This document reflects ongoing work and refinement of regional plans for emergency preparedness and disaster response. The document will be updated periodically to reflect continuous process improvement.

Use of Federal Funds

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Citation

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OVERVIEW AND STRUCTURE

DOCUMENT PURPOSE
This guidance provides the framework to guide the development of regional healthcare coalitions (HCCs) in non-urban Missouri communities for emergency preparedness, disaster response and recovery. This guidance was developed with extensive input from healthcare leaders representing hospitals, emergency medical services, public health, mental health and other organizations across Missouri.

DEFINITION OF A HEALTHCARE COALITION
An HCC is defined as a “collaborative network of healthcare organizations and their respective public and private sector response partners... that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations” (U.S. Department of Health and Human Services, 2012, p.56).

PURPOSE OF A HEALTHCARE COALITION
HCCs are promoted as a method to prepare for and respond to incidents among diverse healthcare organizations (HCOs) within a geographic region. Tiered, scalable and flexible coordination among varied HCOs will facilitate more effective, efficient and timely situational awareness and coordination of resources, resulting in an overall improved healthcare emergency response. The role of HCCs is to communicate and coordinate; HCCs should never replace or interfere with official command and control structure authorized by state and local emergency management.

Through effective vertical and horizontal planning integration, each healthcare coalition aspires to be recognized by its regional partners as having a formally defined and exercised role that is integrated into the state emergency operations plan to facilitate the communication and coordination of healthcare response during a disaster.

BACKGROUND
Through a subcontract with the Missouri Department of Health and Senior Services, the Missouri Hospital Association facilitates healthcare emergency preparedness planning efforts in Missouri Planning Regions B, D, E, F, G, H and I (non-urban) using ASPR
Hospital Preparedness Program funding and resources. The development and refinement of healthcare coalitions is the primary focus of the current five-year project period that began July 1, 2012.

The MHA Coordinating Council was formed July 1, 2010, to direct the collaborative efforts of each non-urban Missouri healthcare coalition and to ensure that coalition plans align for a coordinated statewide response. The council convenes through face-to-face meetings and calls at regular intervals to standardize and strengthen HCC plans and processes.

Council membership includes the leadership of each of the non-urban healthcare coalitions and the identified subject matter experts for the following content areas, as appropriate:

- Healthcare Systems Preparedness (coalition framework and compliance)
- Healthcare System Recovery
- Emergency Operations Coordination
- Fatality Management
- Information Sharing
- Medical Surge
- Responder Safety and Health
- Volunteer Management

APPROACH

The formation of HCCs is based on multiple scholarly and federal resources but specifically aligns with the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP) Capabilities and Functions (HHS, 2012).

The Medical Surge Capacity and Capability (MSCC) Management System describes a management methodology for tiered, scalable disaster response based on principles to effectively coordinate among varied healthcare organizations and to integrate with other response organizations that have established ICS and emergency management systems (Barbera & Macintyre, 2007).

SCOPE

This guidance is limited to HCC planning, recovery and response. This guidance does not replace or interfere with organizational emergency operations plans or jurisdictional plans for official command and control authorized by state and local emergency management agencies. It is recommended this document be included as an annex in healthcare organizational and jurisdictional emergency operations plans.

PLANNING ASSUMPTIONS

The following planning assumptions were used to develop this guidance.

- This guidance provides operational guidance for an all-hazards planning approach.
- All disasters should be managed at the most local level possible, supporting the whole community approach to preparedness and response.
- Planning should be flexible, scalable and adaptable. This document has been written for adoption by

non-urban Missouri HCCs for incidents of varying magnitude; as such, it remains flexible to support the unique geographic characteristics and membership within each region.

- The functional annexes provide more specific detail on technical operations during a variety of hazard-specific activations.

- Health and medical awareness, readiness or response is required for most disasters.

This document is a supplement to organizational emergency operations plans. Hospitals should engage in planning and evaluation activities and develop an EOP that includes, at a minimum (Joint Commission Resources, 2012):

- implementation of an internal incident command system based on the principles of the National Incident Management System (NIMS) and/or Hospital Incident Command System (HICS)
- management of patients and provisions for care in an incident
- systems for communication during incidents
- management of resources and assets during disasters, including maintenance of regional disaster assets
- management of safety and security during incidents
- management of staff during an incident, including competency-based training
- management of volunteer licensed independent practitioners and other licensed, certified, or registered volunteers during an incident
- management of utilities during an incident

Lending and receiving resources within the HCC during a response should be managed through agreements for mutual aid. Therefore, HCC members are expected to be signed participants of respective state mutual aid agreements. Currently, the following state-level mutual aid agreements are established to support HCC resource coordination.

- Missouri Hospital Mutual Aid Agreement (Appendix I)
- Missouri Systems Concept of Operational Planning for Emergencies (MoSCOPE) including the Emergency Medical Services Mutual Aid Plan

HEALTHCARE COALITION PREPAREDNESS

HCCs and overall “healthcare system preparedness is achieved through a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions” (HHS, 2012, pg.1). Healthcare system preparedness is the range of deliberate, critical tasks and activities necessary to build, sustain and improve the capability to protect against, respond to and recover from incidents. Preparedness is a continuous process.

The HCCs’ role in regional health and medical preparedness requires coordination among hospitals, emergency management, public health and emergency medical services. This also should incorporate representation from mental/behavioral health providers, community and faith-based partners, as well as state, local and territorial governments.

The following HCC actions establish the organization and structure required to achieve the preparedness objectives.

- Establish regional boundaries of the coalition (HPP Program Measure 3).
- Define HCC membership criteria and coalition roles and responsibilities (HPP Program Measures 2, 6).
- Develop an organizational structure to establish and sustain the HCC as an entity (HPP Program Measures 1, 10).
- Conduct a regional risk assessment, to include the capacities and capabilities of HCC members (HPP Program Measure 7).
- Integrate the HCC into the healthcare delivery system processes to include engagement of jurisdictional partners, healthcare system delivery executives and clinical leaders (HPP Program Measures 5, 8, 9).
- Develop systems for multi-organizational and multi-agency communication and coordination during response (HPP Program Measure 4).

HCC REGIONAL BOUNDARIES

Currently, there are five non-urban Missouri healthcare coalitions structured primarily on the Missouri highway patrol districts and emergency management planning regions, as illustrated in the following map. As the coalitions have matured, a few have modified their boundaries based on existing healthcare service catchment areas, regional EMS regions and established partnerships. Further detail is outlined in each healthcare coalition description (Appendix III) as well as the MHA healthcare coalition MOU (Appendix II) and other HCC documentation, as appropriate.
HCC MEMBERSHIP

Member designation is important to identify for effective planning. Coalition membership is defined in the regional non-urban coalition memorandum of understanding (Appendix II) as follows.

A. act as signatories on statewide mutual aid agreements within their respective industries, as available

B. demonstrate active participation in the healthcare coalition by:
   1. ensuring organizational representation at 75 percent attendance annually in coalitions that meet quarterly and at least 50 percent attendance annually in coalitions that meet monthly
   2. contributing subject matter expertise
   3. participating in coalition planning and decision making
   4. participating in coalition and regional training and exercises
   5. participating in the EMResource® — Hospital Incident Command System coalition notification process
6. agreeing, as appropriate, to serve on a rotation for the coalition duty officer

C. accept responsibility to proactively agree to serve, as able, in one of the following roles during a disaster response:

1. Support Facility — An HCO capable of facilitating coalition communication and coordination, assisting in the deployment of regional resources and conducting basic supportive patient care such as triage, minor treatment and vaccinations.

2. Receiving Facility (Resources and patients) — An HCO capable of providing care, including triage, treatment, transport and limited trauma services. Despite this capability, the receiving facility does not have the capacity to surge as a primary facility for a large influx of patients or for a prolonged surge.

3. Surge Facility — An acute care facility capable of receiving a large influx of patients for an extended period of time, and serves as a primary trauma facility for the region. The surge facility should be recognized with a trauma designation.

Coalition Partners
HCC members are encouraged to develop partnerships with other essential community members and organizations to strengthen coordinated response during an incident. Partnerships may be dependent on the area, participant availability and relevance to the HCC.

HCC ORGANIZATIONAL STRUCTURE

HCC Governance
A regional non-urban coalition memorandum of understanding has been developed to establish formal roles and responsibilities as a regional healthcare coalition for emergency preparedness, response, recovery and mitigation, as appropriate. In a response role, the healthcare coalition will serve as the medical coordination center referenced in the Missouri Hospital Mutual Aid Agreement, Section VI: Communication.

The purpose of this regional non-urban coalition memorandum of understanding is to serve as a voluntary agreement among organizations that have as their primary mission the purpose to provide or support healthcare services within their community. This may include but is not limited to hospitals, emergency medical services, community health centers, local public health agencies, primary care and specialty clinics, and long-term care facilities. Each HCC will establish and document its process for decision making; this process is outlined in Appendix III.

HCC Procedures
To ensure an established system of preparedness and response among HCC members and among the non-urban coalitions, each HCC is expected to adopt the following processes.
formally convene at regular intervals, a minimum of once per quarter is recommended
update meeting schedules regularly on EMResource® and distribute notifications to members
maintain current coalition membership attendance records in the EMResource® Hospital ICS library
maintain current contact information and use the EMResource® applications for HCC monitoring, notification and document maintenance
document the alignment with local public health and emergency management authorities
conduct a Hazard Vulnerability Analysis (HVA) or Threat Hazard and Identification Risk Assessment (THIRA) in collaboration with regional partners
coalition HVAs should be consensus-based and conducted to identify overarching risks within the geographic region
at least once per year, conduct a formal exercise as a coalition to ensure compliance with HPP exercise requirements.
THE HEALTHCARE COALITION DURING RESPONSE

The role of the HCC in response should be to represent member healthcare organizations by providing multi-agency coordination support to incident management through information and resource coordination for healthcare organizations.

