Establish initial objectives for the HCCAT, then develop strategies and assign resources to achieve the objectives. Setting objectives for the HCCAT, even if formal action planning is not conducted, fosters proactive team management and is important for overall response success.

Incident (Control) Objectives*

- Facilitate situational awareness for Health Care Coalition member organizations
- Provide resource support to Coalition member organizations
- Facilitate coordination across participating Coalition organizations
- Facilitate the interface between jurisdictional authorities and Coalition member organizations

Operational Period Objectives**

- Obtain and aggregate initial situation and resource assessments at individual health care organizations
- Obtain initial situation and resource assessment from jurisdictional authorities and regional sources
- Facilitate early, critical requests for assistance from impacted Coalition member organizations
- Obtain initial response strategies used by Coalition member organizations and assess these to identify potential conflicts or gaps

* Incident or control objective is the NIMS term for overall incident response goals and are not limited to any single operational period.
** Operational period objectives are more specific objectives (compared to incident or control objectives) for the organization to accomplish during a specific operational period, contributing towards achieving the incident objectives.

- Address safety issues for the Health Care Coalition. If a Safety Officer is not assigned to the HCCAT, this responsibility falls to the HCCAT Leader. Safety issues for the Coalition include:
    - Safety issues for HCCAT personnel. These will depend on the type of incident, but may include the use of PPE during a contagious disease outbreak, or addressing irregular sleep cycles for staff who are working during a prolonged incident.
    - Safety issues for Coalition member organizations. Collective issues related to response safety for Coalition member organizations should be addressed as well. However, this is typically addressed through the HCCAT Operations Section, if established.

- Address public information issues for the Health Care Coalition. If a traditional Public Information Officer is not assigned to the HCCAT, this responsibility falls to the HCCAT Leader unless it is specifically assigned elsewhere (e.g., to a member of the Senior Policy Group). Public information issues for the Coalition may include:
    - Media inquiries about the Coalition's response during an emergency. It is important to identify an individual who can be interviewed and appropriately answer questions. Care must be taken to limit the message only to the Coalition's activities. The message should not attempt to address the activities occurring at individual health care organizations, unless requested to do so by those assets.
    - Public information consistency across Coalition member organizations. The public message will need to be coordinated across health care organizations, if this is not specifically addressed by the relevant jurisdictional agency. This activity is best accomplished by the HCCAT Operations Section with HCCAT Leader oversight if a PIO is not specifically assigned.

- Conduct liaison activities. Depending on the complexity of the Health Care Coalition and the demands of an incident, a liaison position may or may not be staffed in the HCCAT during incident operations. Liaison activities, however, must still occur. An essential liaison activity is with the jurisdictional agency or regional jurisdictional agencies. The HCCAT should ensure the following:
    - Appropriate information exchange with Maine CDC's Public Health Emergency Operations Center (PHEOC).
    - Effective interface with other regional Health Care Coalitions, as warranted.
    - Interface with other response agencies that may be operating in parallel with the jurisdictional agency that is directly supporting the Health Care Coalition. For example, Federal Law Enforcement may be onsite at health care facilities to identify possible perpetrators among the incident victims. While formal interface should occur through the jurisdictional agency direct liaison with the agency that is operating at the health care organization is beneficial.

Stage 5: Demobilization

In any type of incident, there will come a point when the worst impact has been encountered and consideration should turn to demobilization. This stage addresses the

transition of resources, and eventually the HCCAT itself, from response activities back to baseline operations. The time frame for this activity may vary by situation, but planning for demobilization should actually begin from the outset of the response. The ultimate decision as to when to move from response mode to demobilization will be made by the HCCAT Leader based on achievement of response objectives.

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

- The request for disaster support is declining to a manageable level using normal personnel and resources
- There is no secondary rise in demand for disaster support expected
- Other responders are beginning their demobilization process
- Other critical community infrastructure are returning to normal operations

The HCCAT Leader will not only consult with the IMT but also with external decision-makers, such as other responding agencies and Maine CDC's PHEOC (if activated), before making a final decision to demobilize. As the CMRHCC demobilizes elements from its response organization, a formal notification will be made to CMRHCC's members and the relevant jurisdictional agency(s).

Demobilization plans are prepared to recover and/or relocate excess supplies, equipment and personnel and/or volunteers throughout an event as needed. Following an event, all supplies, equipment will be properly accounted for, recovered and/or reconstituted, and returned in preparation for a subsequent event or incident. When personnel are no longer needed, the HCCAT Planning Section Chief will ensure all staff are accounted for and checked off the log, and have adequate travel arrangements to return home.

