Inter-Hospital Coordinating Council

Preparedness Planning Guidelines

April 2023

Approval and Implementation Document

Inter-Hospital Coordinating Council Preparedness Planning Guidelines

This Plan is hereby approved for implementation.

Date Preparedness Planning Guidelines Approved: April 14, 2023

APPROVAL OF PREPAREDNESS PLAN: This Guideline is adopted with review by coalition membership and approval by Coalition Core Members.

Inter-Hospital Coordinating Council
Preparedness Planning Guidelines
Record of Changes

Date of Revision	Recommended Changes	Revision Number	Initials
01/2019	HVA, gap and resource analysis, social vulnerability index, goals and objectives, tracking sheet	1	AE
02/2020	HVA, Gap and Resource Analysis, Social Vulnerability index, goals and objectives and clarification throughout document	2	JLL
12/2020	HVA, Gap and Resource Analysis, goals and objectives and clarification throughout document	3	JLL
12/2021	HVA, Gap and Resource Analysis, goals and objectives and clarification throughout document	4	JLL
02/2022	HVA, gap and resource analysis, social vulnerability index, goals and objectives, tracking sheet	5	AE

Inter-Hospital Coordinating Council
Preparedness Planning Guidelines
Record of Distribution

To Whom: Person/Title/Agency	Method of Delivery	Date
Inter-Hospital Coordinating Council	Email/website	January 2018
Inter-Hospital Coordinating Council	Email/website	January 2019
Inter-Hospital Coordinating Council	Email	February 2020
Inter-Hospital Coordinating Council	Email	December 2020
Inter-Hospital Coordinating Council	Email	December 2021
Inter-Hospital Coordinating Council	Email	April 2023

Table of Contents

1. Introduction 5
   1.1 Purpose of Guidelines: 5
   1.2 Scope 5
   1.3 Administrative Support 5
2. Coalition Overview 5
   2.1 Introduction/Purpose of Coalition 5
   2.2 Coalition Boundaries 6
   2.3 Coalition Members 6
      2.4.1 Role of Leadership within Member Organizations 7
   2.5 Risk 8
   2.6 Resources and Gaps 9
   2.7 Compliance Requirements/ Legal Authorities 10
3. Coalition Objectives 10
   3.1 Maintenance and Sustainability 11
   3.2 Engagement of Partners and Stakeholders 11
      3.2.1 Health Care Executives 11
      3.2.2 Clinicians 11
      3.2.3 Community Leaders 11
      3.2.4 Children, Pregnant Women, Seniors, and Individuals with Access and Functional Needs 12
4. Workplan 13
   4.1 Roles and Responsibilities 13
5. Appendices 15
   5.1 Commitment to Participate 16
   5.2 Detailed Information on HVA 17
   5.3 Program Plan and Budget 18
   5.4 Compliance Requirements/ Legal Authorities Table 19
   19
   5.5 2022 Goals and Objectives 20
   5.6 Checklist of proposed activities 21
   5.7 Social Vulnerability Index 2018 – Washoe County 22
   24
   5.8: Communications Plan 24

1. Introduction

These guidelines describe the roles and responsibilities of the Inter-Hospital Coordinating Council (IHCC) in preparing for a public health/healthcare emergency within the region of Washoe County. The coalition can further support preparedness efforts in other regions of the state, if needed and requested.

1.1 Purpose of Guidelines:

The IHCC Preparedness Planning Guidelines establish and describe the emergency response framework and guide the IHCC as it prepares to protect the health, safety, and well-being of Washoe County residents and visitors in areas impacted by a natural or manmade health emergency or disaster. It also outlines how we prioritize and work collectively to develop and test operational capabilities that promote:

- Communication
- Information Sharing
- Resource Coordination
- Operational Response and Recovery

1.2 Scope

These guidelines utilize the input of its members, partners and planning tools to identify the assets, resources and gaps of the coalition. It does not supersede the authorities of participating entities. These guidelines reflect autonomous operations of Hospitals and Healthcare Systems.

1.3 Administrative Support

Review of these guidelines will occur annually and following each major response within the County. Changes are to be approved during an IHCC meeting by the core membership and general census of voting and non-voting members and partners.

2. Coalition Overview

2.1 Introduction/Purpose of Coalition

The IHCC was organized in 1994, for the purpose of collaborating and coordinating the efforts of healthcare facilities and community stakeholders, to mitigate against, prepare for, respond to, and recover from, hazards impacting Northern Nevada's healthcare community and their patients. Activities of the IHCC shall include, but are not limited to:

i. Collaborating and sharing preparedness information between healthcare organizations and community preparedness partners.

ii. Coordinating preparedness activities and training among healthcare organizations and community preparedness partners.

iii. Sharing information, best practices, and lessons learned between healthcare organizations and community preparedness partners.

