

COMMUNITY INTEGRATION

Introduction

Most hospitals are private sector entities that operate independently, either as a single facility or as part of a larger health system. Strong preparedness practices allow a hospital to maximize its capacity to meet surges in patients and continue operations even in the face of incidents that damage utilities and other infrastructure, disrupt supply chains, or otherwise cut off the facility from assistance. However, hospitals should not plan or operate in isolation during an emergency. The effectiveness of a hospital's response to surge incidents, special pathogen outbreaks, and disasters relies heavily on collaboration across the health care system and with community partners to support the entire chain of patient care.

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The hospital emergency manager can help cultivate relationships and planning with health care coalitions and their members, including emergency management agencies, public health departments, emergency medical services (EMS) providers, local fire departments, law enforcement agencies, other health care providers, and community organizations. Like hospitals, each of these partners has its own plans and may have competing responsibilities during an emergency. Collaboration allows the community to leverage the strengths and resources of each partner, understand roles and responsibilities, and identify remaining gaps and weaknesses. This chapter focuses on how hospitals work with partners to boost integrated community planning that improves both hospital readiness and community resilience.

Integration with Community Partners

Health Care Coalitions

A regional health care coalition is a critical asset that can bring together multiple disciplines and coordinate joint planning between multiple hospitals and their community partners in a defined geographic area. Participation in a health care coalition is essential for hospital emergency managers. During steady-state operations, coalitions foster awareness of resources, integrated planning (vetting of key assumptions across disciplines and facilitating joint hazard analysis), sharing and adoption of best practices, enhanced situational awareness, and planning and execution of joint exercises. Coalitions vary significantly in their response roles, but they

traditionally develop a coalition response plan and annexes for specialty care, including pediatric, infectious disease, chemical, radiation, and burn emergencies.

Hospital emergency managers should be well versed in these plans and understand how their coalition integrates with emergency management, public health, and other specific disciplines during an emergency. In addition to their role as a core partner in a health care coalition, hospitals need to have direct relationships with these disciplines and other community-serving organizations not engaged in the coalition to enable integrated planning and response efforts.

Health care coalitions were initially a core requirement of the Hospital Preparedness Program (HPP) cooperative agreement, through which the U.S. Department of Health and Human Services awarded funds to state health departments to be allocated to improve regional health care readiness. Coalitions were envisioned as both planning and response entities with hospitals, EMS, emergency management, and public health as the four core partners, but most include additional health care facilities and partners such as home health and long-term care facilities, public safety agencies, behavioral health providers, and non-governmental organizations. Coalitions tend to be high trust, mutually beneficial organizations that encourage sharing of data and strategies that hospitals might historically be reluctant to share with competitors or regulators. They also encourage relationship building across disciplines and foster joint discussions and planning that save time and produce regionally consistent results.

Emergency Management Agencies

Emergency management agencies have planning responsibilities at the community level that span multiple functional areas and can tie together the diverse efforts of other state, local, territorial, and tribal agencies and private sector organizations for a coordinated response to emergencies. For example, emergency management agencies are responsible for conducting a Threat and Hazard Identification and Risk Assessment (THIRA). In addition to being used as the basis for a risk and gap analysis by hospitals and other planning partners, the THIRA can help the community qualify for federal funding. Given the opportunity to contribute to the THIRA allows hospital emergency managers to build crucial relationships and an understanding of other community resources that may benefit the hospital during a response.

Related Resources

Additional resources are available in ASPR TRACIE's [Hazard Vulnerability/Risk Assessment](#) Topic Collection.

Emergency management agencies are also responsible for ensuring their jurisdiction has plans for various functions and for leading exercises – from discussion-based to full-scale – to test those plans. Scenario-based planning and exercising with local emergency management agencies results in shared assumptions that can aid hospital leadership decision-making during a response. Though legal authorities vary by state, emergency management agencies also have authorities as described later in this chapter that can both provide structure to disaster responses and offer flexibilities that enable hospitals to maximize their resources. Hospital emergency management staff should work with their local emergency management agency to

ensure there is health care sector input into community plans and that health care resources and responsibilities are accurately represented and involved throughout the process.

Public Health Departments

Public health departments also have specific planning and response activities and authorities that can support the health care response to emergencies. They engage in daily activities to encourage healthy behaviors to make the population more resilient and less reliant on the health care system during a disaster. Due to their focus on community health activities, they tend to have established relationships with a wide range of other community serving groups, including those trusted by some of the highest risk members of the community. These relationships can be leveraged when communicating risk, how to stay safe, and when to seek medical care during a disaster, particularly to the hardest to reach populations. Public health agencies usually lead planning efforts for the health and medical response to emergencies. Participating in public health-led training and exercises can help hospital emergency managers better understand available health care capabilities in the community and expected roles and responsibilities. Public health departments also often develop and distribute guidance and best practices, which are particularly valuable to hospitals during public health emergencies.

EMS Agencies

While EMS agencies interact with hospitals every day, they serve four key disaster functions that require coordination and planning:

1. Notification of mass casualty incidents (MCI).
2. Provision of initial triage, treatment, and transport of patients to hospitals based on their condition and location (i.e., primary transport).
3. Transfer of patients to a higher level of medical care (i.e., secondary transfer).
4. Transport of patients to other hospitals/locations during evacuation activities.

Unlike emergency management and public health partners, which are state, local, territorial, and tribal government agencies with specific roles, responsibilities, and authorities, EMS agencies come in various forms. They may be government agencies (sometimes as part of the fire department or another government agency) or private sector companies. They may be volunteer organizations, particularly in rural areas.

EMS providers are not recognized as first responders in all states and their scope of practice may be limited, especially when they are operating outside of their usual jurisdiction. Hospitals routinely work with multiple EMS agencies; it is essential for hospital emergency managers and staff to understand how these interactions may change during disasters and know what capabilities different EMS partners have.