Stage 6: Transition to Recovery and Return to Readiness

This stage encompasses the Health Care Coalition's recovery activities and actions that return the Coalition to a state of readiness for the next emergency/event.

<u>Managing the Health Care Coalition through Recovery</u>

There are additional management considerations for the Health Care Coalition as its response to an incident draws to a close, including:

- The HCCAT Leader and the Planning Section Chief (if this position is staffed) should be the last positions to demobilize.
- If the HCCAT needs to support the recovery of member organizations or the jurisdiction, the staffed positions may vary from the HCCAT response configuration. It may be more limited or staffed by different personnel than those who worked during HCCAT emergency operations.
- In addition to incident recovery objectives, the Coalition may find it useful to address mitigation or improvement in its response capabilities during recovery. Funding opportunities often arise after an emergency. The Coalition should be ready

with targeted initiatives that will increase HCCAT resiliency and/or improve its response capabilities.
- The HCCAT may assign personnel to assist with the Coalition's AAR process or other organizational learning activities. When the HCCAT demobilizes, the supervision of the AAR process transitions to the CMRRC.

Resource and Personnel Rehabilitation for the Health Care Coalition

Resources used during emergency response should be rehabilitated to their pre-response state. Rapid return to readiness of key resources should be a primary focus. Facilities used by the Health Care Coalition should be returned to their normal configuration. Durable equipment must be rehabilitated and non-durable supplies should be re-stocked. Information collected and processed by the HCCAT should be appropriately archived.

Rehabilitation for personnel who conducted incident operations for the HCCAT may entail the following:

- Establishing a formal process for "out-processing" personnel and returning any issued equipment (e.g., radios).
- Debriefing personnel as they are out-processed and use their feedback to inform the AAR process.
- Recognizing the efforts of personnel who staffed the HCCAT and consider giving them personal time to recover before returning to their regular duties.
- Conducting performance evaluations for personnel who staffed HCCAT positions during emergency operations.

Reimbursement for Health Care Coalition Response

The primary cost for operating the HCCAT and Senior Policy Group is usually personnel time, which is often donated by the Coalition member organizations. However, it is still important to keep records of personnel time (or other Coalition expenses), since reimbursement mechanisms may be available.

Organization and Assignment of Responsibilities

National Incident Management System & Incident Command System

Through Homeland Security Presidential Directive 5, states must be compliant with the NIMS and the Incident Command System (ICS) when preparing for and responding to domestic incidents.

"The National Incident Management System provides a consistent nationwide template to establish Federal, State, tribal and local governments and private sector and nongovernmental organizations to work together effectively and efficiently to prepare for, prevent, respond to and recover from domestic incidents, regardless of cause, size or complexity, including acts of catastrophic terrorism. NIMS benefits include a unified approach to incident management;

standard command and management structures; and emphasis on preparedness, mutual aid and resource management."[1]

CMRHCC operates under the NIMS/ICS framework which facilitates multidisciplinary and intergovernmental incident management by establishing common processes, terminology, uniform personnel qualifications, and the equipment and communications standards necessary for interoperability and compatibility. The Incident Command System is put forth by NIMS as the model for organizing and managing emergency personnel and resources during incident response. ICS utilizes a defined chain of command, a common language, common management sections, common functional response roles, and management by objectives. ICS provides the framework to create agency emergency plans and can be used regardless of the size of the incident.

Incident Command Staff Roles

Leader (equivalent to Command in traditional ICS)

This function oversees all HCCAT activities. Because there is no inherent "command" authority within the Health Care Coalition and the Coalition does not directly manage the incident, the term "Leader" is more appropriate to describe this function within the HCCAT. Since this function is responsible for all HCCAT activities, it is the one function that must always be staffed for any incident.

Operations Section

Depending on a Coalition's response objectives, the Operations Section of the HCCAT would be responsible for several activities. If response activities are particularly complex for an incident, this Section may be subdivided into branches, divisions, or groups, but this usually will not be necessary. Factors that may influence the branch construct include the number and size of the organizations within the Coalition, and the complexity of the data and information being processed. Example activities for the HCCAT Operations Section include:

Information management: Provide an information "clearinghouse" to promote enhanced situational awareness. The term clearinghouse is used to emphasize that information is collected, aggregated, and transmitted to health care organizations with only transparent processing of the data. All member organizations are treated equally and provided with a common operating picture of the incident. This promotes consistency in decision-making across the organizations.