2.2 Coalition Boundaries

The geographical boundaries of the coalition are confined to the jurisdictional boundaries of Washoe County. The coalition supports and integrates with the Regional Emergency Operations Center (REOC), when applicable.

2.3 Coalition Members

Membership shall extend to any Northwestern Nevada and Northeastern California healthcare organization (acute care hospital, sub-acute care hospital, behavioral health hospital, skilled nursing facility, ambulatory care center, Federally Qualified Health Center, healthcare associations, etc.) and their agreed upon community preparedness partners (public health, local emergency management, local fire/EMS, local law enforcement, etc.). Any entity that attends a meeting will automatically be considered a member unless otherwise requested.

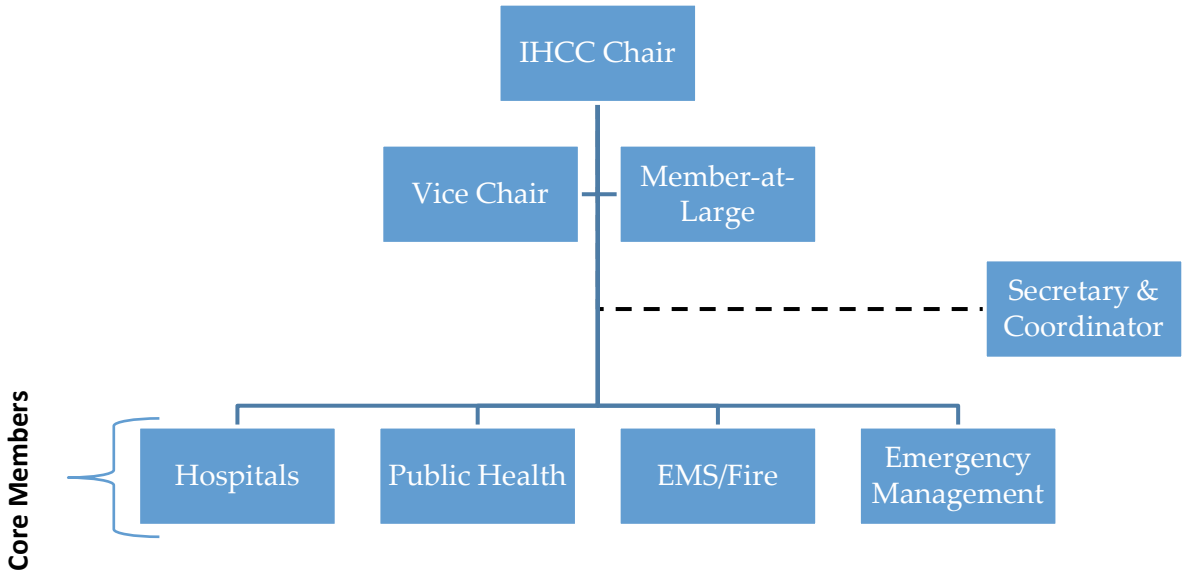
Voting membership is comprised of any member who has attended three consecutive meetings and has been voted on by the IHCC. Core members of the IHCC are Hospitals, Emergency Medical Services, Emergency Management organizations, and Public Health agencies located within Washoe County. These entities are outlined in the attendance record. Additional voting members must be voted in by the IHCC. Each entity only has one vote.

Non-voting membership shall be extended to any entity considered to be a partner in healthcare preparedness, but who does not qualify for voting membership. If a non-voting member wishes to be a voting member, they must be voted in by the IHCC core membership. IHCC values non-voting members and respects their involvement and contribution to the coalition.

Membership includes both voting and non-voting members. Please reference the IHCC attendance list for current membership.

2.4 Organizational Structure/ Governance

Below is an outline of the organizational structure of the coalition. Reference the IHCC bylaws for completed organization structure and governance.



Members (Voting and Nonvoting) include, but not limited to: Behavioral health services and organizations, CERT, MRC, dialysis centers, Federally Qualified Health Centers, home health and hospice agencies, infrastructure companies, jurisdictional partners, tribes, local chapters of health care progression organizations, local public health safety agencies, medical and device manufacturers and distributors, non-governmental organizations, outpatient health care delivery, urgent care centers, primary care providers, schools and universities, support service providers, child care services, dental clinics, social work services, and faith-based organizations.