The regional non-urban healthcare coalitions have adopted the following response objectives. (Barbera & Macintyre, 2009, pg. 2-2)

- "Facilitate the interface between the healthcare coalition and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge."
- "Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy and tactics are consistent for the healthcare response."
- "Facilitate information sharing among participating healthcare organizations and jurisdictional authorities to promote common situational awareness."
- "Facilitate 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."

Because of the widespread geography of non-urban Missouri and the main responsibilities of healthcare coalition members residing at the organization level, primary coalition communication and coordination should occur virtually through sequential and redundant methods of communication accessible to all HCC members. Depending on the incident and resource demands on the healthcare infrastructure, face-to-face coordination may be deemed appropriate to increase response effectiveness and efficiency.

INCIDENT RECOGNITION AND SITUATIONAL AWARENESS

The MHA Coordinating Council has adopted the Intermedix EMResource® platform for primary
monitoring and notification tools for HCC members. The Missouri Department of Health and Senior Services (DHSS) and the Missouri Department of Public Safety’s emergency response personnel have acknowledged EMResource® as the medical platform for Web-based incident communication and coordination. Future plans to incorporate EMResource® into the state license for WebEOC are in process*.

EMResource® provides the following tools to the HCC:

- ongoing situational awareness
  - healthcare facility status
  - mobile medical asset status
- statewide coalition situational awareness
  - coalition status
  - leadership contact information
  - meeting schedules
- statewide status change notifications, including email and text, to all registered users
- statewide event notifications, including email and text, to all registered users

All coalition members will have the ability to monitor the status of each coalition through EMResource®. The following are a description for each coalition status, which are listed in the order of escalation, with activation being the most robust operational status. (Barbera & Macintyre, 2009, pg. 2-2, p. 3-11)

- **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 healthcare organizations even though the organizations may not need to take emergency action.”

- **Alert** — “Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. No immediate response indicated. This category

*Currently, work is in process to align the EMResource® application with the WebEOC application. WebEOC will be fully implemented within the State Emergency Operations Center, DHSS Department Situation Room and many of the local and regional emergency operation centers throughout the state.
may also be used for ongoing notification during an emergency to convey urgent information and recommended actions.”

- **Activation** — Identifies that a response from coalition members is required. Coalition procedure triggers the notification through EMResource® and the activation of EMResource® Hospital ICS to assign coalition members to appropriate response roles.

In addition to the EMResource® application, the EMResource® Hospital ICS platform provides an additional suite of tools for the coalition, including:

- coalition-centered preparedness business tool
  - document library for coalition guidance, meeting minutes, attendance records and other pertinent information to share with all members
  - current members and contact information
- coalition response management tool
  - Incident Response Guide (IRG) driven response
  - direct member notification by email and telephone call
  - incident management to include event log, organizational chart and coalition response objectives

**COALITION ACTIVATION AND COMMUNICATION**

The coalition will function in a decentralized nature during normal day-to-day activities. As an incident or event occurs with potential or actual impact to coalition members, the coalition may be placed on advisory, alert or activated status using EMResource® as the communication tool.

- Notification to the HCC members is critical to ensure situational awareness and to inform other coalition members of real-time situations, activities, current action and projected actions to mitigate and manage the incident. It is expected most activities will occur virtually if at all possible.
- The notification may be an advisory, alert or activation status.
- Notification should be initiated based on the specific incident and procedures of the HCC. For example, a dispatch center, a 24-hour duty officer or hospital liaison officer may initiate the virtual notification.
- Each HCC will implement a process to receive information from an affected facility or those serving on behalf of the affected facility (Appendix III). A duty officer or 24/7
dispatch center can serve to collect this information and effectively notify or activate the coalition or surrounding coalitions, as necessary.

Should EMResource® be unavailable, the following communication resources are available. HCCs should routinely test these processes to ensure redundancies. Refer to Annex A: Information Sharing for further detail.

- POTS — telephone system
- cellular phone
- email
- Hospital Emergency Administrative Radio (HEAR)
- MCI/communication trailer network
- Missouri Statewide Interoperability Network (MOSWIN) — pending implementation Spring 2014
- amateur (HAM) radio

**Advisory or Alert Status**
Coalition members should notify others of a potential or current incident when the following may occur.

- An HCO evacuation is imminent.
- There is a critical shortage of medical and/or ancillary personnel to care for arriving and in-house patients (capacity).
- There is a shortage of medical supplies.
- An HCO is damaged or compromised.
- Critical hospital utility systems and back-up systems are in use or not operational.
- A local emergency and/or all-hazard incident is occurring.
- A statewide or federal emergency is declared.

The following information should be communicated by a healthcare organization when requesting coalition assistance.

- situation status (brief description)
- primary request — critical need
- resources required
- point of contact for delivery of resources and follow-up information/instruction
- best mode of communication within the healthcare facility (based on current situation)
- activation of any mutual aid agreements
Based on the scope and scale of the incident, appropriate essential elements of information will be collected from local, regional and state partners to support the response needs. The primary tool to collect information from healthcare partners will be EMResource®. The application has pre-scripted queries to collect bed availability and resources at both the regional and state level. Documentation of resource management should be recorded using ICS Forms 213 and 214.

Coalition-specific triggers will provide members with a consistent method to determine proper notification, activation and response strategies.

- day-to-day events to be communicated through EMResource®
- hazard–specific occurrences
- automated responses following catastrophic events

**Activation Status**

- The decision to activate should be based on one or more of the following criteria.
  - Assistance is required beyond an organization’s current capabilities.
  - The incident or event will affect two or more coalition members in a region.
  - The incident or event will affect coalitions outside of the region.
  - Scarce resources may be required in multiple facilities.
  - Critical information is unreliable.
  - Communication capability is limited.
  - The incident or event will last multiple operational periods (more than 12 to 24 hours).
  - Activation is requested by another healthcare coalition or jurisdiction.

- Deactivation
  - Coalition members will be notified to stand down.
  - An information debriefing will be held, if deemed necessary by the coalition members.

**COORDINATION OF RESOURCES**

All coalition members should follow appropriate chain of command procedures when identifying and requesting resources from local, regional and state agencies. When activated, the HCC is intended to coordinate HCO requests to the Local Emergency Operations Center (LEOC) or MACC to provide a unified, efficient and effective response. HCCs should establish processes to assist their membership within two hours of receiving a request, unless extreme circumstances exist. Assistance may include the following.

- notifying coalition membership of anticipated resource needs
- assessing coalition members and contiguous HCCs to determine resource availability
requesting resources from the local emergency operations center to state- and federal-level emergency operations

COORDINATION WITH CITY, COUNTY AND STATE EMERGENCY OPERATIONS

The healthcare response must be coordinated with the overall community response. Therefore, it is critical that healthcare organizations and HCCs work within the National Incident Management System (NIMS) framework and communicate to and through their local emergency operations center during an incident.

Healthcare Organization Multi-agency Coordination During Response

Incidents that exceed the resources of a local jurisdiction and require coordination among multiple jurisdictions may require a multi-agency coordination center (MACC). At this time, MACCs vary in scope and structure across the different Missouri regions. HCCs are able to serve as a unified voice at the MACC for healthcare organizations, including local public health agencies and emergency medical services. The regional HCCs may or may not represent the full ESF-8 health and medical response at a MACC, depending on the planning structure. The coordination between the HCC, ESF-8, and the MACC must be developed during planning and must be exercised to ensure coordinated communication and response during an incident. It is likely the MACC system in Missouri will continue to evolve and mature; HCCs must engage in ongoing planning and process improvement to remain aligned with the various regional MACC systems.

Medical Incident Coordination Team (M-ICT)

During response, the emergency preparedness staff from the Missouri Hospital Association, Mid-America Regional Center, the St. Louis Area Regional Response System, the Missouri Disaster Response System (MoDRS), the Missouri Department of Health and Senior Services and other agencies share information to develop a common operating picture and coordinate resource and response requests across all Missouri regions. This system of coordination is referred to as the Medical Incident Coordination Team (M-ICT). The M-ICT is not part of the official NIMS command and control structure that originates at the local jurisdiction or MACC. Rather, it is intended to support health and medical coordination during response.


ACKNOWLEDGEMENTS

The MHA Coordinating Council has contributed countless hours to the development, refinement and review of this document.

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SUGGESTION CITATION

Appendix I: MISSOURI HOSPITAL MUTUAL AID AGREEMENT

I. Introduction

Certain critical incidents in or surrounding the state of Missouri, either regionally or statewide, may generate large numbers of patients requiring immediate emergency medical care including patients with very specialized medical requirements (hazmat injuries, trauma surgery, etc.) that exceed the resources of an individual hospital. Such critical incidents may include, but are not limited to, catastrophic accidents, pandemics, terrorist attacks or severe natural disasters such as earthquake or tornado. For purposes of this Hospital Mutual Aid Agreement, a medical disaster is defined as a critical incident that exceeds the effective response capability of an individual hospital.

II. This Mutual Aid Agreement

The purpose of this Statewide Hospital Mutual Aid Agreement (MAA) is to establish a coordinated system through which hospitals throughout Missouri and in adjoining states will provide mutual aid to each other as necessary in order to support emergency medical care needs in a medical disaster. Hospitals that are parties to this MAA are collectively referred to as “Participating Hospitals” or individually as “Participating Hospital”.

A medical disaster will almost always involve one or more local emergency management agencies, local public health departments, municipal governments or state emergency management or state department of health agencies and may also involve the Federal Emergency Management Agency.

In agreeing to the terms and conditions contained in this MAA, the parties acknowledge that they are not committed as a Participating Hospital to participate in providing aid or assistance to any other Participating Hospital or non-participating organization. This MAA is intended to provide a process and guidance when a Participating Hospital voluntarily acts to provide aid and assistance to another Participating Hospital. However, when a lending hospital commits resources to a receiving hospital pursuant to this MAA, it is the intent of the parties that the MAA is binding and enforceable, especially certain terms and conditions concerning payments by a Receiving Hospital to a Lending Hospital. Specifically, this MAA:

A. Is intended to augment, not replace, each facility’s emergency operations plan;

B. Focuses on coordinating activities between and among participating Missouri hospitals and hospitals in adjoining states; and;

C. Is a framework for Participating Hospitals to coordinate with relevant local emergency management agencies, local public health departments, municipal governments and state emergency management and health agencies.
Generally, this MAA does not replace, but rather supplements the policies and procedures governing interaction between Participating Hospitals with external organizations during a disaster such as law enforcement agencies, local emergency medical services, local public health departments, fire departments, American Red Cross.