Resource coordination and support: Facilitate the ability of member organizations to obtain resource support under the time urgency, uncertainty, and logistical constraints of emergency response. It does not preclude the use of day-to-day resource acquisition methods, nor does it supplant the importance of developing resource acquisition and management methods at each health care organization. Rather, it provides a platform for disseminating resources requested

[1] http://www.fema.gov/emergency/nims/nims_faq.shtm

by impacted organizations. In addition, the HCCAT may facilitate communications between requesting organizations and those willing to provide resource support.

Response coordination: Promote comprehensive and consistent incident action planning by Coalition member organizations through the sharing of response objectives, strategies, and major tactics. Task forces may be established to address unusual response issues, such as urgently needed, consensus-based diagnostic or treatment guidelines, patient transfer protocols, tracking of evaluated patients, or other actions.

Community response integration: Facilitate the integration of the health care response into the general community response by promoting exchange of information between member organizations and responding jurisdictional agencies.

During response, the HCCAT Operations Section interfaces with the member organizations through their designated HCCAT Organizational Liaison within the member organization's IMT. This liaison position must be established to ensure efficient and coordinated Coalition response activities. Depending upon how the Coalition is constructed, the Organizational Liaison could be responsible for:

- Receiving information from the HCCAT and acknowledging receipt of the information
- Transmitting information from the HCCAT to decision makers within the organization (e.g., the organization's IMT)
- Supervising the response to requests for information or resource assistance that comes through the HCCAT
- Participating in meetings or teleconferences convened by the HCCAT to bring together health care organizations.

Support Functions

Consistent with the ICS model, the HCCAT may wish to develop the following Sections to support its response operations. Even if a Coalition defines specific positions for HCCAT response functions, it is important to recognize that the positions are only staffed as needed.

Planning Section: Depending upon the complexity of the Health Care Coalition, the Planning Section could perform a number of response activities focused on aggregating incoming data and formatting information reports to return to member organizations. This collated information would be conveyed to jurisdictional authorities. The following responsibilities for the Planning Section are presented for consideration:

- Aggregate, analyze, format, and document relevant incident information in standard reports. For example, the Planning Section may document incident details or the resource status of member organizations, such as available patient beds. The data should be captured in a standardized format and provided to all Coalition member organizations and relevant jurisdictional agency(s).

- Facilitate internal HCCAT meetings. The Planning Section can facilitate meetings or teleconferences for internal HCCAT planning. The purpose, format, and ground rules for each type of meeting should be pre-determined.
- Oversee action planning for the HCCAT: The HCCAT may wish to conduct formal action planning when indicated by incident circumstances. Action planning is well accepted in MAC Systems even though these systems do not command an incident. The Planning Section could be tasked with assembling and completing the action plan for the Health Care Coalition. If created, the HCCAT action plan should be shared with Coalition member organizations and jurisdictional authorities. The plan itself may be shared or it may be discussed in an operations briefing (often conducted virtually) with relevant organizations.

Logistics Section: Per ICS principles, this Section provides logistical support to the HCCAT and is distinguished from support that is provided to Coalition members, which is a function of the HCCAT Operations Section. Because many of the HCCAT's activities during emergency response and recovery can be conducted virtually, the key logistical issue will be supporting the information and communications technology that is used by the HCCAT and its member organizations. For example, the Logistics Section may address a Coalition member organization's difficulty accessing web-based programs or troubleshoot issues with radio equipment. Other types of support that may be performed by the Logistics Section include:

- Staff scheduling for HCCAT positions during prolonged incidents
- Resource support to the HCCAT including facilities, transportation, and other resources
- Services support, such as food and drinks, communications and information technology support, sleeping quarters, etc.

Administration/Finance Section: Per ICS, this Section focuses on administrative and finance support to the HCCAT and is staffed only as needed. This becomes important if there is an expectation for reimbursement for some of the distributed HCCAT activities, such as reimbursing member organizations for employee time devoted to HCCAT positions staffed during an emergency. Other cost tracking may include any expenses assumed by an organization that provides a physical location for HCCAT operations. This Section notes when spending may be approaching limits set by the Coalition Senior Policy Group and brings this to the attention of the HCCAT Leader. This function is expected to be rarely staffed as a separate HCCAT Section.

Roster

As mentioned previously, the HCCAT will be staffed by the CMRRC and volunteers of member organizations that are not directly affected by an emergency essentially forming a health care specific incident management team. Persons that may potentially function in the HCCAT have received a baseline of NIMS training and have a basic understanding of NIMS and ICS. Mobilization of the HCCAT roster will be via the Health Alert Network Central Maine HCCAT group. Local first responders, using local resources, will manage fires, provide law enforcement and security, provide emergency medical services, manage

local public health issues, provide social services, respond to animal control/animal welfare issues, and generally manage the local event situation.