2.4.1 Role of Leadership within Member Organizations

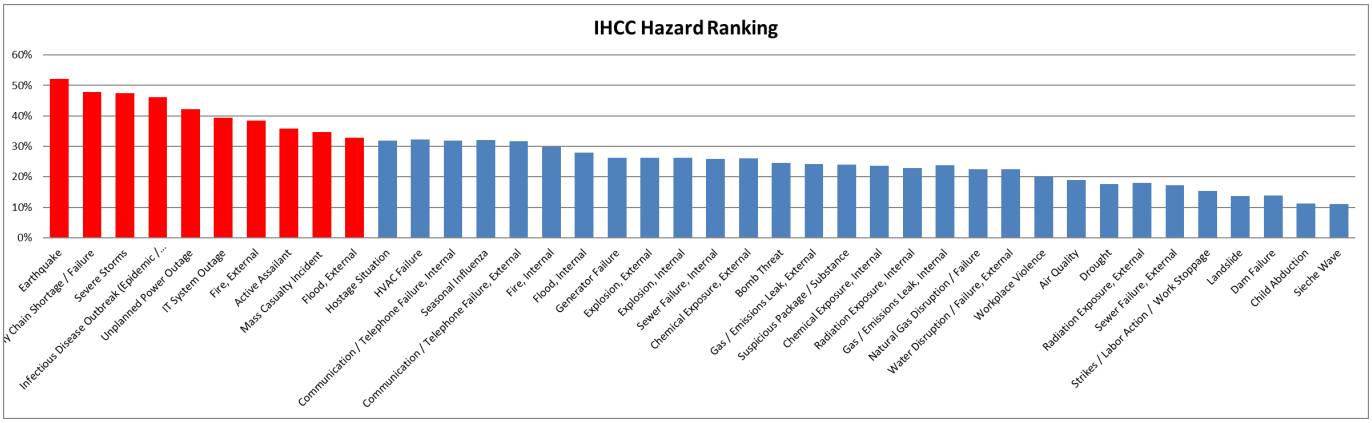
At the beginning of each calendar year, all members sign the IHCC Memorandum of Understanding (MOU). The agreement creates a voluntary agreement on common goals and expectations. See Appendix 5.1 for complete MOU.

2.5 Risk

This section summarizes the results of the coalitions Hazard Vulnerability Assessment (HVA). A standardized template was developed through the IHCC Preparedness Plan Workgroup and approved by IHCC membership. The HVA template was modified from the Kaiser Permanente HVA Tool 2017 and is reviewed annually and collected from members of the coalition.

The top 10 hazards as identified through the coalition's 2022 HVA are as follows:

1. Earthquake - 52%
2. Supply Chain Shortage/Failure– 48%
3. Severe Storms – 47%
4. Infectious Disease Outbreak (Epidemic/Pandemic) – 46%
5. Unplanned Power Outage - 42%
6. IT System Outage – 39%
7. Fire, External – 38%
8. Active Assailant – 36%
9. Mass Casulty Incident– 35%
10. Flood, External - 33%



In addition to compiling the data from the members, the Workgroup developed a weighting mechanism (as outlined below).

Healthcare Provider Type	Weighted Score
Acute Care Hospitals	1
Long-term Care/Skilled Nursing Facilities	0.5
Home Health/Hospice	0.4
Federally Qualified Health Centers/Clinics	0.3
Ambulatory Surgical Centers	0.2
Other*	0.1

*If applicable

The coalition also participates in the revision of the Jurisdictional Risk Assessment (JRA) every three years. The last JRA was completed in 2023 and is available to be utilized when measuring the progress of the coalition gaps.

2.6 Resources and Gaps

This section summarizes the results of the coalition survey and the top preparedness gaps.

The purpose of the survey is to assist the coalition in developing a common understanding of its resources and gaps and assist in prioritizing activities to mitigate gaps. The survey, a resource and gap analysis, was adapted from the ASPR TRACIE Healthcare Coalition Resource and Gap Analysis. The survey identified gaps, such as inadequate plans, staffing, equipment and supplies, skills and expertise, services, and any other resource required to respond during an emergency.

The survey was developed and made available to all coalition members. Depending on provider type, a member was given a series of questions. The results were averaged among member responses and put into the ASPR TRACIE Healthcare Coalition Resource and Gap Analysis tool. Meetings were held to review the results and the top priority areas were identified during the meetings.

The top preparedness gaps by provider type, as identified through the coalition's resource and gap analysis are as follows:

EMS/FIRE

1. MCI Plan Updates: ICS Integration, Individual Responsibilities and Communications
2. General MCI Plan Updates
3. Interagency Training with Law Enforcement

CLINICS/AMBULATORY SURGERY CENTER

1. COOP, Recovery/Business Continuity Planning
2. Emergency Operations Planning
3. Surge Capacity Planning
4. Staff and Resource Sharing Planning

HOSPITAL

1. Training and exercising the MAEA and MCI Plans
2. Decontamination

HOME HEALTH/HOSPICE

1. Information Sharing Plan/Communication Plan
2. Exercise Plan (more participation in exercises to maintain good knowledge and continuity of care, especially with staff turnover)

PUBLIC HEALTH

1. Shelter Support Plan (medical services)
2. MAEA Updates

SKILLED NURSING/MEMORY CARE/ASSISTED LIVING

1. Evacuation Planning/Training
2. Staff and Resource Sharing Plan

The Coalition Survey is available upon request.