III. Definitions. The following definitions apply to the terms and conditions contained in this MAA:

A. Designated Representative — An individual and at least one alternative designee identified by a party as having the authority to issue, receive, and answer requests for resources pursuant to this MAA.

B. Emergency — An emergency, catastrophic event, disaster, public health crises, or other exigency as may be determined in the jurisdiction(s) in which the parties are located.

C. Emergency Declaration — the official declaration by an authorized government official of a state of emergency in the jurisdiction in which one or more parties is located.

D. Emergency Operations Center (EOC) — An entity that coordinates activities organizationally above the field level to prioritize the incident demands for critical or competing resources, thereby assisting the coordination of operations in the field.

E. Employee — A health care worker at a hospital who is employed to render healthcare services under the direct control of the hospital.

F. Healthcare Services — means the provision of medical treatment, care, advice, or other services, or supplies, related to the health of individuals or human populations.

G. Healthcare Professional — an individual licensed under state law to provide health care services.

H. Healthcare Worker — an individual, including a health care professional, who provides healthcare services.

I. Incident Command System (ICS) — A method of operation that provides a structure to enable agencies with different legal, jurisdictional, and functional responsibilities to coordinate, plan and respond to emergencies.

J. Lending Hospital — any Participating Hospital that considers requests and provides personnel for transferred patients pursuant to this MAA.
Appendix I: Missouri Hospital Mutual Aid Agreement

K. Licensed Healthcare Professional — An individual authorized by state law to provide healthcare services within the scope of such authorization.

L. National Incident Management System (NIMS) — The federal coordinating program overseen by the Department of Homeland Security (DHS) requiring hospitals to formulate emergency plans including mechanisms to facilitate mutual aid in the event of inter-jurisdictional emergencies.

M. Participating Hospital — any party that accepts this MAA either as a Lending or Receiving Hospital or a Patient-Receiving or Patient-Transferring Hospital.

N. Party — A hospital that has executed this MAA.

O. Patient-Receiving Hospital — Any Participating Hospital that receives patient transfers during an emergency pursuant to state and federal laws and this MAA.

P. Patient-Transferring Hospital — Any Participating Hospital that transfers patients during an emergency pursuant to state and federal laws and this MAA.

Q. Prescribing Power — The authority to dispense prescription drugs for healthcare purposes pursuant to state licenses and institutional privileges.

R. Receiving Hospital — Any Participating Hospital that requests and receives personnel or other resources pursuant to this MAA.

S. Workers’ Compensation — The government administered system for providing benefits to individuals injured or killed in the course of employment, regardless of fault.

IV. Maintenance of Individual Hospital’s Emergency Management Program

Each Participating Hospital will maintain its own emergency operations plan that includes, at a minimum, provisions for the care of patients in an emergency or disaster situation, maintenance of disaster equipment, appropriate training of staff and implementation of an internal incident command system based on the principles of the National Incident Management System (NIMS) and/or Hospital Incident Command System (HICS).

V. Hospital Participation

Each Party will participate in disaster preparedness education and planning activities at the local, regional, and state level.
VI. Communication

In the event of a medical disaster, hospitals should work together to share resources and coordinate responses until such time the local incident command system (ICS)/Emergency Operations Center (LEOC) is operational. The local incident command system/emergency operations center or a medical coordination center may serve as a center for collecting and disseminating current information about Participating Hospital resources and needs including equipment, bed capacity, personnel, supplies and other relevant matters. The LEOC will serve as a point of contact between Participating Hospitals, state and local emergency management agencies, other governmental and non-governmental agencies as necessary. Each Participating Hospital will provide and update relevant information during drills or disasters to the LEOC. To accomplish this in the event of interruption of the telephone system, each Participating Hospital agrees to use, maintain, and upgrade when necessary the equipment necessary to participate in the following communication systems:

A. Intermedix/EMSSystem — an internet-based hospital system used by all Missouri Hospitals to report situational awareness of operational status at all times and resource, staff and infrastructure needs and capacity in real time during emergency operations.

B. HEAR Network — the Hospital Emergency Administrative Radio Network, operating on VHF radio frequencies 155.340 (ambulance to hospital), 155.220 (hospital to hospital), and 155.160 (incident command).

C. Routine Communications — each Participating Hospital will maintain current contact information for its key emergency personnel including telephone, fax, email, radio or any other useful and relevant information on the EMSSystem.

VII. Mutual Aid Received By or Provided to a Participating Hospital

A. Authority and Communication

Only a senior hospital administrator, (designated representative, including alternate designated representative) of a Participating Hospital that has a need for assistance including additional staff, equipment or supplies has the authority to initiate a request for assistance pursuant to this MAA. This request may be executed directly between two parties but the MAA activation must be communicated to an appropriate local or state governmental entity and posted on EMResource. This is especially important during a non-declared emergency when local and state EOCs may not be activated.
A request also may be made verbally through the local ICS/EOC, but must be followed by a written request if possible within forty eight (48) hours of the verbal request. The local ICS/EOC will follow command and control procedures and communicate the verbal request to the other local, regional, or state government agencies and Participating Hospitals and under the ICS and National Incident Management System. Ongoing MAA activation and coordination among Participating Hospitals must be communicated to the appropriate local and state government agencies and updated on EMResource.

During emergencies that involve state emergency operations center and Missouri Department of Health and Senior Services Department Situation Room activation the state agencies will communicate with local ICSs/EOCs to coordinate requests and assets. A Participating Hospital that sends assistance to another Participating Hospital is referred to as a “Lending Hospital” and the receiving hospital is referred to as the “Recipient Hospital.”

B. General Coordination

1. The Lending Hospital has responsibility to consider the impact on internal services and operations prior to releasing personnel to the Receiving Hospital.

2. The Receiving Hospital will assume direction and control of the personnel, equipment and supplies from Lending Hospital during transit to and from the Receiving Hospital and during the time the personnel, equipment and supplies are at the Receiving Hospital.

3. The Receiving Hospital will reimburse each Lending Hospital for all of the Lending Hospitals costs as determined by the Lending Hospitals established regular rates. Reimbursable costs include salary and benefits for personnel; breakage, damage, replacement and return costs of equipment and supplies. These costs may also include management and administrative costs, not to exceed ten (10) percent of the total reimbursable costs.

4. The Receiving Hospital will be responsible for overtime of loaned personnel including overtime that occurs as a result of being loaned and transferred during the middle of a payroll cycle.

5. The Lending Hospital will continue to pay loaned personnel on the normal pay cycle and without break in benefit of service.

6. If possible, the loaned personnel should submit hours worked to both the Lending and Receiving Hospitals during the period of time their service has been loaned.

C. Transfer of Personnel
1. The Receiving Hospital will provide to the Lending Hospital through direct communication or through the local ICS/EOC the following information:

   a. The number of requested personnel and specific skills requested (transferred personnel).

   b. An estimate of how quickly the request is needed.

   c. The location where the transferred personnel are to report.

   d. Confirmed nutritional and sleeping accommodations for the anticipated duration of the stay for the personnel providing services to the Receiving Hospital.

   e. The length of service and all arrangements which must be mutually agreed upon by the Lending Hospital, Receiving Hospital and loaned personnel prior to the Lending Hospital releasing personnel.

2. The arriving transferred personnel will be required to present their Lending Hospital identification badge upon arrival at the site designated by the Receiving Hospital. The Receiving Hospital will be responsible for the following:

   a. Establishing and following procedures for the arriving transferred personnel consistent with the Joint Commission Standards and state regulations pertaining to Disaster Privileges in effect at the time of the medical disaster.

   b. Confirming the transferred personnel’s ID badge with the list of transferred personnel provided by the Lending Hospital.

   c. Providing appropriate additional identification, e.g. “visiting personnel” badge, to the arriving transferred personnel.

3. The Receiving Hospital’s designated representative shall identify where and to whom the transferred personnel are to report. Health Care Professional or management staff of the Receiving Hospital will supervise the transferred personnel in accordance with incident command structure. The Receiving Hospital’s designated representative shall meet the transferred personnel at the point of entry of the facility and brief the transferred personnel of the situation and their assignments. If appropriate, the “emergency staffing” rules of the Receiving Hospital will govern assigned shifts. The shift for transferred personnel transferred personnel however, should be no longer than required by the Receiving Hospital of its own personnel in such an emergency, but should be scheduled no less than eight (8) hours per shift. Unless catastrophic circumstances exist, transferred personnel should be co-mingled with Receiving Hospital personnel at all times.
4. The Receiving Hospital will reimburse the Lending Hospital for the actual costs of the transferred personnel which shall include salary and benefits. Administrative expenses associated with the transfer to be reimbursed will not exceed 10 percent of the total costs of salary and benefits. Receiving Hospital shall be responsible for reporting data for the determination of workers’ compensation rates and other related purposes as necessary.

5. The Medical Director or other authorized individual of the Receiving Hospital will be responsible for providing a mechanism for granting appropriate emergency privileges for physicians, nurses and other licensed health care providers to provide services at the Receiving Hospital that are consistent with the Joint Commission Standards and state regulations pertaining to disaster privileges in effect at the time of the medical disaster. The procedure for granting such emergency privileges to the patient’s original attending physician shall be in accordance with the patient-receiving Hospital’s Medical Staff Bylaws and/or Medical Staff rules and regulations.

6. The Receiving Hospital will provide and coordinate any necessary demobilization procedures and post event stress debriefing. The Receiving Hospital is responsible for providing the transferred personnel any transportation necessary for their return to the Lending Hospital.