Related Resources

EMS-related resources can be found in ASPR TRACIE's [Pre-Hospital](#) Topic Collection.

Other Community Partners

Beyond the four core health care coalition partners, various other agencies and organizations should be integrated in community disaster planning. Public safety agencies such as fire and law enforcement provide non-medical support that can help hospitals continue to operate during



emergencies. From security and crowd control to decontamination and evacuation support, public safety agencies can offer technical skills and logistical expertise that allow hospital staff to focus on provision of medical care.

Integrated planning with other health care providers in the community can help direct patients and the worried well to appropriate care settings following an MCI or during an infectious disease emergency. While hospitals provide care to the most seriously ill or injured, health clinics, urgent care centers, ambulatory care sites, pharmacies, and private physician practices are other health care providers that could play a role in distributing patients throughout the community by caring for minor injuries, screening patients, prescribing medication or administering vaccines, and educating their usual patient populations on symptoms and risks that may require emergency hospital care. Other community partners – such as dialysis centers, home health agencies, and long-term care facilities – have a role in reducing hospital patient surge by sustaining their operations and continuing to serve their usual clients during disasters. Mental and behavioral health providers play a critical role in helping other health care workers, responders, and the overall community recover from disasters. Whether through the health care coalition or directly, hospital emergency managers should establish relationships with other health care providers in their community to improve understanding of each other’s capabilities and expected roles during emergencies.

Related Resources

Related resources can be found on ASPR TRACIE’s [Engaging Healthcare Partners in Medical Surge](#) Resource Page.

It is also important for hospital emergency managers to know how they will interact with other sectors that have a role in helping hospitals maintain operations during emergencies, particularly utility providers and supply chain vendors. Hospital staff should work with utility providers to understand infrastructure vulnerabilities and redundancies. Hospitals should be prioritized by utility providers for restoration of service and should be notified in advance of any planned outages that may affect hospital services. Similarly, hospital staff should plan with supply chain partners to ensure adequate supplies are available following disasters and during patient surges. This may include developing a standard list of supplies that can be delivered upon request or automatically following specific types of incidents. It also includes understanding commitments utility and supply chain partners have made to other facilities in the region for the same support and resources. The hospital emergency manager should ensure emergency management agency staff are aware of pre-planning between the hospital and its utility and supply chain partners; support from the emergency management agency may be needed to assist these partners in accessing the hospital campus in the event of evacuation orders, road closures, or transportation infrastructure damage.

Related Resources

ASPR TRACIE’s [Utility Failures in Health Care Toolkit](#) and [Partnering with the Healthcare Supply Chain During Disasters](#) provide information to assist hospital emergency managers planning with these sectors.



Finally, hospital emergency managers should consider how to integrate the public in emergency planning.

This could include broad preparedness efforts to

educate community members on where to go and

when for medical care during a disaster. It could also

include targeted preparedness efforts for volunteers, both those who are trained and affiliated with other community partners (e.g., volunteer EMS providers, state defense forces, or Medical Reserve Corps members) and unaffiliated volunteers who come forward during a disaster

because they want to help their community. Hospital emergency managers should be prepared

for volunteers to show up, have pre-identified roles for them if appropriate, have processes to

vet and credential them, and know where to direct them if they cannot be integrated into the

hospital's response efforts. However, hospital plans should also not rely on volunteers who

have no obligation to provide services during an emergency or who may be playing a different

role in the response due to competing professional or volunteer commitments.

Related Resources

Volunteer-related resources can be

found in ASPR TRACIE's [Volunteer](#)

[Management](#) Topic Collection.

As hospital emergency managers engage in integrated planning with their community partners, it is important to remember that some partners (e.g., emergency management and public

health agencies) operate at city, county, regional,

tribal, state, or territorial jurisdictional levels. Health

care coalitions often cross these jurisdictional

boundaries to include multiple hospitals in a given

region, perhaps across state lines. While governmental

EMS agencies may serve a specific jurisdiction, private

and voluntary EMS agencies may operate within

different boundaries. Hospital emergency managers

should be aware of these differing approaches and

priorities and understand which partners, under what

circumstances, and through which processes they

should engage with to obtain information, maintain

communications and situational awareness, request

resources and support, and coordinate response

activities.

From the Field

As an example of these differing boundaries, a hospital may only need to plan with one local emergency management agency, but it may be a member of a health care coalition that includes multiple emergency management agencies. This situation results in some planning being aligned with established patient movement patterns, and other planning being aligned with jurisdictional boundaries and authorities.

[Appendix A: Key Community Partners and Integration with Hospital Emergency Management](#)

includes additional details to aid hospital emergency managers in collaborative planning with partners.

Regulations and Authorities

Jurisdictional emergency management agencies have various statutory responsibilities and

authorities during disasters and public health emergencies. Similarly, state and local health

departments have authorities that may be exercised during incidents that threaten the public's

health. It is important for hospital emergency managers to understand the roles of these



government agencies, what kind of assistance they can provide, and how that assistance can be requested.

The emergency management agency is usually the requestor for a declaration of emergency at the local, state, territorial, or tribal level. State declarations of emergency are often the gateway to engaging additional resources and obtaining state funds – and potentially federal resources (particularly if a Presidential Declaration of Disaster [PDD] is requested and granted) – to support the response.¹ When a declaration of emergency is in force, regulations may be suspended via executive orders and other emergency powers. Local jurisdictions may request relief from state regulations, just as states may request relief from federal regulations. Examples of regulatory relief include relaxing state or federal program requirements, expanding use of telemedicine, enabling the establishment of alternate care sites, and allowing certain health care providers to operate outside of their usual settings or scope of practice. Of particular interest to hospitals are liability protections that may be in place during emergencies.