The IHCC maintains an inventory for medical surge events. A list of the inventory is available upon request.

Through the REOC, the IHCC finance subcommittee and supply chain subcommittee review regional PPE procurement options that could offer significant advantages in pricing and consistency for staff, especially in an emergency.

2.7 Compliance Requirements/ Legal Authorities

This section includes the legal authorities that inform and govern the coalition and its members, as related to emergency preparedness, focusing primarily on Centers of Medicare and Medicaid (CMS) Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers.

These guidelines acknowledge that the following agencies play a crucial role in the success of our members:

- Accreditation Association for Ambulatory Health Care, Inc.
- Accreditation Commission for Health Care
- American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)
- American Osteopathic Association/Healthcare Facilities Accreditation Program
- Center for Improvement in Healthcare Quality (CIHQ)
- Community Health Accreditation Program (CHAP)
- DNV GL - Healthcare
- Healthcare Facilities Accreditation Program
- Institute for Medical Quality
- The Joint Commission
- The Compliance Team
- National Fire Protection Association (NFPA)

Please reference Appendix 5.4 for a crosswalk between the CMS Emergency Preparedness Final Rule Conditions of Participation and existing regulatory and accreditation standards.

3. Coalition Objectives

This section provides the elements to consider for the coalition when developing its objectives. The overarching goals of the coalition are below.

1. Build the foundation for healthcare and medical readiness.
2. Plan and collaborate to share and analyze information, manage and share resources, and coordinate strategies to deliver medical care to all populations during emergencies and planned events.
3. Provide uninterrupted, optimal medical care to all populations in the face of damaged or disabled healthcare infrastructure.

4. Through collaborations and partnerships, deliver timely and efficient care to patients, even when the demand for healthcare services exceeds available supply.

A list of the top priorities, new preparedness activities and reoccurring activities is located in Appendix 5.5.

3.1 Maintenance and Sustainability

This section outlines maintenance and sustainability of the IHCC through the engagement of partners and stakeholders, while promoting the value of health care and medical readiness.

IHCC works towards sustainability through both fiscal and membership. IHCC continually seeks grants and in-kind donation for the preservation of the Coalition objectives. This includes time, resources and continued engagement with its members and the community.

The IHCC and community partners collaborate to share best practices and lessons learned from events to further preparedness efforts within the IHCC boundaries. These practices and lessons are shared during monthly meetings.

3.2 Engagement of Partners and Stakeholders

This section addresses the structure for engaging executives, clinicians, leaders, etc. to meet the objectives of the IHCC.

3.2.1 Health Care Executives

The expectation of the membership is to report to their organizational leadership, to keep executive leadership aware of the activities of IHCC. In addition, the quarterly newsletter is shared among members to provide concrete examples of work being completed.

3.2.2 Clinicians

Clinicians are critical to understanding health/medical emergency response and are invaluable at any planning tables. In addition, clinical leaders are able to provide input regarding strategic and operational planning. IHCC ensures that any projects have providers, nurses and technical experts' participation incorporated, to include the IHCC identified Clinical Advisors.

3.2.3 Community Leaders

The coalition participates in the following meetings to engage community leaders.

- Prepare Washoe
- Washoe County Emergency Preparedness Council (EPC)
- Washoe County Local Emergency Preparedness Committee (LEPC)

3.2.4 Children, Pregnant Women, Seniors, and Individuals with Access and Functional Needs

This IHCC conducts inclusive planning for the whole community with agencies representing children; pregnant women; seniors; individuals with access and functional needs; individuals with pre-existing, serious behavioral health conditions; and others with unique needs. It is important to note, these individuals may require additional assistance before, during, and after an emergency.

Additional planning considerations include the following but not limited to:

