ASPR TRACIE Healthcare Coalition Resource and Gap Analysis Tool

Introduction	This tool was developed by the HHS Assistant Secretary for Preparedness and Response's Technical Resources, Assistance Center, and Information Exchange (ASPR TRACIE) as a template that healthcare coalitions (HCCs) can use as the basis for a resource and gap analysis. Gaps may include inadequate plans or procedures, staffing, equipment and supplies, skills and expertise, services, or any other resources required to respond to an emergency. This tool is complementary and can be used with other tools such as the ASPR Hospital Resource Vulnerability Assessment (https://asprtracie.s3.amazonaws.com/documents/hhs-hospital-rva-final.xlsm) and the HHS ASPR Rapid Infrastructure Assessment Tool (RIST). Go to https://asprtracie.hhs.gov/hcc-resources for a list of select HCC resources. For a 508 compliant version of this tool, copy and paste this link into your browser: https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-healthcarecoalition-resource-and-gap-analysis-pdf.pdf. Coalitions are encouraged to modify this template to reflect their coalition members, resources, and unique community attributes and to use the 'Gaps/Comments' field to enter specific deficits, plans, assets, and other qualifiers specific to their Coalition partners. For questions, comments, or assistance with this spreadsheet, contact ASPR TRACIE at asprtracie.hhs.gov or 1-844-5-TRACIE (587-2243).

Key Points

Purpose	This tool is designed to assist healthcare coalition partners develop a common understanding of their resources, existing gaps, and assist in prioritizing activities to close gaps.
Process	Based on the resources and number of stakeholders a variety of approaches may be taken to complete a gap analysis. Though a gap analysis is part of the HPP 2017-2022 cooperative agreement, there is no federal requirement to use this template. This template is a tool to structure coalition discussions and coalitions may elect to use portions of it as they wish to develop their analysis and priorities. The first time the coalition goes through this process will take the longest and should involve the broadest input. The template is designed as an iterative tool; results from the prior year can be used and updated in subsequent years and the stakeholders will be familiar with the process and outputs. A coalition should determine the best timing of when to conduct this analysis based on their planning process (e.g., some coalitions may find it useful to conduct this analysis after they have completed their hazard vulnerability assessment) and how often to update it. Completion of a Hazard Vulnerability Analysis (HVA) / Threat and Hazard Identification and Risk Assessment (THIRA) must precede use of this template as this information is important to the "event likelihood" scoring in this document and the awareness of current threats in the community will assist with the prioritization process. Examples of HVAs are available on ASPR TRACIE.
Scoring	The scoring used in this tool is designed to support prioritizing gaps, but is not the only factor that should be considered. Based on current events, exercises, available funds or resources, or priorities of member organizations the coalition may elect to choose different gaps to address rather than the highest scoring ones in this tool.
Structure	The tool is designed as an Excel file so that calculations will be made automatically to generate scores. There are several tabs, including introductory material, a tab for the coalition as well as one each for hospitals, EMS, public health, long-term care, and outpatient care as well as supplemental materials including the scoring systems and resources. There are 'sticky notes' with further information on some of the column/row labels including the scores that provide more information and are revealed by hovering over any box that has a small triangle in the upper right corner. This information is consistent with the instructions page and included for easy reference. The tool can also be printed out if desired, however, the sticky notes will not be visible on the printed version. A glossary and acronyms list, and list of additional resources are provided as the last two tabs in this tool.
Outcome	At the end of the process, your coalition will have an overview of its current resources, gaps, and a ranked list of the top thirty apparent priorities (both plans and assets) based on a scoring system considering the likelihood of needing the resource, the impact if it is not available, and the work remaining to be done. Modifiers of cost and time help support the prioritization. This list can then be used by your coalition as a starting point for developing a workplan for the next 1-3 years and may be revised as needed, for example on an annual basis, based on a review and update of the document information.

Process

Goal	Key stakeholders from your coalition should participate in completing this tool. The coalition should decide, based on its membership, size, and resources, how they will cooperatively perform the analysis. A reasonable process could involve completion by a steering committee, or individual discipline workgroups completing their section with a meeting of the chairs and leadership to discuss and finalize priorities, or a virtual process involving multiple stakeholders. Whatever mechanism is chosen, this should be part of a deliberative process with ample opportunity for discussion, input, and modification by the coalition membership. A composite score is generated by adding the "Likelihood, Impact, and Work" scores together to create an overall risk for that particular plan or asset. The higher the score, the higher the vulnerability or gap. The composite score can help Coalitions prioritize their work, as they may wish to direct their efforts at the highest risk areas, though it must be recognized that this score alone cannot represent the Coalition knowledge of the state of plans, threats, and issues in their area and should therefore be used as a guide, with local leaders and subject matter experts having significant input into the decisions on priority gaps and actions.

Scoring

Likelihood of Use	Impact	Work Remaining
On a 1-5 scale how likely it is that the plan/asset will be needed during a response. This risk should be weighed against the specifics of the coalition/community hazards (for example, an emergency response plan would be a "5", in a smaller rural community radiation-specific HAZMAT resources may be a "1") and could change year-to-year (for example if the community is hosting a large and high-risk event that year). **5 = Almost certain** – the plan/asset is used yearly by at least one coalition member **4 = Likely** – the plan/asset is used roughly every other year by a coalition member **3 = Possible** – the plan/asset has been used a few times in the last 10 years by coalition members and has a reasonable chance of being used in the next few years **2 = Unlikely** – the plan/asset has been used rarely in the last 10 years and has a low chance of being needed in the next 10 **1 = Rare** – the plan/asset will be needed a few times in the next 100 years	On a 1-5 scale, assign a score to the resource that illustrates the consequence if the asset or plan was inadequate or absent. This impact may consider human injury/death, coordination/information issues, community resilience, and property damage/economic impact. **5 = Extensive** – multiple deaths, compromise of information with significant ongoing impact, extensive property damage/economic impact (e.g. potential permanent closure of facility, >50% loss of assets) **4 = Significant** – few deaths but multiple major injuries/hospitalizations, compromise of information with significant impact on facility/agency operations, significant property damage/economic impact (e.g. temporary closure, remediation of portions of facility, 25-50% of assets damaged or lost) **3 = Moderate** – a few major injuries/hospitalizations, compromise of information with limited impact on facility/agency operations, moderate property damage/economic impact (e.g. 5-20% of assets damaged or lost) **2 = Insignificant** – several minor injuries, compromise of information with minor consequences for facility/agency, minor property damage/economic impact (e.g. <5% of assets damaged/lost) **1 = Negligible** – rare minor injury, no significant effects from information compromise, minor property/economic damage to single area/asset	On a 1-5 scale assign a score appropriate to the amount of work remaining to operationalize the capability in terms of planning, equipping, training, and exercising. Coalitions should consider how well the plans and assets are known and practiced in exercise or real-world environments when assessing the work remaining. **5 =** No plan or asset currently exists **4 =** Inadequate plan or assets **3 =** Possibly adequate plans or assets, but have not been evaluated, tested, and/or incomplete training **2 =** Adequate plans or assets requiring minor modifications based on exercises, events, or other evaluation **1 =** Sustainability only- strong capability in place, with regular on-going testing/training