Related Resources

Additional resources are available in ASPR TRACIE's [Healthcare-Related Disaster Legal/Regulatory/Federal Policy](#) Topic Collection.

Emergency management agencies may also issue evacuation orders, but an evacuation order does not necessarily compel hospitals to evacuate. In some jurisdictions, community resources are devoted to defending hospitals from threats rather than evacuating them. The authority to issue evacuation orders and whether they apply to hospitals should be understood prior to an incident, particularly in areas that are at risk of/experience multiple natural hazards. The decision to evacuate or not should be shared in a coordinated, transparent effort to ensure response partners and members of the community understand what is happening and why.

While the local emergency management agency typically has the authority to lead the response, local and state health departments are also crucial partners in assessing the potential for regulatory relief, assisting with waivers, and requesting declarations or executive orders. When strain conditions require hospitals to provide crisis standards of care, public health departments can help communicate the situation and influence state-level actions such as liability relief for

Related Resources

Health care coalition authorities are almost always based on voluntary and mutual agreement between the participants, with consensus-driven activities. In addition to tailored governance plans, signed memoranda of understanding/agreement may be maintained; hospital leadership should be aware of these plans and agreements and engaged in coalition activities. Additional materials are available on ASPR TRACIE's [Health Care Coalitions](#) Resource Page.

¹ Though services and materials provided by emergency management during a declared emergency are often offered at no or low cost to the hospital, hospitals are generally *not* candidates for receiving Federal Stafford Act funds for response-related expenses after a PDD, though there are exceptions and some states will cover expenses more broadly. Hospitals should track materials used and expenses incurred as well as any facility damage to ensure documentation for potential reimbursable activities.

health care providers implementing allocations in good faith. Health care coalitions can also support joint policy and guideline development (e.g., for allocation of medication or respirators during shortages). There may be political barriers and reluctance to acknowledge crisis conditions and the support needed by health care providers, which only increases the importance of hospitals working with public health departments and the health care coalition to develop joint policies, set expectations, and involve key partners.

Other partners may have authority to lead specific types of responses. For instance, law enforcement agencies will be in command during any active threat situation and fire departments assume command of fire scenes. Additional information about how hospitals should integrate into the overall response structure during an incident can be found in the [Emergency Management Basics and the Emergency Management Cycle](#) and [Practical ICS for Hospitals](#) chapters of this Guidebook.

One potential challenge for hospitals is that emergencies affecting the health care sector are not always regarded as emergencies by the jurisdiction. The health care coalition can be uniquely helpful in these situations, as integration and coordination of resources and information is still needed in the absence of an Emergency Operations Center (EOC) activation. The public health department can also play an instrumental role in information and resource sharing in these situations. The hospital should have redundant processes to obtain help and coordination when there are no jurisdictional declarations of emergency.

From the Field

The health care sector often manages strain conditions or resource shortages without activation of a jurisdictional EOC. For example, during the H1N1 pandemic in 2009, very few EOCs were activated despite public health emergency declarations.

Coordination and Information Sharing

During a response to an emergency, the local emergency management agency usually opens a physical EOC. In addition to resources, the jurisdictional EOC offers critical coordination functions. The EOC is often organized according to the fifteen federal Emergency Support Functions (ESF), with ESF-8 being focused on the public health and medical aspects of the response. The public health department is often the ESF-8 lead agency, though health care coalitions sometimes take on this role. Hospital emergency managers need to know who the ESF-8 lead agency is in their community and how health care interests are being represented.

The EOC maintains situational awareness in the community through information coordination across all affected domains organized under a Joint Information System (JIS) framework. The EOC is a conduit for threat information (e.g., flood crest forecasts, security concerns) that may be of tremendous value to hospitals and their facility-level decision making. Hospitals should maintain an open flow of information with the EOC through the ESF-8 lead agency, including by sharing their Incident Action Plans. Public communication is coordinated via a Joint Information Center (JIC); hospitals should work with other response partners through the JIC to ensure

messaging is integrated, consistent, and realistically reflects the resources available (e.g., a message suggesting anyone potentially exposed to a hazardous material should go to a hospital for evaluation may be well-intended but unnecessary and could overwhelm an already busy hospital). Staff of public health departments are often trained in crafting risk communication messages that can effectively advise the public when to seek medical care and what options are available, thereby reducing the burden on the overall community response.

From the Field

Many hospitals use a web-based system for MCI alerting, but this should *not* be the only alert mechanism. Web-based alerting applications should always be open, monitored, and able to override other content on the user's screen until acknowledged to avoid missing crucial information.

EMS dispatch is often the first agency aware of a potential MCI in the area. In some cases, the incident clearly requires dispatch of multiple ambulances and notification of area hospitals. In other cases, initial information is unclear, and awareness is delayed until arrival of EMS providers on scene. Hospitals should have agreements with EMS dispatch and public safety answering points (PSAPs, e.g., 911 centers) to be notified when an MCI occurs. EMS, PSAP, and hospital policies should specify who receives such notifications at the hospital (e.g., the emergency department [ED] charge nurse) and what actions that individual takes in response. There should also be processes to keep the hospital contact updated so the hospital response can be calibrated if the incident is different from initially assessed.

Communication with other public safety agencies is also essential. As with EMS, law enforcement agencies serve a similar early warning role and can provide valuable information for the duration of the response. Early sharing of threat information by law enforcement either directly to hospitals or via the EOC or the health care coalition may allow implementation of mitigation and preparedness measures. Fire departments with a hazardous materials (HAZMAT) team can be another valuable source of information for the hospital, helping define specific chemical exposures and concentrations that patients were exposed to and enabling hospitals to prepare decontamination teams and processes.