- **Individuals with Limited Mobility**: Individuals who use assistive devices or equipment for walking or mobility, e.g., wheelchairs, walkers or crutches
- **Individuals who are Blind**: Individuals who are blind or have low vision, night blindness, color blindness, impaired depth perception, etc.
- **Individuals who are Deaf, Deaf-Blind, Hard of Hearing:** Individuals who are deaf, have situational loss of hearing, or limited-range hearing.
- **Individuals with Intellectual Disabilities**: An intellectual disability is a disability characterized by significant limitations both in intellectual functioning (e.g., reasoning, learning, problem solving) and in adaptive behavior.
- **Older Adults and Children:** Individuals whose chronological age may impact their physical or cognitive abilities and who may need assistance with daily activities.
- **Individuals who are Limited or Non-English Speaking:** Individuals who have a limited ability or no ability to speak, read, write or fully understand English
- **Individuals and Families with Limited Resources**: Individuals who may not have the resources available to meet their own or their family's needs
- **Individuals Experiencing Homelessness or Transitional Housing:** Includes persons in shelters, on the streets or temporarily housed -- transitional, safe houses for women and minors.
- **Individuals who are Experiencing Domestic Violence:** Individual living with domestic violence or who are domestic violence survivors.
- **Refugee & Immigrant Communities (New Americans):** Persons who may have difficulty accessing information or services due to cultural differences or unfamiliarity, and possibility distrust of governmental systems.
- **Undocumented Persons:** Individuals who do not have the required documentation to be permanent or temporary residents of the United States.
- **Individuals with Mental Illness**: Individuals who have a diagnosed mental health condition as well as those who may have one that is undiagnosed
- **Individuals with Requiring Supervision**: Individuals unable to safely survive independently, attend to personal care or activities of daily living, etc.
- **Individuals with Medical Needs:** Individuals who take medication or need equipment to sustain life or control conditions for quality of life -- i.e., diabetic; weakened immune systems, those who cannot be in/use public accommodations.
- **People Who are Dependent on Drugs or Alcohol:** Includes people who use legal or illegal substances including injectable drugs and who would experience withdrawal.
- **Clients of Criminal Justice System:** Individuals who are currently or have been previously incarcerated, on parole, under house arrest, or who are registered sex offenders. This includes current clients of the juvenile justice system Emerging or Transient Special Needs: needs/conditions due to emergency, temporary conditions—i.e., loss of glasses, broken leg, tourists/visitors needing care.

- **Emerging or Transient Special Needs:** needs/conditions due to emergency, temporary conditions—i.e., loss of glasses, broken leg, tourists/visitors needing care

Every 6 months, the coalition receives the HHS emPOWER De-Identified Aggregated data for Washoe County. The data should be used for preparedness planning It is understood it does not reflect the entire population of Washoe County. As of March 2023, Washoe County has approximately 96,476 Medicare beneficiaries of which just over 6,000 are electricity-dependent beneficiaries[1]. The electricity-dependent beneficiaries include ventilator, BiPAP, Enteral feeding, UV infusion pump, at-home dialysis, suction pumps, motorized wheelchair or scooters, electronic bed equipment, oxygen concentrator, and implanted cardiac device.

Social vulnerability refers to the resilience of communities when confronted by external stresses on human health, stresses such as natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss. CDC's Social Vulnerability Index uses 15 U.S. census variables at tract level to help local officials identify communities that may need support in preparing for hazards; or recovering from disaster. According to the CDC's Social Vulnerability Index (SVI) Washoe County overall score is 0.5625 which indicates a moderate to high level of vulnerability. Coalition member should consider this score when developing plans and exercises. See Appendix 5.7 for additional information.

4. Workplan

This section focuses on roles and responsibilities of the coalition for executing its preparedness guide. The HCC Readiness and Response Coordinator is the primary responsible entity for coordinating efforts to achieve the short and long-term objectives.

Ad-hoc and standing committees may be created by the coalition chair as needed, to further the objectives. Both voting and non-voting member representatives are eligible to serve on committees; however, only voting member representatives may be appointed as committee chairs.

A checklist of the coalition's proposed activities is located in Appendix 5.6. This checklist is a fluid document and includes the short-term and long-term objectives as identified by anticipated completion dates. Please reference the most up-to-date checklist for the status of the activities.

The checklist will be reviewed during coalition meetings and the person responsible or designee for identified activities will give a progress report to the coalition. This will allow for accountability for the completion of the activities.

4.1 Roles and Responsibilities

[1] https://empowermap.hhs.gov/

The chair is primarily responsible for the execution of these guidelines and may delegate responsibility as appropriate.

The IHCC has roles and responsibilities for executing its preparedness guide and to describe who works on the following:

- Develop policies as needed
- Committees/work groups that develop and update response plans policies and procedures
- Develop educational material and presentations
- Research materials and acquisition, as applicable
- Evaluate exercises and responses to emergencies

Preparedness Functions				**Response Functions**	
	Policy Development & Updates	Work Groups	Educational Material Development	Community Care Standards/Scarce Resource Allocation	After Action Reports
HCC Response Coordinator	X	X	X	X	X
IHCC Leadership	X	X	X	X	X
Clinical Advisors	X	X	X	X	X
IHCC Members	X	X	X	X	X

5. Appendices

This section contains detailed information on the HVA, resource and gap analysis, commitment to participate, compliance requirements/ legal authorities, the program guide, budget, Communications Plan, social vulnerability data, budget period reporting timeline and IHCC Objectives.

5.1 Commitment to Participate

The coalition recognizes the importance of community partners and membership engagement. To reinforce the importance, the IHCC Memorandum of Understanding (MOU) was developed and signed by all voting and non-voting members. This MOU outlines the expectations, benefits and privileges of being a coalition member.

IHCC

This Memorandum of Understanding (MOU) is made and entered between the Inter-Hospital Coordinating Council (IHCC) and _____ (Member). The agreement creates a voluntary agreement on common goals and expectation.