Notes

• Plans and assets are listed to assure that each function is accounted for. It does not imply the need for a separate plan (e.g. a HCC COOP plan may be integrated with the response plan). In all cases, it is the elements or functions listed that should be present, whether in a separate plan, combined, or annexed.
• Many assets and plans listed are for community resource awareness and planning and are not tied to Coalition responsibilities or requirements under the HPP Cooperative Agreement.
• The presence of an item on the template does not imply the accountability of the HCC to correct a specific deficiency, particularly when that deficiency exists at a facility or agency level, however it should at minimum generate discussion about how the deficiency can be addressed or mitigated.
• In a coalition with many hospitals or EMS agencies, the goal is not to evaluate each agency/facility plan but to ensure an adequate number of discipline stakeholders agree on a consensus ranking for work remaining based on the overall level of comfort with the plans/assets in place - understanding that some facilities and agencies may have very robust capabilities and others very few (e.g. of 24 EMS agencies, if 17 reported inadequate COOP plans, even though the others were robust, a score of 4 would be assigned due to the relative weakness in this area).
• The 'Challenges' column contains examples of limitations that the coalition and partners may face in achieving their goals. There is no requirement to use them, and additional challenges may be listed under the 'Gaps/Comments' column. The 'Gaps/Comments' column also should track any specific issues or ideas that the group has relevant to the specific plan or asset.

Coalition Resources

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
HCC Chempack/SNS Plan	In jurisdictions hosting Chempack assets the plan should document hospital and EMS actions related to storage, maintenance, notification mechanism of need for release of assets and authority by whom to release them, accompanying security to distribution point, resupply method. All jurisdictions should have an SNS receipt and distribution plan. Include SNS receipt, distribution, and replacement.				0		
HCC COOP, Recovery/Business Continuity Plan	Coalition role and coordination of HCC recovery activities and continuity of operations (COOP) of HCC response functions (not a healthcare facility or agency) including backup for personnel, communication systems, and logistical support (assets).				0		
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.				0		
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).				0		
HCC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.				0		
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.				0		
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.				0		
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.				0		

Assets – depending on coalition size may track specific numbers or relative adequacy			
Item	**Gap (Number or Y/N)**	**Comments**	**Notes**
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system.* Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Funding		Including sources, structure of funding, budget, and spending authorities.	
Hardware/Connectivity		Coalition owned/managed/utilized with permission computers and other material resources to facilitate virtual or physical coordination center activities, including internet / data access.	
MAC/EOC		Physical and back-up location for HCC coordination efforts.	
Notification Platform		Electronic systems that provide notification to coalition leadership and partners. These systems are designed for event notification only, distinct from communication platforms listed below which are designed for ongoing, interactive information sharing.	
Response Equipment and Supplies (e.g., PPE, Evacuation, Medications, ventilators, mass casualty and specialty equipment)		May track through inventory management systems – this should be coalition owned / managed resources.	
Staff		Designated coalition response staff / team.	
Virtual Coordination		Platform for virtual coordination.	

*Coalitions may need to create a detailed analysis of the systems, strengths, and weaknesses depending on their size and complexity of their systems including consideration of HIPAA-compliant platforms if protected health information is being shared

EMS Resources

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.				0		
EMS Alerting/ Notification Plan	Describes alert and notification of the following during an incident for public safety and private sector based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should including any indicators/triggers for activation of MCI plan.				0		
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.				0		
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.				0		
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).				0		
EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).				0		
EMS Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
EMS HAZMAT/ Decontamination Plan	Describes roles of EMS and Fire including agent identification, setting up hot, warm and cold zones, capability for mass decontamination, and use of medical countermeasures for chemical, biological and radiological incidents. Include use of available antidotes (including CHEMPACK reference). Addresses delivery of contaminated patients to specialty care hospitals when needed and available.				0		
EMS Infectious Disease Plan	Includes guidelines for situational awareness and notification of outbreaks associated with seasonal and emerging infectious disease agents, dispatch communication to crews, hospitals and PH, personal protective equipment, infection prevention and control measures, specialized transport and response protocols to tiered levels of treatment facilities.				0		
EMS IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks (e.g. denial of service attack on 911), redundancy measures, training, PHI substitutions, and recovery measures.				0		
EMS Mutual Aid Plan	Specifies request process, commitment, notification, etc. between EMS agencies and details other services/assets. Include any written MOA/MOU and other agreements.				0		

EMS Patient Distribution Plan	Specifies EMS role in conducting (if applicable) inter-facility transports and patient distribution to hospitals and other healthcare facilities (e.g., freestanding EDs, etc.) – coordinated to minimize overload on single facility when possible. Integrated with hospital MCI plans.				0		
EMS Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including multi-model options- marine, air, ground transports, rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. (NOTE: this may be the same plan as developed under "Coalition Resources"). Should specify policies/procedures for MCI tracking versus healthcare facility evacuation patient tracking of transports.				0		
EMS Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Specifies on-scene command and unified command, roles, triage, staging, integration of response with law enforcement, and notification and casualty distributions to hospitals.				0		

Assets Note: Agency and HCC plans should document these assets as well as any triggers for use and request/activation processes
EMS agencies may need more specific breakdowns for local evacuation planning including NICU-capable transport units, bariatric transport units, etc.