D. Transfer of Pharmaceuticals, Supplies or Equipment

The Receiving Hospital will utilize the Lending Hospital’s standard order requisition forms as documentation of the receipt of the requested materials. The Receiving Hospital is responsible for tracking the borrowed inventory and returning any non-disposable equipment in good condition or paying the Lending Hospital for the cost of replacement. The Receiving Hospital will reimburse the Lending Hospital for any consumable supplies or pharmaceuticals at actual cost including a fee for management and administration associated with the transfer that shall be an amount not to exceed ten percent (10%) of the base costs of the supplies or pharmaceuticals. The Receiving Hospital will pay for all reasonable transportation fees to and from the transfer site. The Receiving Hospital is responsible for appropriate tracking, use and necessary maintenance of all borrowed pharmaceuticals, supplies and equipment during the time such items are in transit or are in the custody of the Receiving Hospital in accordance with law, and shall be responsible for risk of loss and may insure or self insure risk of loss with the right of subrogation reserved.

1. Receiving Hospitals that are private nonprofit entities may be eligible for reimbursement for some of their expenses by the Federal Emergency Management Agency (FEMA) under the Stafford Act for their work associated with providing emergency medical services in a medical disaster. Each Receiving Hospital agrees to keep records required to support its own request for reimbursement under the Stafford Act and when appropriate, to substantiate and support the request for reimbursement of any other Participating Hospital using incident command system documents and other appropriate documentation.

2. All Participating Hospitals, to the extent applicable, agree that they will follow the FEMA procedures that are in effect at the time of a medical disaster that gives rise to reimbursement under the Stafford Act or its successor. At the time of the execution of this MAA, a Receiving Hospital that has paid the Lending Hospital for the services of personnel or for the use of equipment, supplies and pharmaceuticals is the hospital that is entitled to apply for reimbursement. Procedures for reimbursement are managed by the emergency management agency of the state in which a Receiving Hospital is located. Applications should be processed through the local emergency operations center or Medical Coordination Center.

F. Reimbursement Under Other Mutual Aid Agreements or Laws

Participating Hospitals may enter into other mutual aid agreements with governmental or non-governmental agencies including other hospitals and health systems during medical disasters, Participating Hospitals may be eligible for reimbursement under laws other than the Stafford Act that may be in effect at the time of a medical disaster during the effective life of this MAA. In any case, each Participating Hospital agrees to keep the records required to support its own request for reimbursement under any mutual aid agreement or law that provides for reimbursement and when appropriate, to substantiate and support the request for reimbursement of any other Participating Hospital. When a Participating Hospital is reimbursed for part or all of its expenses under other mutual aid agreement or law, it is not entitled to duplicate reimbursement from another Participating Hospital.
VIII. Transfer/Evacuation of Patients

A. Communication and Documentation

In addition to using emergency services and community resources, a request for transfer of patients may be made by the local ICS/EOC. This request may be executed directly between two parties but must be communicated to an appropriate local or state governmental entity and posted on EMResource. This is especially important during a non-declared emergency when local and state EOCs may not be activated.

In making a request to transfer through a local emergency operations or communications center, a Patient Transferring Hospital must specify the number of patients needing to be transferred, the general nature of their illness or condition, any specialized services required en-route or placement required, and the receiving hospital/facility. The Patient Transferring Hospital is responsible for providing copies of the patient’s pertinent medical records, registration information and other information necessary for care to the Patient Receiving Hospital to the extent that is practicable in the context of the medical disaster.

B. Transporting Patients

The Patient Transferring Hospital requesting transfer of its patients is responsible for triage of patients to be transported and any transfer and transportation costs not otherwise reimbursable by the patient or the patient’s third party payer, incurred for the transportation of its patients. The hospitals and local ICS/EOC will coordinate the transportation of patients. The Patient Transferring Hospital is responsible for transfer of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if it has them when and if requested to do so by the Patient Receiving Hospital.

C. Patient Admission

Once the patient arrives at the Patient Receiving Hospital, that hospital will designate the patient’s admitting service, the admitting physician for each patient, and, if requested, the patient’s original attending physician may be eligible for appropriate emergency privileges. The procedure for granting such emergency privileges to the patient’s original attending physician shall be the procedures established pursuant to Paragraph VII of this MAA.

D. Payment for Patient Care

Reimbursement for care should be negotiated with each patient’s insurer under the conditions for admissions without pre-certification requirements in the event of emergencies.
E. Notifications

The Participating Hospital requesting transfer of a patient is responsible for notifying and obtaining transfer authorization from the patient or the patient’s legal representative, as appropriate, and for notifying the patient’s attending physician of the transfer and relocation of the patient as soon as reasonably practical.

IX. Media Relations and Release of Information

In the event of a local or regional disaster, each Participating Hospital agrees to participate in a Joint Public Information Center under the local ICS/EOC that would be the primary source of information for the media related to a medical disaster affecting more than one Participating Hospital. During a multi regional or statewide disaster, state level agencies will coordinate establishment of the Joint Information Center which will speak on behalf of the affected Participating Hospitals to assure consistent, timely flow of information to the public.

X. Role of MHA Disaster Preparedness Planning Advisory Committee

The MHA disaster preparedness planning advisory committee will do the following:

1. continue to monitor, consider and propose amendments to this MAA as may be necessary

2. consider and facilitate additional Mutual Aid Agreements that may be established with governmental or non-governmental agencies including other hospitals or health systems that are designed to enhance emergency medical care during a medical disaster.

XI. General Provisions

A. Term, Termination and Automatic Renewal of this Agreement

1. Any previous Mutual Aid Agreement (MAA) sponsored by the Missouri Hospital Association and entered into by the parties is hereby declared void and of no effect.
2. The term of this MAA is three (3) years commencing on January 1, 2011. Thereafter, for all Participating Hospitals (other than those that opt out of this MAA), the MAA will automatically renew for consecutive one (1) year terms commencing on January 1 of each year until amended or terminated. Any Participating Hospital may terminate its participation in this MAA at any time by providing written notice to MHA and all other Participating Hospitals not less than sixty (60) days prior to the effective date of such termination. The obligation of any Participating Hospital to reimburse any other Participating Hospital that was incurred under this MAA, if not satisfied, shall survive the termination of this MAA.

B. Confidentiality

Each Participating Hospital shall maintain the confidentiality of all patient health information and medical records in accordance with applicable State and Federal laws and regulations, including, but not limited to, the HIPAA privacy regulations unless such applicable laws and regulations are modified or waived by competent authority during the medical disaster in which case each Participating Hospital shall conform to the applicable laws and regulations as modified or waived.

C. Liability for Transferred Personnel, Patients, Equipment and Supplies

1. Liability claims, malpractice claims, workers compensation claims, related attorneys and other incurred costs related to transferred personnel, patients, equipment and supplies shall be the responsibility of the Receiving Hospital. Personnel and equipment shall be considered to be under the direction and control of Recipient Hospital from time of arrival thereto and through the duration of their assignment.

2. Receiving Hospital shall provide for an extension of liability and workers compensation protection to the extent permitted by law and Receiving Hospital’s insurance contracts or self-insurance policies and agreements for coverage of transferred personnel and patients. Transferred personnel shall be deemed agents of the Receiving Hospital for purposes of this clause.

3. Recipient shall not assume responsibility for liability claims that may arise from or be attributable to pre-existing condition or defect of transferred equipment, supplies or medications or the failure to conduct preventive maintenance or to properly repair transferred equipment. Ownership of transferred equipment, supplies or medications shall remain in the Lending Hospital which shall be responsible for claims or injuries that may arise for such pre-existing condition or defect or failure to properly maintain such equipment. Lending Hospital shall retain the right to pursue claims against third parties as provided by law.

4. Liability claims arising during transfer of personnel, patients, supplies or equipment from a Lending Hospital to a Recipient Hospital shall be the
responsibility of the organization or entity in control of such transfer, as the case may be.

5. The provisions provided for in this paragraph XI.C. shall apply to public hospitals created pursuant to the laws of Missouri or other state where a Participating Hospital may be located only to the extent permitted by law and so as to not waive a Receiving Hospital’s sovereign immunity if such Receiving Hospital has a right there to under the law.

D. Payment of Fees

Lending Hospitals must issue an invoice within 90 days of costs incurred for all compensation for equipment, supplies or personnel provided to a Receiving Hospital pursuant to this MAA. A Receiving Hospital must pay the Lending Hospital within ninety (90) days of its receipt of an invoice from the Lending Hospital for such equipment, supplies or personnel, regardless of whether the Receiving Hospital intends to submit, or submits a claim for reimbursement under the Stafford Act.

E. Amendment

This MAA may be amended in writing signed by all Participating Hospitals. Failure to agree to an amendment will result in a Participating Hospital opting out of this Mutual Aid Agreement.

F. Severability

If any of the provisions of this MAA shall be determined to be illegal or unenforceable by a court of competent jurisdiction, those provision shall be severed from this MAA and the remaining terms of this MAA shall remain in full force and effect.

G. Counterparts

This MAA may be signed in counterparts, each of which shall be deemed an original and all of which, when taken together, shall constitute one and the same instrument.

XII. Revocation of Prior MAA

This MAA revokes and renders null and void any and all prior MAA’s addressing emergency preparedness entered into by a party which were developed pursuant to the state wide “ASPR Hospital Preparedness Program, CFDA 93.889” or its predecessors.
XIII. Effective Date

By the signatures below, on behalf of a given hospital such hospital agrees that it will participate in the Missouri Hospital Mutual Aid Agreement with all other signatory hospitals effective January 1, 2011, or the date of execution whichever occurs last under the terms and conditions set forth above.

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Appendix II: MISSOURI REGIONAL COALITION MEMORANDUM OF UNDERSTANDING (MOU)

I. Introduction

Certain critical incidents in or surrounding the state of Missouri, either regionally or statewide, may generate large numbers of patients requiring immediate emergency medical care including patients with very specialized medical requirements (hazmat injuries, trauma surgery, etc.) that exceed the resources of an individual health care entity. Such critical incidents may include, but are not limited to, catastrophic accidents, pandemics, terrorist attacks or severe natural disasters such as earthquakes or tornados. For purposes of this Memorandum of Understanding, a medical disaster is defined as a critical incident that exceeds the effective response capability of an individual health care entity.