Hospitals should establish a relationship with their state or urban area fusion center before an incident. Fusion centers can provide threat assessments, alerts, analytic products, and connections to law enforcement, emergency management, cybersecurity, and critical infrastructure partners. Hospitals should identify personnel authorized to receive and appropriately handle sensitive information and should establish procedures for reporting suspicious activity and other potentially significant observations. This relationship should support a two-way exchange; intelligence should inform hospital decisions, while hospital reporting should improve the broader understanding of threats to the health care sector and community.

Epidemiologic and environmental information gathered by public health partners can benefit hospitals in forecasting community impacts and potential effects on the health care system.

This forecasting may allow time to implement surge strategies and adjust services. Conversely, public health officials may seek hospital data to understand health care impacts and validate epidemiology.

Identifying and supporting a community's vulnerable population groups is another key responsibility of public health departments. Outreach, risk communication, and interventions are often conducted by public health staff, but there are overlapping responsibilities for hospitals to help public health partners maintain situational awareness, identify new populations at risk, assist with risk communication, and provide information about available resources. Home health, hospice, dialysis, behavioral health, ambulatory care, and childcare providers, schools, media, and community organizations serving these at-risk groups also play a critical role in information sharing and in risk communication efforts. Health care coalitions also have a wide range of information sharing responsibilities during responses. Most coalitions serve as liaisons between facilities and other disciplines to support health care response and maintain situational awareness.

The [Information Management](#) chapter of this Guidebook includes additional details about the flow of information during an incident.

From the Field

Coalitions proved invaluable during the COVID-19 pandemic and, in some states, managed the majority of health care coordination activities.

Resource Requests and Management

Based on their authorities and their jurisdictional emergency response coordination role, local emergency management agencies are the designated gateway to obtain community, state, and federal resources. They can also initiate requests for mutual aid through existing agreements or mechanisms such as the Emergency Management Assistance Compact (EMAC). It is important for hospital emergency managers to understand how to contact local emergency management agencies when needed and what resources they can provide.

Hospital emergency managers should also have a clear understanding of what resources can be obtained from other partners. Local, regional, or state stockpiles of pharmaceuticals, personal protective equipment, or other medical supplies may be maintained by public health departments, health care coalitions, emergency management agencies, or other partners. Many coalitions can help broker supplies and staff during resource shortages. The public health department is sometimes the conduit for obtaining medical supplies, including requests for

From the Field

A metropolitan health care coalition was having issues planning for request and distribution of state and federal assets such as personal protective equipment caches and SNS assets. An agreement was reached with multiple local emergency management agencies that the regional coordinating hospital would pool all medical resource requests from the hospitals and make requests through their local EOC on behalf of the region, thus preventing multiple requests and improving situational awareness.

Strategic National Stockpile (SNS) assets. Hospitals should plan with their public health partners to request adequate antibiotics and specific medical countermeasures (e.g., anthrax antitoxin) for hospital use. Ventilators and other medical equipment may also be requested from the SNS. Delays may cost lives; planning which items should be requested and determining rough quantities through tabletop exercises can facilitate timely requests during an incident. Hospitals should also understand the plans for distribution of SNS assets once they arrive in the state.

Generally, requests for both non-medical support (e.g., law enforcement, traffic control, assistance with utility outages, heavy equipment) and state or federal medical assets such as the SNS go through the jurisdictional EOC for action. Each EOC will have a process for these requests and conditions for receiving resources.

Hospital Campus Response

The hospital leads in the provision of patient care, but community partners have various roles in responding on the hospital campus. Should a fire or major structural emergency occur on the hospital campus, the fire department will have incident command. Having hospital maps and other information (e.g., location of the liquid oxygen, generators, fuel, and hazardous materials storage) pre-loaded into the public safety computer-aided dispatch (CAD) system can help the fire department reference information while still enroute to the hospital. Pre-plans can also be loaded into some CAD systems. Ensuring a hospital security and administrative liaison is inserted with fire command as soon as possible facilitates response efforts and helps fire command understand the hospital infrastructure and what is in the specific areas of the building affected. Labeling entrances/exits, stairwells, elevator banks, and other critical areas can assist wayfinding within the facility.

Both HAZMAT and general fire personnel may be able to assist the hospital with decontamination operations. Understanding what equipment and training the fire department has and, ideally, training and exercising together can facilitate integration of their assets into the hospital response. However, it is possible the fire department's decontamination assets will be committed to the incident scene and not available at the hospital. Some regions or states have decontamination strike teams that may be helpful in support of local operations; the hospital emergency manager should understand the request process and timeframe for these mutual aid assets.

Hospital staff should also understand the role of the fire department in non-emergent hospital evacuations. Joint exercises can help both parties identify and address gaps in planning, increasing the likelihood of an efficient evacuation. Evacuation timing and related planning assumptions must be flexible if fire assets are committed to community emergencies.

Law enforcement agencies coordinate the response to bomb, active shooter, and other security threats at the hospital. Officers responding should have immediate access to badges/cards, floor maps, go-kits, and other resources to enable rapid movement through and access to all areas of the hospital campus.

Information included in the public safety CAD system and hospital signage can also aid law enforcement. Hospital security should be prepared to assist officers in navigating the hospital either via radio or by being physically present (and, particularly if unarmed, protected by law enforcement officers) depending on planning assumptions. Determining how law enforcement officers will work with hospital security and liaison with hospital security operations (e.g., camera monitoring) is critical to rapid, effective, and integrated response. Law enforcement agencies may also play a critical role in hospital evacuations, particularly during emergent evacuations when other responders are focused on addressing the threat.

Related Resources

Refer to ASPR TRACIE's [On-Campus Health Care Facility Armed Assailant Planning Considerations](#) for additional suggestions.