Assets

Item	Gap (Number or Y/N)	Comments	Notes
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Community Paramedics		May include other community-based EMS personnel that may assume alternate roles in a disaster (e.g., paramedics are also firefighters, volunteer or paid, reserve personnel who can be called to assist with an MCI; those who are BLS or ACLS trained). In large metro areas may summarize / list agencies rather than specific resources.	
ALS Ambulances		May include scheduled and 911 assets, critical care transport, scheduled assets, reserve rigs, specialized units (pediatric, bariatric, isolation, etc.).	
BLS Ambulances		May include scheduled and 911 assets	
EMS Agencies		Transport agencies – include all emergency transport agencies, may consider including scheduled BLS provider services if applicable. Assure names and contact info for all potential ground, air, marine transport agencies, both emergency and scheduled are available.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)		Should document what regional assets are available to support hospital evacuation. May be listed in Evacuation Plan annex from above. Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies.	
Fixed-wing Units		Within 60 minutes response time to area, specific for flight time to scene/facility. Assure contact information is available for all agencies.	
Rotor-wing Units		Within 60 minutes response time to area, specific for flight time to scene/facility. List contact information/agencies and priority ring down based.	
HAZMAT Radiation Assets		Include detection/survey equipment	
HAZMAT Response Vehicle/Trailer		Include capabilities for agent identification, mass decontamination and throughput for ambulatory/non-ambulatory casualties, storage location, and contact info to request. Consider antidote availability.	
Mass Transit	N/A	Buses (school, public) and other contingencies should be documented – does not require a specific number. Assure points of contact and timeframe available. Include mass transit and paratransit assets and their capacities, contact info, and potential timeframe to mobilize them.	
MCI Trailers		Include contents, estimated number of casualties that can be treated, location, contact agency.	
MCI Bus/Vehicle		Include contents, estimated number of casualties that can be treated/transported, location, contact agency.	

Military Assets	N/A	Include assets that can be state or federally activated to support a medical response (National Guard, ground/air assets including ambulances, CERF-P units, CST, etc.). List key resources if activated by state.	
Other Response Vehicles		May include, supervisor, physician, 'jump' vehicles, etc. In large metro areas may summarize / list agencies rather than specific resources.	
Technical/ Swiftwater/ Collapse Rescue	N/A	Resources and agencies that may be engaged locally or regionally to assist with technical / US&R situations. List point of contact and timeframe.	
Wheelchair Vans		Should include private services. In large metro areas may list points of contact and not specific numbers.	

Hospital/Healthcare Resources

Hospitals may wish to use the more comprehensive TRACIE Resource Vulnerability Analysis (RVA) tool in combination with the Coalition aggregator and integrate these priorities into a more comprehensive annual update/assessment.
An important, and often neglected, part of the planning process involves agreeing on reasonable thresholds for hospital preparedness. All hospitals in the coalition should agree on baseline requirements for communications, HAZMAT/decontamination, mass casualty, pharmacy, incident management, N95 masks, and other resources. These may be adjusted for different event types based on the community HVA/THIRA as well as the size of the hospital and the role of the hospital in the community (e.g. a Level 1 trauma center has different supply needs from a small community hospital). Medication, surgical supply, and other stocks are contingent on planning for a spectrum of what could occur in the community. Developing assumptions for weather related natural disasters (e.g. tornado), active threat (shooting/blast), epidemic/bioterrorism (e.g. moderate pandemic), burn, pediatric, and HAZMAT events (chemical and radiologic) may be very helpful in setting preparedness targets for the community and avoiding situations in which some hospitals are inadequately prepared.

Plan Elements: All plans may not be applicable to all jurisdictions. Some jurisdictions may have additional plans based on area hazards (nuclear detonation response plans, nuclear power plant plans, hurricane response plans, etc.) and some may integrate multiple elements (pediatric, burn, etc.) into a single mass casualty plan. Many of the 'plans' listed may be annexes to an Emergency Operations Plan. As long as the specifics of the existing plans are adequate to address the function, this is completely appropriate. Each facility must have an Emergency Operations Plan including the elements below and conduct appropriate training. Each facility is assumed to use a NIMS-compliant ICS systems (e.g. HICS).

It is difficult to categorize multiple facility plans into an HCC-level analysis due to significant variability between plans - but common areas of deficiency should be identified for regional attention (examples might include HAZMAT/decontamination training, infectious disease response training, burn training, COOP planning) by the hospitals participating in the analysis.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Hospital Behavioral Health Plan	Support within the healthcare system for providers and patients – information, psychological first aid, access to services, assessments, treatment and referral. Include planning collaboration with EMS.				0		
Hospital Blood Bank Plan	Details support for hospitals during a mass casualty incident including delivery during access controlled situations.				0		
Hospital Closed POD Plans	Plans for internal vaccination/prophylaxis of healthcare personnel. May be helpful to quantify the number of employees who would be in need of vaccination or prophylaxis depending on role / job class.				0		
Hospital COOP, Recovery/Business Continuity Plan	Hospital continuity of operation (COOP) plans may help address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, food, communications, transportation, and other issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning, staffing plans, and structural / damage assessments.				0		
Hospital Crisis Care/ Crisis Standards of Care Plan	Details facility and regional approach to coordination of service and resource management, interface with State plans, and plans for on-site and community-based alternate care systems/sites including relevant facility and regional triggers where defined. Should also address 1135 waivers, and modification of other pertinent local/state rules and regulations to address surge issues, ACS, volunteers, etc.				0		
Hospital Decontamination Plan	Details facility and coalition capabilities and policies surrounding decontamination of patients. Includes protocols and training policies, includes CHEMPAK acquisition and utilization.				0		
Hospital Evacuation Plan	Describes process and support for urgent/emergent evacuation of healthcare facility. Include partial and full emergency evacuation decision making and process, shelter-in-place options, and protocols.				0		
Hospital Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
Hospital Infectious Disease Plan	Plans for receiving, assessing, and transferring highly infectious patients including seasonal influenza, Ebola/VHF, avian influenza, and SARS/MERS. Includes protocols and training policies. Include planning collaboration with EMS.				0		
Hospital IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks, redundancy measures, training, PHI substitutions, and recovery measures.				0		