II. Purpose and Expectations of this Memorandum of Understanding

The purpose of this statewide Memorandum of Understanding is to be a voluntary agreement among organizations that have as their primary mission a purpose to provide or support health care within their community. These organizations may include but are not limited to hospitals, emergency medical services, community health centers, local public health agencies, primary care and specialty clinics and long-term care facilities.

This agreement serves to establish formal roles and responsibilities as a regional health care coalition for emergency preparedness, response, recovery and mitigation as appropriate. In a response role, the health care coalition will serve as the medical coordination center referenced in the Hospital Mutual Aid Agreement, section VI: Communication.

Specifically, this MOU:

A. Is intended to augment, not replace, each facility’s emergency operations plan;

B. Focuses on coordinating preparedness and response activities between and among participating Missouri health care organizations located within geographic proximity; and;

C. Focuses on communicating situational awareness during an incident to facilitate a coordinated regional health care response.

D. The framework for regional coalition preparedness, response, recovery and mitigation will be provided through two documents:

   a. the United States Department of Health and Human Services Assistant Secretary of Preparedness and Response, Hospital Preparedness Program Guidance for Healthcare System Preparedness; and,
b. the Missouri Hospital Association Healthcare Coalition Framework and Emergency Coordination Guide. A copy of each of these agreements is available from the Missouri Hospital Association

Specifically, this MOU will not:

A. Serve as the mechanism to lend and receive resources, including staff during a disaster response. Instead, respective statewide Mutual Aid Agreements will be used for that purpose. For example, hospitals needing to receive or lend resources will refer to the previously executed Missouri Hospital Mutual Aid Agreement.

B. Replace the need for health care entities to operate under the principles of the Incident Command System; instead, the health care coalition will serve as a coordination mechanism to facilitate response with the local emergency operations center and emergency managers within appropriate jurisdictions.

III. Definitions

A. Health Care Coalition (HCC) — A collaborative network of healthcare organizations and their respective public and private sector response partners that serve as a multiagency coordinating group to assist with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary functions of a healthcare coalition are planning, organizing and equipping, training, exercises and evaluation. During response, Healthcare Coalitions should represent healthcare organizations by providing multi-agency coordination support to incident management through information and resource coordination for healthcare organizations. This includes either a response role as part of a multi-agency coordination group to assist incident management (area command/unified command) with decisions, or through coordinated plans to guide decisions regarding healthcare organization support.

B. Coalition Member — organizations that have, as their primary mission, a focus on health care services and have signed this MOU.

C. Coalition Partner — an entity that may attend and participate in the Coalition, but represents organizations that are not singularly focused on health care. Examples include: emergency managers and public safety officers.

D. Incident Command System (ICS) — A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
E. Support Facility — A Health care organization (HCO) capable of facilitating coalition communication and coordination, assisting in the deployment of regional resources and conducting basic supportive patient care such as triage, minor treatment and vaccinations.

F. Receiving Facility (Resources and patients) — An HCO capable of providing care, including triage, treatment, transport and limited trauma services. Despite this capability, the receiving facility does not have the capacity to surge as a primary facility for a large influx of patients or for a prolonged surge.

G. Surge Facility — An acute care facility capable of receiving a large influx of patients for an extended period of time, and serves as a primary trauma facility for the region. The surge facility should be recognized with a trauma designation.

IV. Health Care Organization Participation

Health care organizations that sign this MOU are required to:

A. Be signatories on statewide mutual aid agreements within their respective industries.

B. Demonstrate active participation in the health care coalition by:
   a. ensuring organizational representation at 75 percent attendance in coalitions that meet quarterly and at least 50 percent attendance in coalitions that meet monthly
   b. contributing subject matter expertise
   c. participating in coalition planning and decision making
   d. participating in coalition and regional training and exercises
   e. participating in the EMResource™ — Hospital Incident Command System coalition notification process
   f. agreeing, as appropriate, to serve on a rotation for the coalition duty officer

C. Accept responsibility to proactively agree to serve, as able in one of the following roles during a disaster response
   a. support facility
   b. receiving facility (medical patients)
   c. surge facility (medical patients)
Regional emergency preparedness planning, education, training, exercises, and support provided through the ASPR HPP program will be directed to and through the health care coalitions.

V. General Provisions

A. Term and Termination

a. The term of this Memorandum of Understanding is three (3) years commencing January 1, 2014. Thereafter, for all participants, other than those that opt out of this MOU, the MOU will automatically renew for consecutive one (1) year terms commencing upon January 1 of each year until amended or terminated. Any participating organization may terminate its participation in this MOU at any time by providing written notice to MHA and other participating organizations not less than sixty (60) days prior to the effective date of such termination.

b. If a signatory to this agreement consistently does not fulfill the participation requirements outlined in provision IV B., they may be asked to leave the group.

B. Approval. The participants, by executing this MOU, represent and warrant that they have the authority to commit their respective organizations to the terms of this MOU.

C. Review and Amendment. This MOU may be amended in writing signed by all participants. Failure to agree to an amendment will result in the participant opting out of this MOU.

D. Counterparts. This MOU may be signed in counterparts, each of which shall be deemed an original and all of which, when taken together, shall constitute one and the same instrument.

E. Severability. If any of the provisions of this MOU shall be determined to be illegal or unenforceable by a court of competent jurisdiction, those provisions shall be severed from this MOU and the remaining terms of this MOU shall remain in full force and effect.

F. Effective Dates. This MOU is effective upon the date cited above, or upon the date of execution, whichever is later.
I have read the foregoing Regional Mutual Aid Memorandum of Understanding and agree to the terms set forth therein including role designation.

☐ Support facility, or
☐ Receiving facility, or
☐ Surge facility, or

PARTICIPATING AGENCY

__________________________________
Signature

__________________________________
Organization

__________________________________
Printed Name

__________________________________
Title

__________________________________
Date
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Appendix III: HEALTHCARE COALITION DETAIL

Region B HealthCare Coalition

Coalition Mission

To improve all-hazard medical response for Region B through effective all-hazards planning, coordinated exercises and collaboration between regional health care organizations, emergency responders, local/regional emergency management directors, LEPCs & LEOCs, State and Local Public Health Departments, FQHCs, SEMA and other regional and State emergency response planning partners.

Regional Demographics

- 16 counties, total population: 179,989
- 8 hospitals, 1 Level-III trauma center
- Large agricultural community
- Mississippi River serves as the region’s eastern border
- 3 university populations (Truman State University- 5850 students, Hannibal LaGrange University- 1155 students, Culver-Stockton College - 5595 students)

Regional HVA Key Priority Findings

To include the Mississippi River and the bridges and ferries between population densities, agricultural and transportation hazards, and risks associated with various demographics

Top 3 Regional Priorities:

- Severe Storms/Tornado
- HazMat Transportation Incident – Highway, Rail River
- Severe Winter/Ice Storm

Coalition Planning and Response Objectives

Planning Objectives

- Identify mitigation strategies in response to hazards local and regional planners
- Identify training and exercise needs at the local and regional level
- Identify and capitalize on regional strengths
- Identify shortcomings of critical resources
- Maintain a regional plan and collaborate with other regional planners

Response Objectives

- Facilitate information sharing to promote situational awareness
- Facilitate resource support through the mutual aid process
- Facilitate the coordination of incident response actions for coalition members
- Facilitate interface with jurisdictional authorities in regional LEOCs and MACC

COALITION BUSINESS STRUCTURE

- Coalition members meet in localized location quarterly, conducting monthly conference calls
- Meetings convened and facilitated by coordinating entity or designated chairman
- Decisions are made by consensus of those present, ensuring each organization votes once, regardless of the number of attendees at each meeting
- Documentation of participation and progress through consistent use of attendance sheet and minutes
- Information is shared as appropriate with the MHA, other Missouri HCCs, affiliated Local Emergency Planning Commissions (LEPCs), SEMA and Regional Homeland Security Oversight Committees (RHSOC)
- Duty Officer rotation schedule is available on EMResource with current HCC leadership contact information

Last Reviewed: October 1, 2013
## Region B HealthCare Coalition

### Current Members

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Last Reviewed: October 1, 2013
Region F Emergency Healthcare Coalition

Coalition Mission

To improve all-hazard medical response for the region through support of the health care organizations, providers and regional partners by facilitating all-hazards planning, coordinated exercises, and real event response during the mitigation, response and recovery phases.

Regional Demographics

- 13 counties, 2 metropolitan statistical areas
- 14 hospitals (1 Psych, 1 Critical Access, 1 VA)
- 1 Level-I Trauma w/ Burn Unit, 1 Level-III Trauma
- Several university populations (50,000+ Students)
- Major sporting event centers

Regional HVA Key Priority Findings

To include the Missouri State Capitol, Bagnell Dam, Callaway Nuclear Facility, MU Nuclear Research Reactor, MU BSL-3 laboratory, major tourism lake, multiple airports, the Missouri River, bridges between population densities and risks associated with various demographics

Top 5 Regional Priorities:
- Severe Winter/Ice Storm
- Pandemic/Epidemic
- Severe Storms/Tornado
- External Violence/Civil Disobedience
- HazMat Incident (tied for 5th)
- Patient Surge/Mass Casualty (tied for 5th)

Coalition Preparedness and Response Objectives

Preparedness Objectives
- Identify mitigation strategies in response to hazards
- Promote training and exercising at the local and regional level
- Identify and capitalize on regional strengths
- Identify shortcomings of critical resources
- Develop and maintain regional health care plan

Response Objectives
- Facilitate information sharing to promote situational awareness
- Facilitate resource support through the mutual aid process
- Facilitate the coordination of incident response actions for members
- Promote interaction with multi-jurisdictional authorities

Business Structure

- Coalition meets monthly, convening conference calls as appropriate
- Meetings convened and facilitated by coordinating entities or designated chairman, following consent agenda
- Documentation of participation and progress is consistently recorded in the EMResource Hospital ICS application
- Information is shared as appropriate with the affiliated Local Emergency Planning Commissions (LEPCs) and Regional Homeland Security Oversight Committees (RHSOCs)
- Duty Officer rotation schedule is available on EMResource with current HCC leadership contact information

Last Reviewed: October 1, 2013
Region F Emergency Healthcare Coalition

Current Members

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Last Reviewed: October 1, 2013
Region H Emergency Preparedness Coalition

Coalition Mission
To improve all-hazard medical response for the community through effective all-hazards planning, coordinated exercises, and collaboration between area health care organizations, providers and regional partners.