Direction, Control, and Coordination

Direction and Control

In the event of a health care emergency, the primary responsibility of CMRHCC membership is to provide emergency response support locally to their individual organizations. This plan respects the management sovereignty of each organization during incident response and recovery, as well as the inherent governmental authority of Emergency Management, Public Health, Emergency Medical Services, and other relevant public agencies. The primary purpose of the CMRHCC is to promote optimal situational awareness for its member organizations through the collection, aggregation, and dissemination of incident information. This can be facilitated with the use of the HCCAT to coordinate response activities between individual health care organizations, CMRHCC members, and jurisdictional authorities. The HCCAT can also facilitate resource support (mutual aid) between members, as well as assist with the acquisition and distribution of aid from other sources such as the Maine CDC.

Coordination

In any emergency or disaster, health care facilities serve as the "first line of defense" and have the primary responsibility for addressing the immediate health and safety needs of the public. In the event of a response to a major emergency or disaster, a health care facility's command center may be activated according to emergency operations planning protocols. The HCCAT can provide coordination between multiple health care facilities, aggregate the pertinent information and provide it to the appropriate state support agencies, such as the Maine CDC. If the emergency or disaster exceeds the resources of the region, the HCCAT will seek support and coordination from the Maine CDC PHEOC. The Maine CDC PHEOC will coordinate closely with MEMA and other response and recovery partners, and stand ready to provide public health support and assistance as indicated.

Information Collection and Dissemination

This section describes information sharing that will take place between CMRHCC member organizations before, during and after an incident. As mentioned in CONOPS Stage 1, the CMRHCC developed reportable conditions to be provided to the CMRRC. The CMRRC, as well as the HCCAT, if activated, will aggregate individual facility information and provide status reports to the Maine CDC and other jurisdictional partners as needed in order to facilitate regional and/or statewide response decisions. In turn, if Maine CDC or

jurisdictional partners need additional information from CMRHCC member organizations they may request CMRRC or the HCCAT to gather that information of members either through email, phone, conference call, meeting, WebEOC, EMResource, or the Health Alert Network (HAN).

The following table summarizes the type of information collected from health care organizations, the timeframe for reporting the information to the RRC/HCCAT, the method of communication to the RRC/HCCAT, the target audience to receive that information, and finally how the target audience will be notified:

Type of Information Collected	Timeframe for Reporting	Method of Information Collection	Target Audience	Method of Information Dissemination
Health care organizations reporting lack of necessary care resources	Within 8 hours	Email, phone	CMRHCC, Maine CDC if resources cannot be supplied locally	Email, phone
Health care organizations reporting high rates of absenteeism for essential staff members to the point that it is impacting normal operations	Within 48 hours	Email, phone	CMRHCC, Maine CDC if absenteeism is occurring at multiple facilities concurrently	Email, phone, conference call, meeting
National vendors reporting that they are unable to fill supply request / resource request on back order	Within 48 hours	Email, phone	CMRHCC, Maine CDC if resources constraints are occurring at multiple facilities concurrently	Email, phone, conference call, meeting
Health care organizations reporting lack of surge capacity	Within 8 hours	Email, phone	CMRHCC	Email, phone, conference call, meeting, HAN if need is urgent
An organizational emergency causing a change in normal	Within 24 hours	Email, phone	CMRHCC if it will be a prolonged event	Email, phone, conference call, meeting

operations (ex. diversion)				
An organizational or geographical area emergency causing the need to evacuate or initiate the organization's disaster plan	Immediately	Phone	CMRHCC, Maine CDC	HAN notification to all coalition members by all available modalities

Communications

The CMRRC and HCCAT, when activated, will serve as the clearinghouse for information collection and dissemination between health care coalition members when needed. CMRRC/HCCAT will also be responsible for informing and coordinating with Maine CDC regarding situational awareness and coordination of health-related communications with Maine CDC and their State and Federal response and recovery partners, as well as the general public. While most health care coalition members have Public Information Officers within their facilities, CMRRC/HCCAT will attempt to coordinate public messaging between health care coalition members. A conference call will be coordinated between coalition member PIOs and the health care facility suffering the disaster, if it is not a regional disaster, as the lead PIO developing the public message. This will leverage the entire health care coalition to provide a unified and consistent message during a disaster, leveraging communication systems already in place at each facility.

Administration, Finance, and Logistics

Administration

The HCCAT Planning Section Chief is responsible for collecting and compiling event documentation including the Incident Action Plans and all completed ICS forms. These official records serve to document the response and recovery process of CMRHCC and provide an historical record as well as form the basis for cost recovery, identification of insurance needs, and will guide mitigation strategies.