Hospital Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. Also include inbound and outbound patient movement and airhead plans including coalition NDMS facilities. (NOTE: this may be the same plan as developed under "Coalition Resources")				0		
Hospital Pediatric MCI Plan	Include local and regional supplies and patient distribution, pediatric referral centers and resources. Detail hospital's level of preparedness to manage pediatric casualties.				0		
Hospital Security Plan	Facility plans may be supported by jurisdictional EM and law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence, active shooter, suspected explosive devices, and civil unrest.				0		
Hospital Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols. Include written plan for how needed assistance will be reported to others (phone, information sharing platform etc.) and hospital's role in HCC MOU/MAA to support emergency staffing and resource support.				0		
Hospital Surge Capacity Plan	Describe how the hospital will prepare for a surge of patients requiring medical treatment beyond normal operating capacity. Include immediate bed availability as a means to provide adequate levels of care to all patients during a disaster as applicable.				0		
Hospital Surgical/ Burn MCI Plan	Including local and regional supplies and patient distribution. Includes protocols and training policies. Surgical burn mass casualty incident (MCI) plans can address events such as active shooter or bombings.				0		
Hospital Volunteer Management Plan	Including capabilities, deployment parameters/priorities, and process inclusive of Medical Reserve Corps as applicable.				0		

* Numbers may be taken from subsequent LTC and outpatient tabs if available on those sheets

Assets

Item	Gap (Number or Y/N)	Comments	Notes
Number of Hospitals		Total hospitals in coalition providing emergency care / acute care services	
Critical Access Hospitals		Should include in total number above	
Specialty Hospitals		Long-term care hospitals, psychiatric or other specialty hospitals that do not provide emergency services	
Level 1 / Level 2 Trauma Centers			
Level 3 / Level 4 Trauma Centers		May include other/non-designated in this category if receive trauma	
ED Capacity		Based on usual spaces used for patient care for hospital-based ED	
ED Isolation (AIIR) Rooms		Alternate may be ED Positive /Negative pressure rooms.	

ED Surge Beds		These are beds in addition to usual ED beds – overflow / surge capacity only – may include adjacent procedure or other areas used for ED care.	
Operating Rooms			
Pre / Post Anesthesia Beds (PACU)		To be used for trauma, ICU overflow / boarding.	
Intensive Care Bed Adult			
Intensive Care Bed Pediatric			
NICU Beds		Consider Level in the case of evacuating NICU to other NICU's.	
Intensive Care Surge Beds		May include doubling, use of step-down areas (therefore may count stepdown and some monitored beds twice), and procedure areas. Must have dedicated cardiac monitors, appropriate medical gases, etc. Include capacity for NICU, PICU and Adult beds. Do not include PACU space here (list under PACU-specific line) – include both PICU and adult ICU potential surge beds.	
Stepdown (Intermediate Care) Beds		Intermediate care including cardiovascular drip medications, potentially BiPAP but not mechanical ventilation or pressor support.	
Stepdown Surge Beds		Must include cardiorespiratory monitoring capability including remote telemetry.	
Medical/Surgical Beds		Include operating (not licensed) adult and pediatric.	
Medical/Surgical Surge Beds		May include activating closed areas or doubling patients in private rooms.	
Inpatient Isolation (AIIR) Rooms		Include capacity for AIIR's and for cohorting.	
Inpatient Psychiatry Beds		Include capacity including for adults and pediatric patients.	
Burn Center Beds		Dedicated burn beds	
Surge Discharge Potential		Number of beds that could be made available via early discharge based on exercises or real-world events.	
Crisis Care		Number of cots that could be appropriately placed in flat space areas on hospital premises to create alternate care areas and including utilizing space where patients can be held awaiting treatment, actual treatment space (using cots, chairs, recliners, mobile vans, tents, air mattresses etc.).	
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Decontamination Capacity - Ambulatory		Patients / hour based on exercises - assume 10 minutes/person through process (e.g. 6 patients/hour per decon station)	

Decontamination Capacity – Non-ambulatory		Patients / hour based on exercises - assume 10 minutes/person at each decon station	
Patient Redress / Dry Decon Kits		Redress kits that allow a patient to disrobe under a large bag/cover and therefore remove contaminated clothing that can then be sealed in another bag. Limits continued exposure and potential for secondary contamination of EMS/hospital assets.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)		May be listed in Evacuation Plan annex from above. Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies. Include availability of adult, child and infant evacuation equipment.	
Long-term care (LTC) Beds*		May approximate in large metro areas – skilled nursing facility only. Quantify in the event of emergency evacuations.	
Outpatient Clinics*		Not at hospitals, may approximate in large metro areas. Do plans incorporate use of clinics in response and communication with clinics?	
Home Health Agencies / Home Hospice*		May approximate in large metro areas	
Personal Protective Equipment (PPE)– Infectious Disease		Please note a report of inventory is not expected, but that facilities should agree on baseline stocks that should be maintained and identify resources/caches that could be used and/or purchase caches if reasonable. Consider an acceptable par level of 20% above daily use. Includes surgical masks and N-95 masks. Consider adding the number of PAPR kits (Butyl and Bio specific), spare Tyvek suits of various sizes, and Bio hoods.	
PPE HAZMAT		PPE ensembles for the decontamination team including respiratory protection.	
Ventilators (Hospital Owned)		Do not include anesthesia machines in OR. Include transport ventilators with high/low pressure and other alarms suitable for longer-duration simple ventilation situations. Quantify adult & pediatric vents. Also ECMO.	

*Other Coalition, regional, or facility-based caches of disaster materials should be added in rows in this section as applicable by clicking 'Add New Row' at top.
Bed numbers are based on actual operating beds, not licensed beds.