The IHCC was organized in 1994 for the purpose of collaborating and coordinating the efforts of healthcare facilities and other community stakeholders to mitigate against, prepare for, respond to, and recover from hazards impacting Northern Nevada's healthcare community and patients. The IHCC is a healthcare preparedness coalition and is not a response entity.

Expectations of Members:

- Assign a primary and secondary representative to the IHCC.
- Complete Incident Command System courses (ICS) 100, 200, 700 and 800.
- Leadership completion of ICS 300 and 400 is recommended.
- Miss no more than two consecutive meetings.
- Participate in the review of preparedness plans as deemed appropriate from the IHCC.
- Participate outside of the once a month meeting, as needed.
- Participate in situational awareness initiatives.
- Participate in the IHCC survey and HVA.
- Respect all other members.

Member Benefits and Privileges:

- Participation in collaboration, projects, capacity building and other efforts.
- Participation in meetings, trainings, workgroups/subcommittees related to healthcare preparedness.
- Increased partnerships in the community.
- Increased understanding of healthcare preparedness planning.
- Meet accreditation standards, as applicable.

State of Agreement

This Memorandum of Understanding (MOU) reflects an entirely voluntary commitment among the parties to cooperate and work together to achieve the purpose of the IHCC. This MOU in no way obligates or restricts the activity of any party in any way. No Member shall obligate, or purport to obligate, any other member with respect to any matter. Any party may withdraw from the IHCC at any time with 30-day written notice. Members agree to the above expectations and further agree that they read and understood this agreement.

_____	_____	_____
Primary Member-Please PRINT	Secondary Member-Please PRINT	Date
email: _____	email: _____	
24-hr Phone: _____	24-hr Phone: _____	

_____	_____	_____
IHCC Chair	IHCC Vice Chair	IHCC Member-at-Large

5.2 Detailed Information on HVA

*This is an example; current version is available upon request.