Finance

The primary cost for operating the HCCAT and Senior Policy Group is usually personnel time, which is often donated by the Coalition member organizations. However, it is still

important to keep records of personnel time (or other Coalition expenses), since reimbursement mechanisms may be available.

Logistics

The CMRRC/HCCAT will be the coordination center for health care coalition members to share resources during a disaster. Hospitals in the central Maine region have pre-staged assets detailed in the Inventory Management Tracking System (IMATS). In the event of a disaster health care coalition members can request these assets with the use of the Public Health Resource Request Form ICS 213 RR (http://cmrrc.org/wp-content/uploads/2015/07/ICS-213-PH-Resource-Request-Form-FINAL.pdf). If the request is for volunteers, health care coalition member can submit a request with the use of the Maine CDC Public Health Emergency Preparedness Request for Volunteers (http://cmrrc.org/wp-content/uploads/2015/07/SOP-Request-for-PHEP-Volunteers-FINAL-AUG-2015-2.pdf). When submitted to the CMRRC/HCCAT, the request can be fulfilled by other health care coalition members or forwarded to Maine CDC if no local resources are available. Request forms are included in Appendices C and D, respectively.

Plan Development and Maintenance

This EOP was developed by the members of CMRHCC, written by the CMRRC, and approved by the CSC. The EOP will be reviewed by CMRHCC yearly and revised as needed once an agreed upon version is reached. Lessons learned as they emerge from After Action Report/ Improvement Plans following real events or planned training exercises will be incorporated into the EOP.

Authorities and References

Federal Authorities

Centers for Medicare and Medicaid Services (CMS), Regulations and Guidance. Accessed February 3, 2016 at: http://www.cms.hhs.gov/home/regsguidance.asp.

Centers for Medicare and Medicaid Services (CMS), Emergency Medical Treatment and Labor Act (EMTALA). Accessed February 3, 2016 at: http://www.cms.hhs.gov/emtala/.

Homeland Security Act, Department of Homeland Security Act, 2002

Homeland Security Presidential Directives (HSPD) # 5, Management of Domestic Incidents, Office of the President, 2003

Homeland Security Presidential Directives (HSPD) # 8, National Preparedness Goal, Office of the President, 2003

National Incident Management System, Department of Homeland Security, 2009

National Response Framework, Department of Homeland Security, 2009

U.S. Department of Health and Human Services, Health Insurance Portability and Accountability Act (HIPAA), "Understanding HIPAA Privacy." Accessed February 3, 2016 at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, "Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies." Accessed December 10, 2015 at: http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/executivesummary.aspx.

National Fire Protection Agency Standard 1600, 2007 Edition: Standard on Disaster/Emergency Management and Business Continuity Programs. Accessed February 3, 2016 at: http://www.nfpa.org/assets/files/PDF/NFPA1600.pdf.

State Authority

Legal Authority: Title 22 M.R.S.A. Chapter 250, Subchapter II-A, Extreme Public Health Emergencies

The Maine CDC is the lead state agency responsible for the protection of public health in the event of a public health emergency. Situated within the Maine CDC is the Emergency Public Health Preparedness unit, responsible for development and implementation of public health emergency planning and coordination of public health interventions in the State of Maine. The Maine CDC has broad statutory and regulatory authority, in the event of a public health emergency, to establish and implement procedures to identify persons exposed to communicable, environmental or occupational diseases, or toxic agents, and impose appropriate educational, counseling or treatment programs to prevent the transmission of communicable disease. The Center may designate facilities appropriate for the quarantine, isolation and treatment of persons exposed to or at significant risk of exposure to notifiable conditions, environmental hazards or toxic agents and to initiate court actions to secure involuntary disease control measures if necessary.

The Department may, with the approval of the Attorney General, issue administrative subpoenas to access health information relevant to any public health threat. If necessary to avoid a clear and immediate public health threat, the Department may obtain ex parte orders to place individuals into emergency temporary custody and seek court ordered public health measures to compel individuals to participate in medical examinations, health counseling, treatment, quarantine, isolation, and other public health measures. Quarantine, isolation and treatment of persons exposed or at significant risk of exposure to notifiable conditions, environmental hazards or toxic agents and to initiate court actions to secure involuntary disease control measures if necessary. In this regard, the Department may impose administrative emergency public health orders, exclude infected persons from school, and conduct investigations necessary to address any public health threat. The statutory procedures for the processing of public health measures are established in Title 22 M.R.S.A. Chapter 250, Subchapter II.