Total Conventional Beds:	0
Total Contingency Beds:	0

Public Health Resources

Some of the functions described below have significant overlap with the roles and responsibilities of other coalition partners. However, public health must provide oversight and coordination to ensure the functions are addressed. Coalitions must verify their assumptions are consistent with the expectations of other partners, and that planning is complete enough and/or exercised enough to assure success. These functions may vary between jurisdictions within a single healthcare coalition and these variations should be identified and discussed when generating 'work' scores. The variability between plans may itself require additional discussion and contingency planning to ensure conflict or misunderstandings do not result during a response.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Public Health Access and Functional Needs Plan*	Defines populations in the community at risk of potential access/care based on emPOWER and other databases, demographic information, coordination with renal and other patient networks, liaison with cultural and advocacy groups and defining challenges and solutions for the needs of specific populations in relation to access to care, appropriate shelter accommodations, transport, and treatment needs.				0		
Public Health Alternate Care Systems/ Sites Plan	Including telephonic/telemedicine, screening/early treatment, and non-ambulatory care – EM and hospitals will have contributing responsibilities.				0		
Public Health Behavioral Health Plan	Including identification of population at risk, community support, screening, access to services, treatment.				0		
Public Health COOP, Recovery/Business Continuity Plan	Describes the continuity of operations (COOP) of public health response functions including backup for personnel, communication systems, and logistical support (assets).				0		
Public Health ESF-8 / Emergency Operations Plan	The jurisdictional emergency management plan should specify the lead agency for health and medical issues. Either this plan or the Public Health Emergency Operations Plan should specify the integration of the hospitals and EMS into the jurisdictional plan. This should include how information is shared with and between agencies, the process for resource requests, and the role of PH and EM relative to the coalition partners.				0		
Public Health Evacuation Plan	Describes the PH role and coordination efforts during an evacuation. (NOTE: this can be the same plan or coordinated with coalition evacuation plans for hospitals, long term care, etc.).				0		
Public Health Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
Public Health Family Assistance Center Plan	Integrated with hospitals, EOCs, and support organizations (e.g. ARC) – may include physical and virtual operations for re-unification and notifications				0		
Public Health IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks, redundancy measures, training, PHI substitutions, and recovery measures.				0		
Public Health Legal/ Regulatory Plan	Defines powers of State vs. local jurisdictions and local ordinances that may affect disaster response (e.g. disaster declarations, emergency orders, seizure powers, isolation and quarantine, changes to usual rules/requirements in disasters)				0		
Public Health Mass Mortuary/Fatality Plan	Includes role of the facilities, medical examiner/coroner and roles and responsibilities of the local agencies.				0		
Public Health Medical Countermeasures Plan	Include mass vaccination/prophylaxis (closed and open PODs), Chempack, and plans for receipt and distribution of other countermeasures from the SNS and other assets.				0		
Public Health Risk Communication Plan	Integrated with community / state JIS and coalition partners				0		
Public Health Shelter Support Plan	Provision of medical care / support in shelter environments.				0		
Public Health Volunteer Management Plan	Including capabilities, deployment parameters/priorities, and process inclusive of Medical Reserve Corps as applicable.				0		

*Including for example children, pregnant women, seniors, those with disabilities or physical/cognitive limitations, behavioral health conditions, and renal patients

Assets

Item	Gap (Number or Y/N)	Comments	Notes
Alternate Care System / Site		Includes materials for alternate care sites – may be managed by hospitals or EM	
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Mass Mortuary / Body Bags		Including processing / identification / storage	
Medical Countermeasures Administration/Distribution		Physical assets that support Chempack, antidote, vaccination/prophylaxis operations and distribution of other countermeasures from SNS and state and local assets that may include databases and electronic systems as well as physical resources (signage, badging systems, coolers, etc.)	
PH Agencies		Number of agencies participating in the coalition	

Long Term Care/ Skilled Nursing Facility Resources

Though LTC facilities are not a 'core' coalition member, their partnership is critical to community response success particularly when infrastructure is damaged. Therefore, completion of this section is highly encouraged. Enagement with the long-term care (LTC)/ skilled nursing sector is critical to encourage resilience and realistic planning and avoid failure that would further strain emergency and inpatient resources. Facility-level plans are difficult to incorporate into an HCC-level analysis as there is significant variability between plans but common areas of deficiency should be identified for regional attention (examples might include evacuation planning and training).

Individual health care entities are not permitted to use HPP funds to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation, including CMS-3178-F Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; however, HCCs are permitted to use HPP funding to provide technical assistance to their individual members to assist them with the development of plans, policies and procedures, and exercises that may enable individual health care entities to meet the CMS conditions of participation. The primary goal of the funding is to improve the ability of the community to provide acute medical care to disaster survivors. As a part of that effort, prepared and resilient LTC services are important to ensure facility resilience and reduce the likelihood of LTC facilities evacuating, which would further stress acute care services.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
LTC COOP, Recovery/ Business Continuity Plan	LTC continuity of operations (COOP) plans should address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, food, communications, transportation, and other relevant issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning as well as IT/IS contingency plans, staffing plans, and structural / damage assessments.				0		
LTC Emergency Operations Plan	All-hazards response plan for the facility. Include appropriate incident management system (NIMS, modified HICS) and relevant training. This should include documentation of information sharing and coordination process with the healthcare coalition and its partners.				0		
LTC Evacuation Plan	Describes process and support for urgent/emergent evacuation of healthcare facility. Includes triggers for patient movement and evacuation, protocols and policies as well as records and belongings transfer (to and from LTC). The facility plan should integrate with coalition-level plans for evacuation coordination.				0		
LTC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
LTC Infectious Disease Plan	Details response plans / process for an epidemic / pandemic affecting the facility, including any closed points of dispensing plans.				0		
LTC Information Sharing Plan/ Communications Plan	Including between LTC facilities and with the coalition during preparedness and response activities.				0		
LTC Security Plan	Facility plans should be coordinated with and supported by jurisdictional law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for workplace violence and active shooter events.				0		
LTC Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.				0		

Assets

Item	Gap (Number or Y/N)	Comments	Notes
Assisted Living Facilities		Optional	
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Evacuation Resources (Sleds, Stair Chairs, Pediatric Equipment, Evacuation Buses)		Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies	
Group Homes		Optional	
Long-term Acute Care Facilities		For prolonged, high-intensity management of chronic conditions	
Long-term Acute Care Beds			
LTC Beds		May approximate in large metro areas – skilled nursing facility only	
PPE		Including N95 masks, training/fit-testing. Do not need to track masks at individual facilities but should reflect overall situation as well as any caches / specific assets	
Skilled Nursing Facilities (SNF)		Number of free-standing facilities	
SNF as Part of Hospital		Number of SNF (included in the total above) that are physically connected to an acute care hospital	

Outpatient Care Resources

Though outpatient care facilities are not a 'core' coalition member, their partnership is critical to community response success particularly when infrastructure is damaged. Therefore, completion of this section is highly encouraged. Engagement with the outpatient care sector is critical to encourage resilience and realistic planning and avoid failure that would further strain emergency and inpatient resources. Facility-level plans are difficult to incorporate into an HCC-level analysis as there is significant variability between plans but common areas of deficiency should be identified for regional attention (examples might include evacuation planning and training, role in pandemic / epidemic). Note that some items/issues are specific to facilities and others are generic.

Individual health care entities are not permitted to use HPP funds to meet Centers for Medicare and Medicaid Services (CMS) conditions of participation, including CMS-3178-F Medicare and Medicaid Programs: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; however, HCCs are permitted to use HPP funding to provide technical assistance to their individual members to assist them with the development of plans, policies and procedures, and exercises that may enable individual health care entities to meet the CMS conditions of participation. The primary goal of the funding is to improve the ability of the community to provide acute medical care to disaster survivors, but prepared and resilient outpatient services are important to prevent additional patient surge on acute care services, and to assist with rapid decompression of acute care facilities in the wake of a disaster.