Regional Demographics
- 15 counties, 7,509 square miles
- Total population: 233,295 (Estimated pop. Density: 31 persons per sq. mile)
- 9 Hospitals, 1 Level-II Trauma Center, 1 state psychiatric rehabilitation hospital
- 13 local public health departments, 1 federally qualified health center
- 3 university populations totaling 15,000+ Students
- 5 Missouri Department of Corrections facilities

Regional HVA Key Priority Findings
Top Three Identified Risks:
- Ice/Winter Storm
- Hazmat Incident/external
- Infrastructure/Power outage

Coalition Planning and Response Objectives

Planning Objectives
- Identify Hazards through a Regional HVA
- Identify mitigation strategies in response to hazards
- Identify training and exercise needs
- Identify and capitalize on regional strengths
- Identify shortcomings of critical resources
- House/maintain regional plan
- Implement mitigation strategies for response to identified hazards and needs

Response Objectives
- Facilitate information sharing to promote situational awareness
- Facilitate resource support through the mutual aid process
- Facilitate the coordination of incident response actions for members
- Facilitate interface with jurisdictional authorities

Business Structure
- Coalition meets monthly, alternating face-to-face and conference call formats
- Meetings convened and facilitated by chairperson and/or coordinating entities, as necessary
- Documentation of participation and progress is consistently recorded through meeting minutes and is posted in the EMResource Hospital ICS application for reference.
- Decisions are made by consensus of those present, ensuring each organization votes once, regardless of the number of attendees at each meeting.
  - 1 vote per member, 50% attendance of meetings within the current calendar year required
  - Each member identifies a primary and secondary proxy
  - As possible, agenda items requiring a vote will be published in advance

Last Reviewed: October 1, 2013
Region H Emergency Preparedness Coalition

- Information is shared as appropriate with the affiliated Local Emergency Planning Commissions (LEPCs) and Regional Homeland Security Oversight Committees (RHSOCs)
- Membership requirements:
  - Be signatories on statewide mutual aid agreements within respective industries
  - Demonstrate active participation in the healthcare coalition by:
    - Ensuring organizational representation at least 50 percent attendance
    - Contributing subject matter expertise, when appropriate
    - Participating in coalition planning and decision making
    - Participate in coalition and regional training and exercises
    - Participation in EMResource-Hospital Incident Command System coalition notification process
- To assist with coalition development, the coalition has elected the following coalition positions and subject matter experts:
  - Coalition Chair
  - Coalition Vice-Chair
  - Coalition Secretary
  - Communications Officer (SME)
  - Exercise Officer (SME)
  - Coalition Development (SME)

Coalition Activation

- All coalition members will have the ability to monitor the status of the coalition through EMResource.
- Coalition members may issue an advisory, alert, or activation by contacting Heartland Regional Medical Center Dispatch Center. The Dispatch Center, using EMResource, will activate the coalition based on level requested by the caller.
- The decision to activate should be based on the following criteria:
  - The incident will impact your organization to the point where assistance is required beyond your current capabilities
  - The incident will impact coalitions outside the region
  - Scarce resources may be required in multiple facilities
  - Critical information is unreliable
  - Communication capability is limited
  - The incident will last multiple operational periods (more than 12-24 hours)
- Coalition members should respond with their availability through EMResource, prepare to respond to requests and continue to monitor EMResource for situational awareness.
- EMResource Hospital Incident Command System (HICS) provides an additional tool for incident management for the coalition. The first coalition member to log into EMResource HICS application should assume Incident Command. Duty officer rotation schedule is available on EMResource with current HCC leadership contact information.
Region H Emergency Preparedness Coalition

## Current Members

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Southeast Missouri Regional Healthcare Coalition

**Coalition Mission**

To improve all-hazard medical response for the community through effective all-hazards planning, coordinated exercises, and collaboration between area health care organizations, providers and regional partners.

**Regional Demographics**

- 15 counties, 8,796 square miles
- Population: 371,936
- 15 hospitals
- 1 Level-III Trauma, 4 CAHs, 1 VA, 1 LTAC
- University Population (12,000+ Students)
- Major transportation route (Interstate 55)
- Mississippi River as the region’s eastern border
- Large agricultural community

**Regional HVA Key Priority Findings**

*To include the New Madrid Seismic Zone, Mississippi River and the bridges and ferries between population densities, agricultural and transportation hazards, and risks associated with various demographics*

**Top 5 Regional Priorities:**

- Severe Winter/Ice Storm
- Pandemic/Epidemic
- Severe Storms/Tornado
- Patient Surge/Mass Casualty (New Madrid Seismic Zone event)
- HazMat Incident

**Coalition Planning and Response Objectives**

**Planning Objectives**

- Identify mitigation strategies in response to hazards
- Identify training and exercise needs
- Identify and capitalize on regional strengths
- Identify shortcomings of critical resources
- House/maintain regional plan

**Response Objectives**

- Facilitate information sharing to promote situational awareness
- Facilitate resource support through the mutual aid process
- Facilitate the coordination of incident response actions for members
- Facilitate interface with jurisdictional authorities

**Business Structure**

- Coalition meets quarterly, convening conference calls as appropriate
- Meetings convened and facilitated by coordinating entities, following consent agenda
- Documentation of participation and progress is consistently recorded
- Information is shared as appropriate with the affiliated Local Emergency Planning Commissions (LEPCs) and Regional Homeland Security Oversight Committees (RHSOCs)
- Duty Officer rotation schedule is available on EMResource with current HCC leadership contact information

Last Reviewed: October 1, 2013
Southeast Missouri Regional Healthcare Coalition

Current Members

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Last Reviewed: October 1, 2013
Southwest Healthcare Coalition

Coalition Mission

To improve all-hazard medical response for the region through effective all-hazards planning, coordinated exercises, and collaboration between area health care organizations, providers and regional partners.

Regional Demographics

- 30 counties, 2 small metropolitan statistical areas
- 31 hospitals (1 federal military hospital)
- 2 Level-I trauma centers, 2 Level-II trauma centers, 1 Level-III trauma center
- 3 large university populations (Springfield, Joplin and Rolla)

Regional HVA Key Priority Findings

To include major transportation thoroughfare, multiple airports, Federal military base, three university populations, major tourism lake, entertainment district drawing large crowds to theatre venues and risks associated with various demographics

Top 5 Regional Priorities:
- Severe Winter/Ice Storm
- Pandemic/Epidemic
- Severe Storms/Tornado
- HazMat Incident
- Patient Surge/Mass Casualty

Coalition Planning and Response Objectives

Preparedness Objectives

- Identify mitigation strategies in response to hazards
- Promote training and exercising at the local and regional level
- Identify and capitalize on regional strengths
- Identify shortcomings of critical resources
- Develop and maintain regional healthcare plan

Response Objectives

- Facilitate information sharing to promote situational awareness
- Facilitate resource support through the mutual aid process
- Facilitate the coordination of incident response actions for members
- Promote interaction with multijurisdictional authorities

Business Structure

- Coalition meets quarterly, convening conference calls as appropriate
- Meetings convened and facilitated by coordinating entities or designated chairman, following consent agenda
- Documentation of participation and progress is consistently recorded
- Information is shared as appropriate with the seven Southwest Healthcare Coalition divisions, Local Emergency Planning Commissions, (LEPCs), Regional Homeland Security Oversight Committees (RHSOCs), Regional EMS Committees and Emergency Management Partners
- Duty Officer schedule established and available on EMResource

Last Reviewed: October 1, 2013
# Southwest Healthcare Coalition

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Last Reviewed: October 1, 2013
INTRODUCTION

This functional annex was prepared to address the process for initiating and sustaining emergency interoperable communications between healthcare organizations, healthcare coalitions, coordination centers and ESF-8 command and control locations. The annex will outline the established modes of communications available to Missouri healthcare organizations, their guidelines for use and the deployment strategy of the MCI/communication trailers deployed through outstate Missouri.

PURPOSE

Coordinate healthcare coalition communications to provide situational awareness on the status of healthcare delivery through information sharing among healthcare organizations, healthcare coalitions and their respective jurisdictional authorities.

TIER ONE ORGANIZATION PLANNING ASSUMPTIONS

The Local Emergency Operations Center (LEOC) is the official point of contact for command and control and is the conduit for resource requests and other assistance from the State Emergency Management Agency (SEMA) and federal agencies.

The following may serve as a conduit for collecting and disseminating current information about healthcare organization resources and needs, including equipment, bed capacity, personnel, supplies and other relevant matters.

- healthcare coalitions through EMResource®
- local/regional dispatch centers
- local emergency operations centers

HEALTHCARE COALITION COMMUNICATION AND COORDINATION

INCIDENT RECOGNITION AND SITUATIONAL AWARENESS

The MHA Coordinating Council has adopted the Intermedix EMResource® platform for primary monitoring and notification tools for HCC members. The Missouri Department of Health and Senior Services (DHSS) and the Missouri

Notification features are available to all EMResource® users. However, notification preferences need to be set up in advance by individual users who wish to receive them. More important, coalition response protocols must instruct members to update the coalition status within EMResource® to trigger these notifications.

*Currently, work is in process to align the EMResource® application with the WebEOC application. This application will be fully implemented within the State Emergency Operations Center, DHSS Department Situation Room and many of the local and regional emergency operation centers throughout the state.
Department of Public Safety’s emergency response personnel have acknowledged EMResource® as the medical platform for Web-based incident communication and coordination. Future plans to incorporate EMResource® into the state license for WebEOC are in process.