In the event the Governor declares an extreme public health emergency, the Department has enhanced powers necessary to collect additional health information from medical providers, pharmacists, and veterinarians and place persons into prescribed care, including involuntary examination, vaccination, treatment, quarantine and isolation. In periods of extreme public health emergency, the Department may impose prescribed care upon individuals without court order if necessary to prevent disease transmission. The statutory procedures for the processing of control measures in periods of declared extreme public health emergency are established in Title 22, Chapter 250, Subchapter II-A.

The Maine Department of Health and Human Services has adopted rules, which establish public health control measures to address public health threats, public health emergencies and extreme public health emergencies. The rules establish procedures governing the Departments' investigation and intervention into potential public health threats. In the event persons are unable or unwilling to cooperate in the Department's disease control programs, the rules establish step-wise interventions depending upon the characteristics of the suspected disease entity and the risk of disease transmission. The interventions available to the Department include counseling, treatment, disease control measures, administrative orders and court ordered examination, treatment and confinement. The rules also establish departmental protocol governing the

investigation and response to outbreaks of communicable disease, epidemic investigation and intervention. In the event the Governor has declared an extreme public health emergency, the Department may also impose additional control measures, including the management of persons, control of property, commandeering of private property to provide emergency health care, the seizure and destruction of contaminated property, and the disposal of human and animal remains.

The Governor may assume direct operational control over all or any part of the civil emergency preparedness or public safety functions of the State and directly, or through the Adjutant General, cooperate with federal agencies and the offices of other states and foreign governments and private agencies in all matters relating to the civil emergency preparedness of the State. Furthermore the Governor may declare a state of emergency and thereby activate a host of extraordinary powers, including the authority to suspend regulatory legislation, direct the evacuation of affected geographical regions, control traffic to and from affected areas, exercise control over private property, enlist the aid of emergency personnel and undertake all other measures necessary to mitigate or respond to the disaster emergency. The Governor's powers in this regard are complimentary to the powers of the Department of Health and Human Services in responding to a public health emergency. It is noteworthy, however, that among the enumerated powers of the Governor in a period of disaster emergency is the power to transfer the direction, personnel, or functions of state government for the purpose of performing or facilitating emergency services. Hence the Governor can effectively exercise all the authority of the Maine DHHS Commissioner in a period of public health emergency.

In order for the Department to exercise the extraordinary public health powers vested in it pursuant to Title 22, chapter. 250, subchapter II-A, the Governor must have declared an extreme public health emergency pursuant to his or her authority under Title 37-B, chapter 13, subchapter 11.

Volunteer Liability Protections

Federal and Maine laws contain protections for individuals from liability for performance of certain emergency management activities. The applicable provisions of the laws are:

1. **Title 37-B M.R.S.A. § 784-A**. This section of Maine law provides that MEMA and local emergency management organizations may employ any person considered "necessary to assist with emergency management activities". The statute states that a health care worker, licensed in Maine, who is designated by MEMA to perform emergency management or health activities in Maine in a declared disaster or civil emergency pursuant to Title 37-B M.R.S.A. §742 is deemed to be an employee of the state for purposes of immunity from liability and workers compensation. Title 37-B M.R.S.A. § 822, provides that any person who is called out pursuant to Section 784-A and while engaged in emergency management activities is not liable for the death or injury to any person, or for damage to any property as a result of such activities. However, a disaster or civil emergency under Title 37-B M.R.S.A. § 742 and 742-A, requires a proclamation by the Governor that such an emergency exists.

2. **Title 22 M.R.S.A. § 816**. This section of Maine law provides immunity to private institutions, their employees and agents from civil liability to the extent provided by the Maine Tort Claims Act for engaging in any prescribed care as defined by the statue in support of the State's response to a declared extreme public health emergency. An extreme public health emergency is defined in Title 22 M.R.S.A. § 2-A and requires a proclamation by the Governor that such an emergency exists.

3. **VOLUNTEER PROTECTION ACT OF 1997**
In 1997 the United States Congress passed the Volunteer Protection Act (VPA). The stated purpose of this Act was to encourage volunteers to continue to volunteer without fear of liability. It established a minimum level of protection that pre-empted state law unless the state provides greater protections under its own laws than the VPA. The VPA also does not apply in a state where the state has enacted a statute expressly declaring the VPA provisions will not apply. Maine has not enacted this type of a statute, so the VPA does apply.

4. **Good Samaritan Law**
In Maine, any person who renders first aid, emergency treatment or rescue assistance voluntarily, without expecting any type of compensation (monetary or otherwise) from the person they assist, is not liable for any damages for injuries sustained by that person or for damages for that person's death because of the aid, treatment, or assistance. An exception to this rule applies if the injuries or death is caused willfully, wantonly, recklessly, or by gross negligence on the part of the person giving the aid, treatment, or assistance.