During an MCI response, law enforcement agencies may also be able to offer the hospital officers to maintain access controls and personnel to manage arriving traffic. Understanding the potential timeframes and resources available helps the hospital recognize limitations and make appropriate requests of law enforcement partners during emergencies. Involving law enforcement agencies in exercises is one of the most effective ways to validate policies and adjust expectations.

During response to some MCIs, EMS personnel may provide support to the emergency department when activities at the incident scene are concluding but response activities at the hospital have not yet peaked. Knowing whether EMS personnel may be able to help provide basic care until adequate hospital staff arrive is helpful for both EMS and ED staff planning. Having an EMS liaison to the hospital ED during an MCI response can also be invaluable. This liaison (who may be a crew member, supervisor, or other available EMS personnel) can provide updates on the situation at the scene such as the potential number of patients still to be transported and facilitate communications with EMS dispatch about conditions at the hospital and any interfacility transfer support requirements that need to be balanced against community emergency responses. Ideally, this EMS liaison function is written into EMS and hospital plans and exercised.

From the Field

While fire department personnel from throughout the region battled a late-night blaze that destroyed a hospital wing, EMS providers and state and local law enforcement officers helped hospital staff safely evacuate nearly 80 patients. County transit agency buses were used to warm hospital staff and patient loved ones during the full evacuation in freezing temperatures.

Understanding area EMS assets and the potential transport needs of the hospital during an evacuation can help solve challenges and create realistic plans. Local EMS agencies may be able to obtain significant mutual aid, but this can take hours (depending on the jurisdiction) and be of limited help in an emergent evacuation. EMS agencies may also have access to specialty



transport resources such as mass casualty buses, depending on the agency and services provided. The EMS role in coordinating destination hospitals (if any) should be understood and practiced. That role may differ depending on whether the evacuation is emergent or not. Patient transfer centers and hospital-to-hospital discussions may be needed to ensure patients are evacuated to appropriate destinations to avoid re-triage and re-transport if the receiving hospital cannot meet their needs.

From the Field

After a recent mass shooting, EMS crews bringing patients to a trauma center stayed with their patients and continued to support care as the ED was overwhelmed. An EMS supervisor was able to coordinate the use of a mass casualty bus to help redistribute patients from a non-trauma center to a trauma center during the same incident.

Community Response

Patient Movement

Depending on the number of health care facilities in the area, a hospital may be the only EMS destination or EMS personnel may triage and transport patients to multiple hospitals based on their available services. During a disaster, however, these destinations are often modified. For instance, penetrating trauma patients with extremity wounds may be transported to non-trauma centers to reduce the patient load on the trauma center following an MCI.

Understanding EMS agency MCI plans bolsters integrated community planning and helps the hospital adjust its risk analysis and supplies. Hospital staff should understand EMS triage plans and any patient tagging, pre-registered MCI accounts, or other tracking system that is used (e.g., whether hospital staff should preserve the number system used by EMS triage tags for patient tracking).

In addition to this primary transport role, EMS agencies are integral in the secondary transfer of patients to higher levels of care. As with hospital evacuations, the EMS agency may be able to contribute staff and resources to the movement of critically injured patients to hospitals outside of the affected region or with higher levels of capability, such as pediatric or burn care. EMS agencies may also have access to specialized capabilities, such as bariatric transport or air assets.

Relationships between hospitals and EMS staff are critical to coordinating primary and secondary patient transport, but other partners also have roles. The emergency management agency may be able to supplement patient transport assets via mutual aid or contracts. Requests through the EOC for federal ambulance assets are also managed by emergency management agency staff. Some health care coalitions and public health departments have roles in acquiring patient transport assets or managing patient movement. Long-term care facilities may be able to assist with transport of ambulatory patients. Schools and transit agencies may also have vans and buses

Related Resources

MOCCs are an important resource for facilitating patient transfers and monitoring and balancing hospital patient loads during surge conditions. Refer to ASPR TRACIE's [MOCCs](#) Resource Page for additional information.



available to transport ambulatory patients. Hospital staff should know whether a Medical Operations Coordination Center (MOCC) is present in the community and, if so, understand policies and protocols governing its operations.

Medical Countermeasures

The jurisdictional public health agency is responsible for planning distribution of medical countermeasures (MCM) (e.g., prophylactic antibiotics, vaccine, and other pharmaceutical and medical supplies). Integrated distribution plans should be scalable to meet the needs of a variety of incident sizes and types or product availability. Other community partners will also be involved in MCM planning and response. Law enforcement agencies may provide security functions and partners such as schools, recreation centers, or libraries may serve as distribution sites. Pharmacies, EMS providers, long-term care and assisted living facilities, home health and hospice providers, ambulatory care providers, and volunteer organizations such as the Medical Reserve Corps may assist with dispensing drugs or administering vaccines. MCM planning is complex and hospital emergency managers should understand the basics of these plans, particularly to ensure the hospital is not relied upon as a physical site where community members are screened/provided MCMs (i.e., an open point of dispensing [POD]).

Hospital emergency managers should discuss with public health partners the potential to be a closed POD, in which case the hospital assumes responsibility for distributing MCM to its staff (and, potentially, loved ones who meet eligibility criteria). In closed POD planning, the hospital provides the public health department with its number of employees and ensures a plan is in place to dispense MCM to them. Public health officials, in turn, ensure sufficient MCM are allocated and rapidly distributed to the hospital. Closed PODs offer hospitals the opportunity to control MCM distribution to employees and ensure it is accomplished rapidly, thereby protecting staff and their family members, saving them the time and effort of going to a public POD, and maximizing the availability of protected staff to continue caring for patients.

From the Field

Some hospitals test their closed POD plans by using them for distribution of routine operational items such as staff seasonal influenza vaccination or employee giveaways.