All coalition members will have the ability to monitor the status of each coalition through EMResource®. The following are a description for each coalition status, listed in the order of escalation, with “activation” being the most robust operational status. (MSCC, 2007; MSCC, 2009)

**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 healthcare organizations even though the organizations may not need to take emergency action.

**Alert** — Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. No immediate response indicated. This category also may be used for ongoing notification during an emergency to convey urgent information and recommended actions.

**Activation** — Identifies that a response from coalition members is required. Coalition procedure triggers the notification through EMResource® and the activation of EMResource® Hospital ICS to assign coalition members to appropriate response roles.

**COALITION ACTIVATION AND COMMUNICATION**

The coalition will function in a decentralized nature during normal day-to-day activities. As an incident or event occurs with potential or actual impact to coalition members, the coalition may be placed on advisory, alert or activated status using EMResource® as the communication tool.

Because of the widespread geography of non-urban Missouri and the main responsibilities of healthcare coalition members residing at the organization level, primary coalition communication and coordination should occur virtually through sequential and redundant methods of communication accessible to all HCC members. Depending on the incident and resource demands on the healthcare infrastructure, face-to-face coordination may be deemed appropriate to increase response effectiveness and efficiency.

**ADVISORY OR ALERT STATUS**

Coalition members should notify others of a potential or current incident when the following may occur.

- An HCO evacuation is imminent.
- There is a critical shortage of medical and/or ancillary personnel to care for arriving and in-house patients (capacity).
- There is a shortage of medical supplies.
- An HCO is damaged or compromised.
- Critical hospital utility systems and back-up systems are in use or not operational.
- A local emergency and/or all-hazard incident is occurring.
- A statewide or federal emergency is declared.
Healthcare coalitions, healthcare organizations, emergency management, relevant response partners and stakeholders coordinate to determine reportable healthcare incident specific information to be used during response. This information identifies the essential elements of information that can be reasonably shared during an incident.

Minimal information requirements should include but are not limited to the following elements.

- elements of information that are coordinated and agreed upon by healthcare organizations and local, state and federal response partners
- types of information that can be shared
- frequency that information should be shared
- participants authorized to receive and share data
- data use and re-release parameters
- data protections
- legal, statutory, privacy and intellectual property considerations
- information system security

Based on the scope and scale of the incident, appropriate essential elements of information will be collected from local, regional and state partners to support the response needs. The primary tool to collect information from healthcare partners will be EMResource®. The application has pre-scripted queries to collect bed availability and resources at both the regional and state level.

The following information should be communicated by a healthcare organization when requesting coalition assistance.

- situation status (brief description)
- primary request — critical need
- resources required
- point of contact for delivery of resources and follow-up information/instruction
- best mode of communication within the healthcare facility (based on current situation)
- activation of any mutual aid agreements

**ACTIVATION STATUS**

The decision to **activate** should be based on one or more of the following criteria.

- Assistance is required beyond an organization’s current capabilities.
- The incident or event will affect two or more coalition members in a region.
- The incident or event will affect coalitions outside of the region.
- Scarce resources may be required in multiple facilities.
- Critical information is unreliable.
- Communication capability is limited.
- The incident or event will last multiple operational periods (more than 12 to 24 hours).
- Activation is requested by another healthcare coalition or jurisdiction.
ESTABLISHED MODES OF COMMUNICATION FOR HEALTHCARE ORGANIZATIONS

All coalition members have access to and have shared the necessary landline telephone, cellular telephone and email contact information for inclusion on the coalition contact information roster.

EMResource®

- EMResource® is a Web-based data management tool that is available to all healthcare organizations in Missouri. The tool is used for daily bed management, as well as for emergency preparedness and response. The regular use of the system helps ensure accurate and timely information sharing during unplanned events.
- EMResource® lists each healthcare organization as an individual resource, as well as each healthcare coalition and metropolitan coordinating entity.
- EMResource® users can request, in advance, automated notifications from the application when statuses change or when events occur.
  - Hospitals can alert “followers” when their diversion or incident command activation status changes.
  - Local public health agencies and federally qualified health centers can adjust their operational status, triggering a notification to those registered to receive the information.
  - Furthermore, healthcare coalitions can alert members of changes in their activation status, whether providing an advisory, an alert, or activating the coalition.
- EMResource® Hospital ICS is a complimentary Web-based application for incident management available to hospitals and healthcare coalitions. The application provides the following features.
  - contact list and automated notification
  - library for plans, standard operating guidelines and preparedness documentation
  - incident response guides that facilitate an appropriate response based on pre-established response objectives and key action items
  - post-event documentation and report generation

HOSPITAL EMERGENCY ADMINISTRATIVE RADIO (HEAR)

All acute care hospitals with emergency departments are able to monitor HEAR 155.340 with a dedicated receiver/base station to communicate with:
  - incoming ambulances, as well as possible EMS commander at on-scene triage areas
  - surrounding hospitals with similar capability within an estimated 30 mile range
  - all Missouri HEAR radios were upgraded for narrowband compliance in 2012

VHF and 800 MHz RADIO

All hospital command staff should have access to their local agencies and first responders via local radio systems.

ASPR HPP acquired HT-1250s (where applicable) to link healthcare organizations with:
  - local IC
  - local EOC
  - local 911
  - hospital emergency room
If VHF is not the system used by local agencies, hospital-specific emergency preparedness plans should include access to local agencies and any related mutual aid talk groups.

**AMATEUR RADIO**

Healthcare coalition members should use amateur radio as a backup communications service, specifically for point-to-point communications.

An amateur radio communications plan for each healthcare coalition is pending.

**MISSOURI STATEWIDE INTEROPERABILITY RADIO NETWORK**

The HCC plan for use of the MOSWIN is to be developed as this resource is purchased, deployed and programmed in 2014.

**REGIONAL COMMUNICATION ASSETS**

MHA facilitates the coordination of 19 mobile communication assets in the outstate area. Each are owned and maintained by a participating hospital in the ASPR Hospital Preparedness Program.

- Current asset status, inventory and contact information is available on the Mobile Medical Asset view of EMResource®.
- The catastrophic deployment plan for these assets is under development.

Each communication asset maintains the following capabilities.

- satellite connectivity for Internet and phone communication
- VHF/UHF radio
- radio scanner
- wireless Internet
- voice over Internet protocol
- radio over internet protocol/PCNXU software
- amateur radio (optional)
- MOSWIN (expected spring 2014)

The 19 units are stored and maintained at the following facilities (listed by healthcare coalition).

- Region B Healthcare Coalition
  - Hannibal Regional Healthcare
  - Northeast Regional Medical Center, Kirksville*
- Southwest Healthcare Coalition
  - Cox Health, Springfield (expected completion spring 2014)
  - Freeman Health System, Joplin** (expected completion spring 2014)
  - Mercy Springfield
  - Mercy Joplin*
- Ozarks Medical Center, West Plains*
- Phelps County Regional Medical Center, Rolla*

### Southeast Missouri Regional Healthcare Coalition
- Madison Medical Center, Fredericktown*
- Missouri Delta Medical Center, Sikeston*
- Poplar Bluff Regional Medical Center*
- Saint Francis Medical Center, Cape Girardeau
- Southeast Health, Cape Girardeau*

### Region F Emergency Healthcare Coalition
- Boone Hospital Center, Columbia
- Capital Region Medical Center, Jefferson City*
- University of Missouri Healthcare, Columbia *
- University of Missouri Healthcare, Columbia**
- Lake Regional Hospital, Osage Beach*

### Region H Emergency Preparedness Coalition
- Heartland Regional Medical Center, St. Joseph

*denotes communication asset is co-located with MCI/Trauma supplies.
** denotes communications equipment is located in an ambulance vehicle.

---

The following communications algorithm provides a sequential and redundant method of communication for healthcare coalition members.

**Start here**
- **Advisory**
  - Cold start
  - EMResource® notice
  - No response required

**Did this work?**

If no, **Alert**
- Warm start
- EMResource® query
- Feedback sought

**Did this work?**

If no, **Activation**
- Hot start
- EMResource® and HICS notifications
- Automated phone call

**Did this work?**

If no, **Communication Failure**
- Runner/messenger
- Deployment of communication resource

**Did this work?**

**Radio Communication**
- HEAR
- MOSWIN
- Amateur

**Did this work?**

**Manual Voice Communication**
- Landline
- Cell phone

**Did this work?**

If no, **Start here**

If urgent, **Start here**

If no, **Advisory**
- Cold start
- EMResource® notice
- No response required

---

*Please note that urgent incidents should be prioritized and initiated immediately.*
DETAILED PROCEDURES AND ACTIONS FOR COALITION COMMUNICATION

TWO TYPES OF SENT MESSAGES

For the purpose of this annex, there are two types of messages communicated during response. These two types of messages facilitate the most accurate method of transmitting, sending and receiving essential communications. Categorizing messages as either reports or requests allows for the effective management of communications during response.

Report — A report is a broadcast or “one-way message” that requires no feedback from the message receiver and declares current status and operational capability. It provides the basic information of position, progress and forecast.

Reports are widely-transmitted and broadly disseminated so that all stakeholders are aware of the operational status. These one-way broadcasts can be effectively disseminated through EMResource®, websites, SMS text messages, voice mail greetings and radio broadcasts.

Request — A request is sent to a specific recipient. The message is sent with the intent that the recipient will act upon receiving. A request requires feedback from the recipient and is therefore a form of two-way communication. A request communicates current status and operational needs. It specifically requests resources to meet the operational demand brought on by the emergency or disaster. Requests can be effectively transmitted by phone, radios, email, data management systems, fax or face-to-face.

FACILITATED CONNECTIVITY OF “SENDER/RECEIVERS”

There are numerous modes of communication available to anyone at any time. During emergency situations, communication systems may become overloaded because of an increased need for messaging, and a system failure can occur as a result. One way to improve emergency communications is to have plans that broadly identify communication modes and associated methodology in sequential order to create a communication framework.