INTERHOSPITAL COORDINATING COUNCIL HAZARD VULNERABILITY ANALYSIS - WEIGHTED SUMMARY

Organization	Advanced Health Care of Reno	Barton	CHA	Comprehensive Integrated Care	Eden HHnH	Eye Surgery Center of Northern Nevada	IVCH	Lake Tahoe Surgery Center	Life Care Center	Mountain West Surgery Center	NNMC	NNSMC	Nothern Nevada State Veterans Home	Quail	Post Acute Medical Specialty Hospital of Sparks	REMSA	Renown HHnH	Renown Regional	Renown Rehab Hosptital	Renown South Meadows	Rosewood Skilled Nursing	Saint Mary's Home Care	SMRMC	Surgery Center of Reno	Tahoe Forest	VA Medical Center	Willow Springs Hospital		Weighted HVA
Weighting	0.5	1.0	0.3	0.2	0.4	0.2	1.0	0.2	0.5	0.2	1.0	1.0	0.5	0.2	1.0	0.0	0.4	1.0	1.0	1.0	0.5	0.4	1.0	0.2	1.0	1.0	1.0	17.0	16.7
Active Assailant	0%	48%	7%	4%	0%	4%	22%	5%	22%	0%	28%	28%	6%	5%	67%	0%	19%	52%	52%	52%	9%	8%	78%	4%	22%	41%	17%	22%	36%
Air Quality	0%	24%	0%	8%	0%	4%	30%	10%	0%	0%	22%	22%	0%	4%	0%	0%	0%	0%	0%	0%	0%	15%	56%	4%	30%	30%	39%	12%	19%
Bomb Threat	11%	22%	7%	3%	0%	5%	26%	5%	17%	0%	22%	22%	5%	7%	28%	0%	10%	37%	37%	37%	11%	0%	24%	4%	26%	20%	24%	15%	25%
Chemical Exposure, External	10%	15%	7%	2%	0%	3%	44%	4%	0%	0%	22%	22%	5%	4%	13%	0%	19%	41%	41%	41%	10%	0%	44%	3%	44%	19%	19%	16%	26%
Chemical Exposure, Internal	6%	17%	7%	2%	0%	3%	11%	7%	0%	0%	17%	17%	5%	9%	11%	0%	7%	61%	61%	61%	15%	0%	33%	3%	22%	20%	0%	15%	24%
Child Abduction	0%	44%	0%	0%	0%	0%	15%	3%	0%	0%	17%	17%	0%	4%	0%	0%	0%	0%	0%	0%	0%	0%	48%	4%	15%	0%	20%	7%	11%
Communication / Telephone Failure, External	5%	67%	12%	2%	0%	4%	41%	9%	11%	0%	17%	17%	6%	1%	56%	0%	16%	37%	37%	37%	33%	9%	41%	3%	41%	13%	17%	20%	32%
Communication / Telephone Failure, Internal	0%	0%	12%	2%	0%	4%	44%	12%	11%	0%	17%	17%	6%	1%	61%	0%	12%	56%	56%	56%	19%	8%	61%	3%	44%	13%	17%	20%	32%
Dam Failure	6%	26%	0%	0%	0%	3%	0%	0%	0%	0%	17%	17%	0%	0%	19%	0%	8%	19%	19%	19%	11%	0%	22%	4%	0%	24%	20%	9%	14%
Drought	17%	19%	0%	4%	0%	7%	56%	13%	0%	0%	28%	28%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	33%	1%	56%	22%	11%	11%	18%
Earthquake	33%	28%	13%	10%	0%	8%	44%	10%	33%	0%	56%	56%	31%	11%	61%	0%	21%	78%	78%	78%	25%	16%	59%	13%	44%	56%	9%	32%	52%
Explosion, External	0%	22%	0%	2%	0%	3%	22%	4%	15%	0%	22%	22%	5%	1%	41%	0%	7%	44%	44%	44%	11%	0%	52%	4%	22%	26%	22%	16%	26%
Explosion, Internal	0%	22%	7%	2%	0%	3%	22%	6%	15%	0%	22%	22%	7%	1%	41%	0%	10%	48%	48%	48%	14%	0%	20%	4%	22%	26%	26%	16%	26%
Flood, External	9%	19%	7%	6%	0%	4%	11%	4%	33%	0%	26%	48%	7%	1%	67%	0%	22%	61%	61%	61%	11%	6%	11%	6%	11%	37%	17%	20%	33%
Flood, Internal	8%	26%	7%	2%	15%	4%	11%	4%	28%	2%	11%	11%	6%	1%	24%	0%	12%	44%	44%	44%	22%	0%	61%	3%	11%	44%	19%	17%	28%
Gas / Emissions Leak, External	0%	22%	3%	2%	7%	0%	19%	4%	4%	2%	22%	22%	5%	1%	44%	0%	7%	50%	50%	50%	15%	0%	20%	3%	19%	15%	19%	15%	24%
Gas / Emissions Leak, Internal	0%	15%	8%	2%	7%	0%	17%	5%	4%	2%	22%	22%	7%	1%	28%	0%	7%	44%	44%	44%	30%	0%	22%	3%	26%	15%	22%	15%	24%
Generator Failure	10%	33%	10%	2%	0%	4%	31%	5%	17%	2%	56%	28%	7%	1%	61%	0%	6%	17%	17%	17%	7%	0%	19%	4%	28%	37%	19%	16%	26%
Hostage Situation	9%	39%	6%	3%	7%	4%	20%	3%	15%	2%	26%	26%	4%	1%	44%	0%	7%	52%	52%	52%	11%	0%	52%	4%	20%	52%	20%	20%	32%
HVAC Failure	0%	56%	4%	2%	7%	4%	20%	8%	19%	2%	22%	22%	9%	1%	48%	0%	4%	52%	26%	78%	25%	0%	44%	7%	20%	37%	19%	20%	32%
Infectious Disease Outbreak (Epidemic / Pandemic)	22%	24%	13%	6%	15%	4%	72%	8%	28%	2%	48%	48%	19%	4%	78%	0%	22%	44%	44%	44%	25%	15%	44%	9%	33%	67%	30%	19%	46%
Fire, External	24%	61%	10%	6%	13%	8%	61%	11%	31%	2%	17%	17%	4%	3%	67%	0%	27%	20%	20%	20%	11%	0%	30%	7%	61%	61%	30%	24%	38%
Fire, Internal	8%	7%	13%	2%	7%	4%	30%	5%	20%	2%	17%	17%	28%	3%	17%	0%	9%	61%	61%	61%	22%	7%	22%	7%	30%	17%	20%	18%	30%
IT System Outage	24%	41%	9%	2%	7%	3%	15%	8%	25%	2%	20%	20%	7%	1%	67%	0%	20%	83%	83%	83%	17%	9%	30%	3%	15%	33%	9%	24%	39%
Landslide	1%	0%	0%	2%	7%	3%	11%	9%	3%	2%	44%	22%	0%	1%	48%	0%	10%	7%	7%	7%	6%	0%	7%	1%	11%	17%	0%	8%	14%
Mass Casualty Incident	11%	28%	10%	2%	7%	4%	17%	9%	16%	2%	26%	26%	11%	4%	44%	0%	7%	67%	67%	67%	22%	7%	44%	4%	17%	33%	26%	21%	35%
Natural Gas Disruption / Failure	6%	24%	10%	2%	7%	4%	44%	4%	6%	2%	17%	17%	11%	0%	20%	0%	7%	33%	33%	33%	13%	0%	13%	4%	26%	15%	24%	14%	23%
Radiation Exposure, External	11%	33%	2%	2%	7%	4%	17%	6%	0%	2%	22%	22%	7%	0%	0%	0%	7%	13%	13%	13%	11%	0%	44%	4%	17%	19%	24%	11%	18%
Radiation Exposure, Internal	24%	67%	2%	2%	7%	4%	17%	7%	0%	2%	22%	22%	7%	0%	17%	0%	7%	37%	37%	37%	11%	0%	17%	3%	17%	15%	0%	14%	23%
Seasonal Influenza	0%	20%	13%	5%	15%	7%	28%	7%	22%	2%	33%	33%	22%	0%	33%	0%	20%	33%	33%	33%	19%	15%	39%	3%	28%	44%	22%	20%	32%
Severe Storms	19%	44%	14%	7%	9%	0%	50%	13%	11%	2%	44%	44%	11%	1%	61%	0%	20%	67%	67%	67%	13%	16%	78%	7%	50%	41%	33%	29%	47%
Sewer Failure, External	0%	30%	2%	2%	7%	0%	19%	3%	22%	2%	22%	22%	6%	1%	26%	0%	9%	13%	13%	13%	6%	0%	2%	3%	19%	30%	19%	11%	17%
Sewer Failure, Internal	0%	22%	11%	2%	7%	0%	19%	9%	22%	2%	22%	22%	6%	1%	44%	0%	6%	44%	44%	44%	13%	0%	19%	3%	19%	30%	20%	16%	26%
Sieche Wave	0%	67%	0%	0%	7%	0%	13%	6%	0%	2%	13%	13%	0%	0%	0%	0%	9%	13%	13%	13%	11%	0%	0%	0%	0%	0%	0%	7%	11%
Strikes / Labor Action / Work Stoppage	0%	37%	3%	2%	7%	0%	17%	5%	0%	2%	2%	2%	5%	0%	20%	0%	6%	19%	19%	19%	12%	8%	30%	4%	17%	0%	22%	9%	15%
Supply Chain Shortage / Failure	7%	56%	9%	3%	7%	0%	50%	12%	28%	2%	37%	37%	13%	0%	61%	0%	20%	72%	72%	72%	19%	12%	78%	7%	50%	56%	19%	30%	48%
Suspicious Package / Substance	0%	22%	5%	2%	7%	0%	17%	7%	22%	2%	11%	11%	6%	0%	22%	0%	7%	52%	52%	52%	11%	0%	33%	3%	17%	20%	19%	15%	24%
Unplanned Power Outage	11%	56%	20%	3%	9%	0%	44%	10%	11%	2%	33%	17%	5%	0%	56%	0%	22%	72%	72%	72%	17%	16%	33%	7%	44%	56%	15%	26%	42%
Water Disruption / Failure, External	0%	0%	0%	2%	7%	0%	26%	4%	17%	2%	22%	22%	5%	0%	37%	0%	8%	37%	37%	37%	15%	0%	19%	3%	26%	19%	19%	13%	23%
Workplace Violence	11%	0%	0%	3%	7%	0%	44%	12%	0%	2%	67%	67%	4%	4%	0%	0%	0%	0%	0%	0%	7%	0%	0%	2%	44%	30%	30%	12%	20%