Alternate Care Sites

Significant increases in patient care services ranging from illness screening and early treatment to MCM administration by medical personnel (e.g., monoclonal antibody administration) heighten the need for additional hospital capacity. Establishing alternate care sites (ACS) on the hospital premises is preferred and hospital surge plans should account for the crisis use of flat space areas that can be converted to patient care. However, when the capacity of the health care system is overwhelmed, the emergency management agency typically has a planning and logistical role (and should have agreements in place) in establishing an ACS in multiple public buildings in the community. The operational management of these community ACS is usually delegated to the jurisdictional public health agency.



Hospitals should collaborate with their public health and emergency management partners to identify suitable, potential community-based locations for ACS. Determining how local, state, regional, and federal resources and staffing may contribute to community ACS operations and what supplies, policies, regulatory and legal support, catering, hygiene, and security may be needed is outside the scope of this Guidebook, but these are core planning issues that hospital emergency managers should address with their community partners.

Community Shelters

Establishing and operating community shelters following a disaster requires the coordination of many partners. Emergency management agencies may be partially responsible for operating general population shelters in the community with assistance from the American Red Cross and other non-governmental organizations. The public health department also has a role in planning shelter services and ensuring their safe operations. Some jurisdictions operate shelters for people with special medical needs. These are often staffed by public health nurses and trained volunteers such as Medical Reserve Corps members, but hospitals sometimes also contribute to staffing.

Hospitals have a vested interest in ensuring shelters can provide services to community members with chronic medical needs, particularly those who are usually able to care for themselves at home but are dependent on oxygen or medical devices they are not able to rely on during a disaster. Many patients with chronic medical conditions will require assistance with prescription management, diabetes monitoring and management, and other services that will lead to ED visits if not addressed at the shelter. All shelters should be prepared to offer appropriate support to these community members.

Additionally, some basic medical care and screening should be available in all shelters on an ongoing basis. This care may be provided by a community nurse, supplemented by a physician or other provider during certain hours of the day. As with special medical shelters, hospitals should discuss their role with emergency management, public health, and other response partners in providing basic medical care in general population shelters.

Community Screening

The public health department may be responsible for setting up population-based testing locations during large epidemics when screening tests are required. These locations tend to be staffed by public health employees and often supplemented by trained volunteers. However, once a patient becomes ill, most public health departments refer these cases to their health care partners. Hospitals should work closely with public health staff to understand the scope of testing based on the incident and be prepared to scale up screening and early treatment clinics.

Related Resources

Additional information about the roles of hospitals and their partners is available in ASPR TRACIE's [Alternate Care Sites \(including shelter medical care\)](#), [Family Reunification and Support](#), [Mass Distribution and Dispensing/Administration of Medical Countermeasures](#), [Radiological and Nuclear](#), and [Volunteer Management](#) Topic Collections.



Other health care providers – including community health centers, urgent care centers, and private medical practices – should also be engaged in this collaborative planning to effectively direct patients to care sites most able to meet their treatment needs.

Following a radiation exposure, public health agencies set up Community Reception Centers (CRC) to screen people who are concerned about exposure but do not have acute medical needs. If this exposure follows the release of radioactive materials from a nuclear power plant, state and local emergency management agencies will be the lead with public health agencies supporting. In the aftermath of a “dirty bomb” or other intentional incident, public health staff would lead screening once the immediate response phase concludes. In many communities, planning for CRC is absent or rudimentary, compounding the risk of a very large number of residents presenting to the hospital seeking screening.

Family Support

Hospitals should be prepared to manage family members seeking information about their loved ones following an MCI. The hospital emergency manager should identify a location for a temporary, onsite Family Support Center to register and reunite families who arrive at the hospital. The jurisdictional emergency management agency or another designated entity depending on the type of incident will establish a Family Assistance Center (FAC). The hospital should contribute to FAC planning along with other community partners, know where a FAC is established and when it opens, have a process to refer loved ones to that location, and understand the FAC’s procedures. Additional information is available in the [Family Support](#) chapter of the Guidebook.

Conclusion

A successful hospital response to an incident is rarely based on hospital efforts alone, though hospitals should have robust disaster plans and, if part of a health system, understand what enterprise-level support is available. Coordination with key community partners will help guide realistic policies and facilitate alerting, information sharing, and resource requests during an incident. Understanding partner strategies and resources can also help the hospital anticipate community-based actions during an incident and hopefully focus hospital activities on the care of acutely ill or injured patients. Hospital emergency managers have an obligation to develop relationships with key community partners and ensure ongoing communication, planning, and exercising.

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Appendix A: Key Community Partners and Integration with Hospital Emergency Management

The following table highlights partners that hospitals frequently engage with along with activities they are commonly responsible for as part of an integrated community response to public health emergencies and other disasters. This is not an inclusive list; partnerships will vary by community and hospital type. Additional partners to consider are listed following the table. Planning questions are included for hospital emergency managers to consider when developing and improving their facilities' preparedness and response plans.

Health Care Coalitions		
Responsibilities	• Convening members for preparedness and response activities • Sharing information among members • Planning/exercising	• Developing/distributing best practices/guidance • Coordinating during an incident • Providing situational awareness • Acquiring/brokering resources
Planning Questions	• What is the role of the coalition during response (i.e., what functions does the coalition perform versus emergency management and other partners)? • How does the hospital provide input into coalition plans, including those for specialty care?	