In the first minutes to hours of an escalating situation, the emergency communications process will be managed through an algorithm in EMResource® that will outline how routine communications normally should occur between two members of a healthcare coalition and which modes of communication each of them should use to communicate when the normal method is inadequate or inoperable. This algorithm will outline which modes and methods should be used first and which ones should be attempted in sequence until the message is transmitted and received.

COALITION DEMOBILIZATION

As the healthcare coalition starts planning for termination and demobilization of coordination personnel and assets, a detailed assessment of communications needs, resources and limitations should be performed by a coalition member. These recommendations should be included in the incident command objectives, and timelines for demobilization of MHA communications resources and mutual aid personnel should be maintained or released consistent with the best support for the incident.
INTRODUCTION

PURPOSE

This guidance is intended to structure communication and coordination for the healthcare coalition during the onset and duration of a fatality management incident.

BACKGROUND

Characteristics of a mass fatality incident:

■ overwhelms local resources
■ differing threshold for each community that is critical to identify early
■ factors to consider
■ number of deaths
■ scope of destruction
■ rate of recovery
■ resources

Major Operational Areas of a Fatality Management Response

■ human remains recovery operations
■ collection of remains and personal effects
■ fatality collection sites
■ medical examiner/coroner role

Morgue/Forensic Services Operations

■ cause and manner of death
■ identification
■ reunification with next of kin

Family Assistance Services

■ primary purpose — identification and reunification
■ security, safety, support
■ perception — direct connection with family, media, public
■ may be virtual

TIER 1 ORGANIZATION PLANNING ASSUMPTIONS

■ Fatality management has been incorporated into disaster planning and exercises for the hospital.
■ A written fatality management plan has been developed.
■ Primary and backup responsibility has been assigned for coordinating planning and response efforts surrounding incidents resulting in multiple fatalities.
HEALTHCARE COALITION FATALITY MANAGEMENT RESPONSE

INCIDENT RECOGNITION AND SITUATIONAL AWARENESS

**Tier 1 — Coroner/Medical Examiner**

An event has occurred producing fewer than 10 fatalities, and normal operations are being conducted by local healthcare entities to manage the decedents. Deceased bodies at this phase are generally intact and do not require decontamination, nor have the fatalities been the result of suspected criminal activity or terrorist involvement. If the deceased require decontamination procedures, involve suspected criminal or terrorist activity, or are generally fragmented remains, please consider proceeding to Tier 3 Activation.

- Hospitals are self-sustaining and maintain routine operations.
- EMS provides triage, treatment and transport of the ill and/or injured while the local public health agency communicates with and notifies the coroner and other health officers within the affected area.
- The coroner retains overall fatality management responsibilities and facilitates transport of deceased bodies to the examination center and to final disposition locations.
- If necessary or appropriate, the county office of emergency management provides overall “on-scene” management and mitigation of the incident as it facilitates communication of resource requests between county and state levels.

**Tier 2 — Healthcare Coalition**

An event has occurred producing between 10 and 30 fatalities, and routine fatality management plans are activated by local healthcare entities. Deceased bodies at Tier 2 are generally intact and do not require decontamination procedures, nor are fatalities a result of suspected criminal activity or terrorist involvement. If the deceased require decontamination procedures, involve suspected criminal or terrorist activity, or are generally fragmented remains, please consider proceeding to Tier 3 Activation.

- Hospitals remain self-sufficient to the capacity that their resources allow but actively communicate resource and situational status with the healthcare coalition through the use of EMResource®.
- An “advisory” notice is sent to members of the healthcare coalition.
- If the response is projected to remain in operation through multiple operational periods, the coalition is placed on “alert” status, and surrounding coalitions are advised of the incident.
- EMS continually provides triage, treatment and transport of the ill and/or injured while the local public health agency communicates with and notifies the coroner and other health officers within the affected area.
- The county EOC is activated and remains in constant communication with the coroner, who retains overall fatality management responsibilities.

**Tier 3 — County Emergency Operations Center**

An event has occurred producing fewer than 100 fatalities, and heightened mass fatality plans are activated by local healthcare entities. The county coroner holds the responsibility to authorize a Tier 3 Activation. Deceased bodies at Tier 3 may include those that require decontamination...
procedures, are fragmented in nature, require excessive effort to locate/recover remains, involve suspected criminal or terrorist activity, or other factors that require the enhanced level of management and coordination.

- The county office of emergency management facilitates the development of the local emergency declaration. The county OEM also facilitates resource requests between county and state levels and provides coordination to government as per the National Incident Management System.
- The coalition is “activated” and surrounding coalitions are placed on “alert.”
- Throughout the response, hospitals exhaust their resources to the fullest extent available and incorporate coalition resources and support as needed.
- EMS continually provides triage, treatment and transport of the ill and/or injured throughout the incident.
- Local entities continue with their respective responsibilities but with expanded coalition support and guidance from the county coroner.

**Tier 4 — State Assistance**

An event has occurred producing more than 100 anticipated fatalities, and contingency mass fatality plans are activated by local and state healthcare entities. Deceased bodies at Tier 4 may include those that require decontamination procedures, are fragmented in nature, require excessive effort to locate/recover remains, involve suspected criminal or terrorist activity, or other factors that require the enhanced level of management and coordination. Tier 4 fatality response activations also may require the use of nontraditional or alternative death care delivery methods as coordinated by the county coroner. The coroner assesses the need to request assistance from state and federal mortuary response teams and/or the Disaster Portable Morgue Unit (DPMU) communicating this request to the county EOC.

- Hospitals will operate at a level that their resources and those resources obtained from coalition members and the state can sustain.
- Additional healthcare coalitions are activated as appropriate, with communication and situational awareness through EMResource®.
- State-level involvement becomes readily apparent in a Tier 4 activation and requires cooperation of county EOC to notify appropriate Incident Command Systems of resource availability. Actions taken during a Tier 4 activation are focused on maintaining the integrity of the medical/health system throughout the affected area.

**Tier 5 — Interstate Resources**

A mass fatality event has occurred that has exceeded the capacity of a hospital, its healthcare coalition members and the resources available within the associated county. These events have exceeded the county’s ability to manage or mitigate the event without the assistance of state and interstate/federal resources. In a Tier 5 crisis activation, resources from neighboring jurisdictions will most likely not be available. This tier of activation will likely require the use of nontraditional or alternative death care delivery methods as coordinated by the county coroner.

Throughout the response, hospitals will operate to the best of their ability with the resources and supplies they do have but will likely require extensive critical supply levels from state and federal resources. These resource needs will be requested through the regional healthcare coalition that will
make appropriate mutual aid requests to the county EOC. Actions taken during Tier 5 activations are focused on maintaining the continuity of operations and essential functions, allowing the integrity of the medical/health system to remain intact.

**Tier 6 — Federal Assistance/DMORT**

A mass fatality event has occurred that has not only exceeded the surge and fatality management capacities of a hospital and the surrounding healthcare coalition but of the entire region and/or state, as well. This type of event is dramatically more complex and difficult to mitigate/manage than a Tier 5 fatality response and demands the direct involvement of federal response teams and supplies for local assistance. Primarily, the federal disaster mortuary response teams will offer guidance and assistance directly to regional partners to help assist in the response. Hospitals will work closely with state and federal teams to facilitate triage, medical staging, casualty clearing and definitive medical care for the imminent surge of walking wounded post-response.

The medical response to a Tier 6 fatality event will require the use of nontraditional or alternative death care delivery methods as coordinated by the county coroner. The county EOC will receive resource requests from the healthcare coalition and will facilitate obtaining supplies from state and federal partners. The overall focus during a Tier 6 fatality response should be to maintain basic and essential operations that manage the surge of those wounded from the event and to retain continuity of fatality management between healthcare entities and the coroner’s administration.

**AVAILABLE RESOURCES FOR HEALTHCARE ORGANIZATIONS**

Throughout 2013, the Missouri Department of Health and Senior Services and the Missouri Department of Public Safety have been collaborating with the Missouri Disaster Response System (MODRS) to develop a statewide fatality management response system, using the federal Disaster Mortuary Operational Response Team (DMORT) as a model. The new resource will be introduced to communities once the necessary systems are in place.

In addition to state level programs/resource described above, Missouri hospitals have secured regional fatality resources to increase capacity for decedents. Three Mortuary Enhanced Remains Cooling (MERC) Systems, each with a capacity of 24 decedents, are located strategically in close proximity to population densities and transportation routes for expedited deployment.

More information on these assets can be found on the Mobile Medical Asset view on EMResource® and in the Regional Resource Guide that will accompany this guidance beginning in January 2014.
Mass Fatality Healthcare Tiered-Response Structure

**TIER-6**
**HHS/DMORT & DOD**
Healthcare Coalitions serving the impacted areas will continue to communicate and coordinate local healthcare system operations, requesting resources as recognized from their local Emergency Operations Centers. State officials will engage federal partners as needed.

**TIER-5**
**EMAC**
Healthcare Coalitions serving the impacted areas will continue to communicate and coordinate local healthcare system operations, requesting resources as recognized from their local Emergency Operations Centers. State officials will engage interstate partners as needed.

**TIER-4**
**MODRS**
Hospitals ‘activate’ healthcare coalition and require regional and state-level resources to maintain operations and manage medical surge and fatalities.

**TIER-3**
**COUNTY EOC**
Hospitals ‘alert’ healthcare coalition and communicate possible needs for regional supply/staffing resources. The surge of patients/deceased is extensive and the hospital prepares to maximize its capacity to provide care and manage fatalities.

**TIER-2**
**HEALTHCARE COALITION**
Hospital initiates ‘advisory’ status to healthcare coalition and attempts to remain self-sufficient as its resources allow. Medical surge is expected and hospitals implement their surge plans to manage the increase.

**TIER-1**
**CORONER/MEDICAL EXAMINER**
Hospital operates under normal decedent management plans and actively communicates with the county coroner/medical examiner to facilitate response.