This law applies to members or employees of nonprofit volunteer or governmental ambulance, rescue or emergency units – whether or not a fee is charged for the services by the nonprofit or governmental entity and whether or not the members or employees receive salaries or other compensation from the nonprofit or governmental entity. The law does not apply if the aid, treatment, or assistance is given on the premises of a hospital or clinic.

References

General References

- ASPR, Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness, January 2012
- CDC, Public Health Preparedness Capabilities: National Standards for State and Local Planning, March, 2011
- FEMA, Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, November 2012
- NACCHO, 2010 PPHR Criteria for Local Health Departments, All Hazards Preparedness Planning, 2012

State Plans

- Connecticut Department of Public Health, Public Health Emergency Response Plan, September 2005
- Florida Emergency Operations Plan, v 2.2, March 2009
- Lane County Oregon, Public Health Services Emergency Operations Plan, Version 1, May, 2008
- Maine Emergency Operations Plan, June 2015
- Minnesota DOH All Hazards Response and Recovery Base Plan, v 2011
- Montana, Department of Public Health and Human Services, Emergency Operations Plan, December 2010
- Wyoming Department of Health, Emergency Operations Plan, revision #3, November, 2010
- Maine CDC, Hazards Vulnerability Analysis Report, May 2, 2012
- MEMA, Maine State Hazard Mitigation Plan, 2010

Section II Annexes: Record of Revision

Functional Annexes	**Date of Revision**	**Revision Number**
Communications Plan	To be developed	
Medical Surge	To be developed	
Responder Health and Safety	To be developed	
Volunteer Management	To be developed	
Hazard Specific Annexes	**Date of Revision**	**Revision Number**
TBD		
Support Annexes	**Date of Revision**	**Revision Number**
TBD		

Appendix

A. List of Acronyms
B. HCCAT ICS Form 207
C. Resource Request Form
D. Volunteer Request Form
E. Important Contact Information
F. Helpful Links

A. List of Acronyms

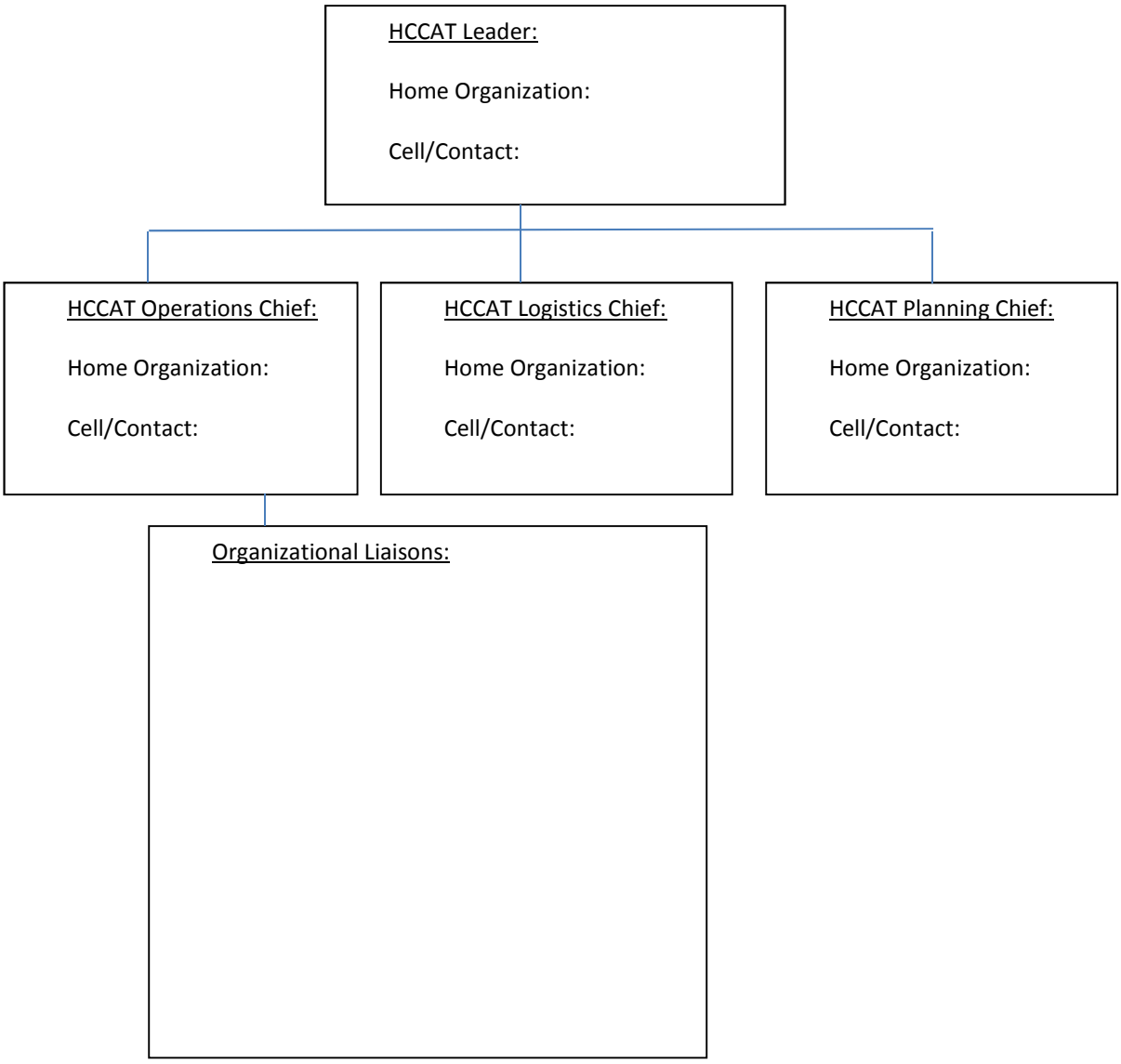
AAR	After Action Report
AHOC	After Hours on Call
AOC	Administrator on Call
ARC	American Red Cross
ASPR	Assistant Secretary for Preparedness and Response
BPH	Bangor Public Health
CBRN	Chemical, Biological, Radiological, Nuclear Threat
CEMA	County Emergency Management Agency
CMRHCC	Central Maine Regional Health Care Coalition
CMRRC	Central Maine Regional Resource Center
CONOPS	Concept of Operations
COOP	Continuity of Operations Plan
CPG	Capabilities Planning Guide
CSC	Coalition Steering Committee
DBH	Disaster Behavioral Health
DEH	Department of Environmental Health
DEP	Department of Environmental Protection
DHHS	Department of Health and Human Services
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DOA	Department of Agriculture
DOE	Department of Education
DOT	Department of Transportation
DLs	District Liaisons
EMA	Emergency Management Agency
EMS	Emergency Medical Service
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EPI	Epidemiology
FAC	Family Assistance Center
FQHC	Federally Qualified Health Center
HAN	Health Alert Network
HAvBED	Hospital Available Beds for Emergencies and Disasters (software)
HCC	Health Care Coalition
HCCAT	Health Care Coalition Assistance Team
HETL	Health and Environmental Testing Laboratory
HICS	Hospital Incident Command System
HVA	Hazard Vulnerability Analysis
IAP	Incident Action Plan
IC	Incident Commander