State/Local Public Health Departments		
Responsibilities	• Providing epidemiologic information • Invoking authorities during emergencies • Requesting/receiving/distributing medical countermeasures (MCM) • Planning with hospitals and other partners to serve as closed point of dispensing [POD] sites • Encouraging community-based interventions (e.g., masking, distancing) • Providing regulatory oversight and relief • Communicating public health risk • Engaging at-risk populations	• Operating alternate care sites (ACS) • Providing special pathogen support • Coordinating with Medical Reserve Corps (MRC) and other volunteers • Leading community-based screening/testing • Managing public health and medical planning • Developing/distributing guidance/best practices • Operating medical shelters • Establishing community reception centers following radiological incidents

Planning Questions	• Is the public health department the lead Emergency Support Function (ESF)-8 agency? If not, what is the lead agency? • What are the resources (e.g., caches, Strategic National Stockpile [SNS], MCM for closed POD, Chempack) accessible through the public health department and what is needed from the hospital to plan for and request those assets? • What are current plans for shelter medical support and ACS in the jurisdiction/area and what are the implications for health care partners? • What authorities and protections are available for health care providers through public health powers during an emergency? • How do health care entities coordinate messaging with the public health department during an emergency? • What resources for epidemics and special pathogens are available from the public health department versus through the National Emerging Special Pathogens Training and Education Center (NETEC)/Regional Emerging Special Pathogen Treatment Centers (RESPCTs)? • How can health care and public health partners complement at-risk population services prior to and during incidents? • What support can hospitals provide to public health-led community MCM planning and response?
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State/Local Emergency Management Agencies		
Responsibilities	• Assessing community risks • Invoking emergency declarations and legal authorities • Leading jurisdictional planning • Planning community exercises • Activating the jurisdictional Emergency Operations Center (EOC) and coordinating response to incidents • Providing and tracking completion of initial, refresher, and just-in-timing training on the Incident Command System and response roles • Managing and requesting resources • Providing situational awareness for incidents and special events	• Requesting mutual aid through both existing agency agreements and the Emergency Management Assistance Compact (EMAC) • Establishing a Joint Information System (JIS) and managing information (including through a Joint Information Center [JIC]) • Issuing evacuation/shelter-in-place orders • Establishing community sheltering • Managing and vetting lay volunteers/assistance from non-governmental organizations (NGO) • Establishing a Family Assistance Center (FAC) • Ensuring plans address access and functional needs of community members • Assisting with mass fatality management

Planning Questions	• How are health care/hospital needs represented in ESF-8? • What emergency management agency authorities and protections affect hospital response? • How can the hospital participate in ongoing threat analysis, exercises, and special events planning? • What resources might support the hospital during an emergency (e.g., sandbagging, transportation, using lay volunteers) and how are they accessed? • When local evacuation or travel restriction orders are issued, how does that affect hospitals and movement of their staff and patients? • What is the emergency management agency (versus public health department) role in medical support of shelters and ACS? • How does the emergency management agency include public health and health care partners in their JIS? • What joint planning between emergency management and hospital personnel is needed for periodic revisions to the Medical Annex of the local Emergency Operations Plan? • What joint planning between emergency management and hospital personnel is needed for mass casualty incidents (MCI)? • Does the emergency management agency lead mass fatality planning? If not, who has that responsibility?
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Emergency Medical Services (EMS) Agencies		
Responsibilities	• Notifying hospitals of MCI/other situations • Providing patient triage and initial transport • Providing secondary patient transport (including inter-facility transfers and hospital evacuation support)	• Liaising between the incident scene and the hospital • Tracking patients • Responding to major incidents at the hospital • Supporting patient care in the ED when possible
Planning Questions	• How does EMS notify hospitals of incidents/provide information? • Does EMS try to provide a liaison to the hospital during an MCI to help coordinate secondary transfers/provide updates? • Does EMS change their destination hospitals during an MCI based on hospital capability/capacity? • What is the EMS process during a hospital evacuation (both emergent and urgent)? • What other mutual aid resources may be available to support patient transportation? • How does EMS track patients during an MCI? • If there is a violent incident at the hospital, will victims be taken to the hospital emergency department for initial treatment or to another hospital for trauma care? • What specialized transport capabilities (e.g., special pathogen, bariatric, air medical, evacuation buses) exist?	

Fire Departments		
Responsibilities	- Responding to fires on-campus - Responding to other emergencies (e.g., active violence) on-campus	- Assisting with hazardous materials (HAZMAT) response/decontamination - Providing evacuation support
Planning Questions	- Where should the hospital incident command expect to find the fire incident command? - How does the hospital keep the fire department updated on locations of potentially dangerous materials (e.g., liquid oxygen generators, fuel) and changes to the hospital campus/map? - What decontamination/HAZMAT resources are locally available and is there an opportunity to support hospital decontamination operations? - What support can the fire department provide during emergent/urgent evacuations and is joint training/planning needed? - Does the fire department have protocols with law enforcement agencies to respond to active violence incidents on a hospital campus (e.g., Rescue Task Force)?	

Law Enforcement Agencies		
Responsibilities	- Sharing Intelligence/threat analysis and information - Responding to on-campus threats (including active violence)	- Providing traffic control - Providing campus protection/access control - Assisting with evacuation activities
Planning Questions	- What mechanisms are used to share threat information with hospitals? - How is sensitive information received and designated? - What is the law enforcement role in intelligence sharing versus the state/urban area fusion center role (if there is one in the area)? - What joint planning between law enforcement and hospital personnel is needed to ensure a safe on-campus response to active violence? - What can law enforcement offer the hospital for traffic/access controls during an MCI (if anything)? - Can law enforcement offer support during emergent evacuations? - What protocols are in place for preserving evidence? - How will hospital incident command coordinate with law enforcement incident command? - What protocols are in place to enable staff and critical vendor access to the hospital during road closures, detours, and community evacuations?	