Plan Elements

Item	Notes	Likelihood of Use	Impact	Work Remaining	Composite Risk (L+I+W)	Challenges	Gaps/Comments
Outpatient Care COOP, Recovery/ Business Continuity Plan	Outpatient continuity of operations (COOP) plans may help address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, communications, transportation, and other issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning as well as IT/IS contingency plans, staffing plans, and structural / damage assessments.				0		
Outpatient Care Crisis Care/ Service Prioritization Plan	Details facility and regional approach to coordination of service and resource management and plans for on-site alternate care areas. This includes plans to determine what critical services/patient care activities can be sustained given the impact of the incident as well as triggers for changes to conventional practice.				0		
Outpatient Care Emergency Operations Plan	All-hazards response plan for the facility. Include appropriate incident management system and relevant training.				0		
Outpatient Care Evacuation Plan	Describes triggers, process, and support for urgent/emergent evacuation of healthcare facility. Includes protocols and policies as well as records and belongings transfer expectations/process.				0		
Outpatient Care Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.				0		
Outpatient Care Infectious Disease Plan	Details response plans / process for an epidemic / pandemic affecting the facility.				0		
Outpatient Care Information Sharing Plan/ Communications Plan	Including with any parent organizations and with the coalition during preparedness and response activities.				0		

Outpatient Care Security Plan	Facility plans may be supported by jurisdictional EM or law enforcement. Facility plans must include access controls and policies (for example, media and family access), as well as policies and training for violent patients, active shooter, suspected explosive devices, and civil unrest.				0		
Outpatient Care Staff and Resource Sharing Plan	Details how staff and resources will be shared between facilities and policies/protocols.				0		
Outpatient Care Surge Capacity Plan	Describe the facility role in common disasters including potential role supporting emergency care as well as communication and notification procedures.				0		

Assets

Item	Gap (Number or Y/N)	Comments	Notes
Ambulatory Surgery Centers		May be used for overflow acute care, overflow outpatient care	
Communication Assets		May include traditional phone lines, radios, cellular, satellite, internet-based – at least one primary and one redundant system. Radios (800mhz, amateur radio, other), web-based system, ability to receive HAN alerts, etc.	
Dialysis Centers		Number of facilities optional – document major chains and interface with coalition activities	
Evacuation Resources		Equipment (may be facility or cache-based) including patient movement, triage/tracking supplies (NOTE: this may only apply to ambulatory surgery centers and freestanding emergency rooms for non-ambulatory patients)	
Home Health Agencies		May approximate in large metro areas. Point of contact list should be available to coalition.	
Home Hospice Agencies		May approximate in large metro areas. Point of contact list should be available to coalition.	
Mental Health Providers	N/A	Document interface of major associations / provider groups / MRC or other assets with coalition activities	
Outpatient Clinics		Not on hospital campus, may approximate in large metro areas	
Retail Pharmacy		Number optional – document major chains and interface with coalition activities	
Surge Supplies		Does not need to include specifics of facility supplies but each facility should be accountable to be prepared according to their role in a disaster	
Telephone / Web-based Care	N/A	Document local system providers and interface with coalition activities	
Urgent Care Centers / Freestanding Emergency Rooms		Not at hospitals, may approximate in large metro areas – note may have significant differences in level of service/capabilities particularly for imaging. May also inlclude number of ORs.	

Gap Analysis

The thirty highest scoring plans and assets items are pre-populated into the following table. Based on the scores, these are gaps that the Coalition should consider closing. To assist in priority setting, this section allows inclusion of the time and cost required to address the gap. Though this is not a required step it may help the Coalition recognize areas with the greatest return on investment.

These gaps should be discussed by subject matter experts / coalition planners / coalition leadership to determine which of these items will be the focus of coalition and member work. The scores are not the only variables that may be considered when assigning priority. The motivation to close certain gaps may be stronger based on partner priorities, available funds, recent or upcoming events, and other factors. Therefore, an inclusive prioritization process should be developed by the coalition. The discussion may take place at a workgroup meeting or with the Coalition general or steering committee members to assure broad input and agreement. For each priority agreed upon by the Coalition a lead individual / agency should be documented and initial estimates of commitments should be discussed. The final list of priorities should be brought to the broader Coalition membership for discussion and acceptance and can then be integrated into a Preparedness Plan / workplan and specific strategies and tactics developed.

30 Highest Scoring Plan and Action Items

Item	Notes	Composite Risk (L+I+W)	Cost to address ($)	Time to address (T)	Priority (L+R+W) / $+T	Priority List
HCC Chempack/SNS Plan	In jurisdictions hosting Chempack assets the plan should document hospital and EMS actions related to storage, maintenance, notification mechanism of need for release of assets and authority by whom to release them, accompanying security to distribution point, resupply method. All jurisdictions should have an SNS receipt and distribution plan. Include SNS receipt, distribution, and replacement.	0			0.00	
HCC COOP, Recovery/Business Continuity Plan	Coalition role and coordination of HCC recovery activities and continuity of operations (COOP) of HCC response functions (not a healthcare facility or agency) including backup for personnel, communication systems, and logistical support (assets).	0			0.00	
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.	0			0.00	
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).	0			0.00	
HCC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	0			0.00	
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.	0			0.00	
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.	0			0.00	
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.	0			0.00	
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.	0			0.00	
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.	0			0.00	
EMS Alerting/ Notification Plan	Describes alert and notification of the following during an incident for public safety and private sector based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should including any indicators/triggers for activation of MCI plan.	0			0.00	
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.	0			0.00	
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.	0			0.00	
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).	0			0.00	

EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).	0			0.00	
EMS Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	0			0.00	
EMS HAZMAT/ Decontamination Plan	Describes roles of EMS and Fire including agent identification, setting up hot, warm and cold zones, capability for mass decontamination, and use of medical countermeasures for chemical, biological and radiological incidents. Include use of available antidotes (including CHEMPACK reference). Addresses delivery of contaminated patients to specialty care hospitals when needed and available.	0			0.00	
EMS Infectious Disease Plan	Includes guidelines for situational awareness and notification of outbreaks associated with seasonal and emerging infectious disease agents, dispatch communication to crews, hospitals and PH, personal protective equipment, infection prevention and control measures, specialized transport and response protocols to tiered levels of treatment facilities.	0			0.00	
EMS IS/IT System Failure/ Compromise Plan	Includes downtime, cyberattacks (e.g. denial of service attack on 911), redundancy measures, training, PHI substitutions, and recovery measures.	0			0.00	
EMS Mutual Aid Plan	Specifies request process, commitment, notification, etc. between EMS agencies and details other services/assets. Include any written MOA/MOU and other agreements.	0			0.00	
EMS Patient Distribution Plan	Specifies EMS role in conducting (if applicable) inter-facility transports and patient distribution to hospitals and other healthcare facilities (e.g., freestanding EDs, etc.) – coordinated to minimize overload on single facility when possible. Integrated with hospital MCI plans.	0			0.00	
EMS Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patients and during patient redistribution activities or patient reception activities (e.g. NDMS) in the area. Urban areas should reflect secondary patient movement to achieve load-balancing between hospitals. Rural areas should specify plans to obtain EMS support (including multi-model options- marine, air, ground transports, rotor-wing) to transport multiple patients to other receiving facilities from the overloaded local facility. (NOTE: this may be the same plan as developed under "Coalition Resources"). Should specify policies/procedures for MCI tracking versus healthcare facility evacuation patient tracking of transports.	0			0.00	
EMS Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Specifies on-scene command and unified command, roles, triage, staging, integration of response with law enforcement, and notification and casualty distributions to hospitals.	0			0.00	
Hospital Behavioral Health Plan	Support within the healthcare system for providers and patients – information, psychological first aid, access to services, assessments, treatment and referral. Include planning collaboration with EMS.	0			0.00	
Hospital Blood Bank Plan	Details support for hospitals during a mass casualty incident including delivery during access controlled situations.	0			0.00	
Hospital Closed POD Plans	Plans for internal vaccination/prophylaxis of healthcare personnel. May be helpful to quantify the number of employees who would be in need of vaccination or prophylaxis depending on role / job class.	0			0.00	
Hospital COOP, Recovery/Business Continuity Plan	Hospital continuity of operation (COOP) plans may help address HVAC, IT/EMR, utility, potable water, power, fuel, vendor / supply chain, food, communications, transportation, and other issues. Facility plans should incorporate these issues with detailed mitigation/redundancy planning, staffing plans, and structural / damage assessments.	0			0.00	
Hospital Crisis Care/ Crisis Standards of Care Plan	Details facility and regional approach to coordination of service and resource management, interface with State plans, and plans for on-site and community-based alternate care systems/sites including relevant facility and regional triggers where defined. Should also address 1135 waivers, and modification of other pertinent local/state rules and regulations to address surge issues, ACS, volunteers, etc.	0			0.00	
Hospital Decontamination Plan	Details facility and coalition capabilities and policies surrounding decontamination of patients. Includes protocols and training policies, includes CHEMPAK acquisition and utilization.	0			0.00	
Hospital Evacuation Plan	Describes process and support for urgent/emergent evacuation of healthcare facility. Include partial and full emergency evacuation decision making and process, shelter-in-place options, and protocols.	0			0.00	

High Priority Plan and Action Items

The list below displays the highest scoring plans based on the user-selected values in the Priority List column on the "Gap Analysis - Plans" tab. Please add additional details or plans of action in the rightmost column.

15 Highest Scoring Plan and Action Items

Item	Notes	Priority List	Priority Score	Additional Details/Plan of Action
HCC Chempack/SNS Plan	In jurisdictions hosting Chempack assets the plan should document hospital and EMS actions related to storage, maintenance, notification mechanism of need for release of assets and authority by whom to release them, accompanying security to distribution point, resupply method. All jurisdictions should have an SNS receipt and distribution plan. Include SNS receipt, distribution, and replacement.	0	0.00	
HCC COOP, Recovery/Business Continuity Plan	Coalition role and coordination of HCC recovery activities and continuity of operations (COOP) of HCC response functions (not a healthcare facility or agency) including backup for personnel, communication systems, and logistical support (assets).	0	0.00	
HCC Crisis Standards of Care Plan	Coalition-level plans for crisis situations summarizing the discipline-specific coordination mechanisms and referencing any coalition-level activities including resource management, regional triage / medical advisory teams, and information coordination.	0	0.00	
HCC Evacuation Plan	Describes the coalition role and coordination efforts during an evacuation of a health care facility and its repatriation (when needed). (NOTE: this can be the same plan or coordinated with evacuation plans for EM, EMS, hospital, long term care, etc.).	0	0.00	
HCC Exercise Plan	Including engagement in community / coalition level exercises. Exercises should meet the needs of regulatory agencies/accrediting bodies and are coordinated between the coalition disciplines to assure a community-based exercise at least yearly involves the four core coalition stakeholders and ideally more.	0	0.00	
HCC Patient Tracking and Movement Plan	Documents the responsibilities of EMS/PH/Hospitals/EM for tracking incident-related patient tracking during field triage, emergency evacuation, and transport. Includes patient redistribution activities to minimize surge and promote load-balancing among reception and treatment facilities. Include planning for activation by NDMS as a host or reception site. Specify process to obtain multimodal patient transport assets including ground, vehicular and marine options.	0	0.00	
HCC Resource Plan/Annex	Describes the resource request and sharing process including the coalition interface with EM/PH. This includes a list of specific assets purchased with federal or state funds or under direct control of HCC partner members. Includes cache materials, response resources for CBRNE, MCI's or emergency evacuation, specific adult and pediatric patient care items, and other assets to support facility operations.	0	0.00	
HCC Response Plan	Describes who will be notified, how, and when (specifying indicators and triggers) during a community incident; specific mechanisms for information sharing and coordination among coalition partners; responsibilities of coalition members, response partners, and HCC "Response Team" members. Document Regional Patient Tracking and Mutual Aid Plans or agreements (e.g., MOU, MOA, MAA) between coalition members or partners.	0	0.00	
HCC Specialty Mass Casualty Plans (e.g., MCI, Pediatric, Burn)	Coalition-level plans for specialty situations should specify coordination, patient distribution, primary and surge facilities and resources, and coordination with specialty centers.	0	0.00	
EMS Active Shooter/ Armed Assailant/ Active Threat Response Plan	Documents integration with law enforcement during response to active shooter/blast event scenes prioritizing access to victims, the role of EMS providers, mass triage, rapid interventions including hemorrhage control, early evacuation, and treatment/transport.	0	0.00	
EMS Alerting/ Notification Plan	Describes alert and notification of the following during an incident for public safety and private sector based systems: 911 PSAP/dispatch centers, area hospitals, and EMS supervisors/management/ medical direction staff. Should including any indicators/triggers for activation of MCI plan.	0	0.00	
EMS Behavioral Health Plan	Includes critical incident stress support, access to information about normal stress responses, psychological first aid training, and professional behavioral health support to providers. Ideally, this should also include tracking and follow up of at-risk employees after critical incidents.	0	0.00	
EMS COOP, Recovery/Business Continuity Plan	Include provisions for reconstitution of 911 answering, dispatch, and response functions if local capabilities are inoperable.	0	0.00	
EMS Crisis Care/ Crisis Standards of Care Plan	Details protocols / policies to be used at dispatch and response level when demand severely overwhelms capacity (staffing, dispatch, triage/treatment plans, including triggers).	0	0.00	
EMS Evacuation Plan	Describes the EMS role and coordination efforts during emergency healthcare facility evacuation integrated with HCC partners and the Emergency Operations Center. (NOTE: this can be the same plan or coordinated with evacuation plans for the coalition, hospital, long term care, etc.).	0	0.00	