ICS	Incident Command System
ID	Infectious Disease
IMATS	Inventory Management Tracking System
IMT	Incident Management Team
IZ	Immunizations
JAS	Job Action Sheet
JIC	Joint Information Center
MAA	Mutual Aid Agreement
MAC	Multiagency Coordination System
Maine CDC	Maine Center for Disease Control and Prevention
MEMA	Maine Emergency Management Agency
MENG	Maine National Guard
MFDA	Maine Funeral Directors Association
MOU	Memoranda of Understanding
MPCA	Maine Primary Care Association
MRC	Medical Reserve Corps
NACCHO	National Association of County and City Health Officials
NIMS	National Incident Management System
NNEPCC	Northern New England Poison Control Center
NWS	National Weather Service
OIT	Office of Information Technology
OCME	Office of the Chief Medical Examiner
PIO	Public Information Officer
PHEP	Public Health Emergency Preparedness
PHEOC	Public Health Incident Command Center
PHN	Public Health Nursing
POD	Point of Dispensing
PPE	Personal Protective Equipment
PPH	Portland Public Health
PSC	Planning Section Chief
RAD	Radiation Control
RRC	Regional Resource Center
SME	Subject Matter Expert
SMT	Senior Management Team
SNS	Strategic National Stockpile
SOP	Standard Operation Procedure
WebEOC	Web based incident management software
US CDC	United States Center for Disease Control and Prevention

B. HCCAT ICS Form 207

HCCAT ORGANIZATIONAL CHART		HCCAT 207 REV. 11/16/2016
Use this form to document personnel assigned to positions in the Health Care Coalition Assistance Team (HCCAT). Initial assignments may change and this form should be updated as necessary (even within an operational period).		COMMAND STAFF GENERAL STAFF
1. INCIDENT NAME:	2. DATE/TIME PREPARED:	3. OPERATIONAL PERIOD:

4. ORGANIZATIONAL STRUCTURE:



5. PREPARED BY (print and sign)