Fusion Center		
Responsibilities	• Providing threat assessments • Analyzing suspicious activities and threat patterns • Providing analytic support for planned events and during prolonged incidents	• Assessing the significance of observations reported by hospitals and other partners • Establishing connections among preparedness and response partners
Planning Questions	• Does the hospital have a relationship with a state/urban area fusion center? • What type of intelligence is available from the fusion center and how can the hospital access it? • Which hospital personnel are authorized to receive and act upon sensitive information? • Does the hospital have procedures for reporting suspicious or unusual activities to a fusion center for assessment? • Does the fusion center have a health care or critical infrastructure liaison?	

Dialysis Providers		
Responsibilities	• Planning contingencies for weather/infrastructure impacts on dialysis services	• Maintaining continuity of patient care • Educating existing clients
Planning Questions	• How can health care and dialysis providers partner to provide pre- and post-incident information to patients? • Are key relationships established with major dialysis providers in the area to understand plans and synchronize response? • Does the dialysis provider have a continuity plan that relies on the hospital? If so, is the hospital prepared to support the provider and their patients? • Does the dialysis provider also provide inpatient services for any hospitals in the area?	

Long Term Care (LTC) and Assisted Living Facilities		
Responsibilities	• Maintaining operations and mutual aid agreements to avoid evacuating to hospitals	• Planning for the return of patients following hospitalization
Planning Questions	• To what degree can the hospital help support LTC planning for resilience and evacuation? (Ideally, this does NOT involve residents being taken to the hospital who do not have acute medical needs [e.g., agreement with other LTC facilities in area].)	

Home Health Agencies		
Responsibilities	• Maintaining operations and mutual aid agreements • Planning contingencies for weather/infrastructure impacts on home health services	• Educating existing clients
Planning Questions	• To what degree can the hospital help support home health agency planning for resilience? • How can health care and home health providers partner to provide pre- and post-incident information to patients?	

Ambulatory Care Providers		
Responsibilities	• Maintaining/expanding operations to relieve strain on emergency/inpatient care • Caring for minor illnesses/injuries • Supporting screening/testing for existing patients/the greater community	• Participating in mass prophylaxis/vaccination efforts • Educating patients
Planning Questions	• To what degree can the hospital understand and support planning for service resiliency and expansion to reduce added stress on hospital acute care?	

Behavioral Health Providers		
Responsibilities	• Providing behavioral health support to hospital staff, patients, and their loved ones • Maintaining continuity of patient care	• Supporting community resilience • Assisting at sites including ACS, PODs, shelters, and the FAC
Planning Questions	• What mental and behavioral health resources are available to hospital staff? • How can the hospital refer patients for support?	

Pharmacies		
Responsibilities	• Participating in mass prophylaxis/vaccination efforts	• Educating patients
Planning Questions	• To what degree can the hospital understand and support pharmacy planning for service resiliency and expansion?	

Utility Providers		
Responsibilities	Maintaining/prioritizing restoration of services to hospital	Identifying vulnerabilities in utilities infrastructure.
Planning Questions	- What is the joint understanding of the hospital and its utility providers of supply vulnerabilities and redundancies in power, water, internet, oxygen, and natural gas/steam? - How are points of contact established and maintained? Is 24/7/365 contact information available for immediate issue resolution? - Do utility providers prioritize hospitals for restoration? What other sites are also prioritized? - How can utility providers support hospital planning for system failures? - Do utility providers give hospitals advance notification of planned outages?	

Non-Governmental Organizations (NGO)		
Responsibilities	- Conducting outreach to at-risk populations - Coordinating trained volunteers - Supporting community sheltering efforts - Supporting the FAC	- Supporting mass prophylaxis/vaccination efforts - Supporting community testing/screening - Assisting with resource management - Supporting community resilience
Planning Questions	- Which NGOs have specified roles in the community's response plans (e.g., American Red Cross operating community shelters)? - Does the hospital have an arrangement with any NGOs to assist with donation management?	

Private Sector Partners		
Responsibilities	Providing emergency resources	Prioritizing hospitals for resupply
Planning Questions	- How is the hospital working with private sector partners on emergency supply chain planning? - How can the hospital work with vendors to pre-identify likely needed supplies for automatic or expedited delivery following an MCI? - How are points of contact established and maintained? - What other customers are being prioritized for the same private sector resources?	

Volunteers		
Responsibilities	- Assisting with pre-identified non-clinical tasks in the hospital - Supporting community sheltering efforts	- Supporting mass prophylaxis/vaccination efforts - Supporting community testing/screening - Supporting public health PODs
Planning Questions	- What hospital roles, if any, have been identified for trained volunteers? - Has the hospital discussed potential roles for volunteers affiliated with the MRC, American Red Cross, Voluntary Organizations Active in Disasters, state defense forces, or other voluntary groups? - Where will the hospital direct unaffiliated volunteers who offer their services? - Does the hospital know how to access information through the Emergency System for Advance Registration of Volunteer Health Professionals or other volunteer registries? - What is the hospital's process for vetting and credentialing volunteers?	

Other Potential Partners

This is not an exhaustive list of potential community partners. Hospital emergency managers should identify additional agencies and organizations serving their region and explore possible ways to collaborate. Some suggestions to consider include:

- Blood centers and tissue providers
- Chaplaincy and spiritual care
- Childcare providers
- Cyber partners
- Emergency communications providers (e.g., amateur radio)
- Hospice providers
- Laboratories
- Mass fatality management partners (e.g., coroner, medical examiner, funeral industry)
- Mass transit agencies
- Media
- National Guard, state defense forces, and nearby military installations
- [National Special Pathogen System](#) partners
- Poison control center
- Public safety answering points
- [Regional Disaster Health Response System](#) partners
- Schools and universities
- Supply chain partners
- Other jurisdictional government agencies (e.g., transportation, parks and recreation, community relations)