Selected Glossary/Definitions

Burn Center Beds	Dedicated Burn Unit beds with qualified nursing and surgical staff. Usually ABA-verified center though dedicated burn beds at other centers should be included in local/regional plans.
Chemical, Biological, Radiological, and Nuclear Response Enterprise	The U.S. military domestic CBRN Response Enterprise includes National Guard units assigned to the National Guard's Weapons of Mass Destruction Civil Support Teams (WMD-CSTs), CBRN Enhanced Response Force Packages (CERF-Ps), and Homeland Response Forces (HRFs). • The CERF-Ps are located in each of the 10 FEMA Regions. They are designed to deploy within 6 hours of notification using a phased deployment. They have the ability to integrate with first responder teams, augment, or operate independently. The CERFP is comprised of four elements staffed by personnel from already established National Guard units. Elements include: search and extraction, decontamination, medical, and command and control. • The WMD CSTs are located in each state, US Territory, and Washington DC, with two each in California, Florida, and New York. They identify CBRN agents and substances, assess current and projected consequences, advise on response measures, and assist with requests for additional state support. • When directed by proper authority and upon consent of the Governor(s), the HRF alerts and assembles within 6-12 hours; on order, deploys and conducts command and control; casualty assistance; search and extraction; decontamination; medical triage and stabilization, Fatality Search and Recovery to save lives and mitigate human suffering. On order, transitions operations to civil authorities and redeploys.
Dry Decontamination Kits	Redress kits that allow a patient to disrobe under a large bag/cover and therefore remove contaminated clothing that can then be sealed in another bag. Limits continued exposure and potential for secondary contamination of EMS/hospital assets.
Medical/Surgical Beds	General medical / surgical ward bed - bed and staff can provide basic interval vital sign monitoring, oxygen, and inhaled, oral, and intravenous or intramuscular medications. Patients on these units are generally stable with limited potential for acute deterioration. Pediatric and adult beds are bundled together.
Intensive Care Unit	Bed and staff can support above plus mechanical ventilation, sedation, hemodynamic support (pressor agents), and similar advanced cares for unstable or dangerously ill patients. There is not an expectation that the facility have ventilators for each identified ICU surge bed but monitors are expected. Adult and pediatric beds are bundled together as a listed resource for disaster planning purposes. Coalitions may wish to break out pediatric ICU beds for their regional planning efforts to understand conventional capabilities.
Stepdown	Bed and staff can provide cardiorespiratory monitoring (cardiac monitor, oxygen saturation monitoring) and intravenous medications and fluid support for currently stable patients with significant oxygen or other needs and potential for dangerous rhythm disturbances and deterioration. Pediatric and adult beds are bundled together.

Surge Beds	Beds that can be used during a disaster event. This may involve making appropriate single rooms double, using observation, pre or post-anesthesia care areas, or opening closed units. The facility should only declare the number of beds it actually has on hand and could achieve within 24 hours, though the Coalition may wish to track potential additional beds that could be opened with leased/supplied beds and over a longer timeframe (e.g. some remodeling / temporary walls would be constructed, etc.).
Surge discharge potential	The number of patients that could safely be moved to a discharge holding area / out of their usual rooms pending discharge to make room for incoming patients. Hospital needs to have a process for selecting these patients and generate a point estimate of the number of beds that could be made available based on exercises or real-world activation of the process. The aggregate number of beds made available across the coalition hospitals should be listed.

Acronym Index

AIIR	Airborne Infection Isolation Room
ALS	Advanced Life Support
ARC	American Red Cross
ASPR	Assistant Secretary for Preparedness and Response
BLS	Basic Life Support
COOP	Continuity of Operations Planning
ED	Emergency Department
EM	Emergency Management
EMS	Emergency Medical Services
EOC	Emergency Operations Center
GETS	Government Emergency Telephone Service
HAZMAT	Hazardous Materials
HCC	Health Care Coalition
HICS	Hospital Incident Command System
HVA	Hazard Vulnerability Analysis
HVAC	Heating, ventilation, and air conditioning
ICS	Incident Command System
ICU	Intensive Care Unit
IT/IS	Information Technology / Information Systems
JIS	Joint Information System
LTC	Long Term Care
MAC	Multi-Agency Coordination
MCI	Mass Casualty Incident
NDMS	National Disaster Medical System
NIMS	National Incident Management System
OR	Operating Room
PACU	Post-Anesthesia Care Unit
PH	Public Health
POD	POD
PPE	Personal Protective Equipment
PSAP	Public Safety Answering Point

RVA	Resource Vulnerability Analysis
SARS/MERS	Severe Acute Respiratory Syndrome / Middle East Respiratory Syndrome
THIRA	Threat and Hazard Identification and Risk Assessment
TRACIE	Technical Resources, Assistance Center, Information Exchange (asprtracie.hhs.gov)
US&R	Urban Search and Rescue
VHF	Viral Hemorrhagic Fever
WPS	Wireless Priority Service

Resources

ASPR TRACIE Hazard Vulnerability/ Risk Assessment Topic Collection
ASPR TRACIE Select HCC Resources
HHS ASPR
Hospital Resource Vulnerability Assessment (RVA)
RVA Implementation Guide