5.3 Program Plan and Budget

The coalition has a finance subcommittee comprised of at least one member of leadership, one core member and one other member. This subcommittee is responsible for reviewing and approving funds spent under the ASPR cooperative agreement and other secured funding. The subcommittee will also be provided an update of the ASPR Scope of Work monthly to ensure deliverables are achieved.

ASPR Required	**2019-2020**	**2020-2021**	**2021-2022**	**2022-2023**	**2023-2024**
Communications Drill (2x/yr.)	X	X	X	X	X
Coalition Surge Exercise	X	X	X	X	X
Pediatric Surge Plan & Exercise	X				
Partner Full-Scale Exercise (influenza)		X			
Burn Care Plan & Tabletop (TTX)		X			
Infectious Disease Care Plan & TTX			X		
Radiation Care Plan & TTX				X	
Chemical Care Plan and TTX					X

Please reference current budget for updated financials.

5.4 Compliance Requirements/ Legal Authorities Table

The below is a screenshot of the crosswalk between the 2022 Emergency Preparedness CMS Conditions of Participation & accreditation organizations created by the Yale New Haven Center for Emergency Preparedness and Disaster Response.

CMS Emergency Preparedness Conditions of Performance Language	CMS Emergency Preparedness Conditions of Performance Reference	Accreditation Association for Ambulatory Health Care (AAAHC) www.aaahc.org	American Association for Accreditation of Ambulatory Surgery Facilities www.aaaasf.org	American Osteopathic Association/Healthcare Facilities Accreditation Program www.hfap.org	The Joint Commission Standards www.jointcommission.org	NFPA 1600	NFPA 99
Communication Plan	Communication Plan						
Be required to develop and maintain an emergency preparedness communication plan that complies with local, state and Federal law and required to review and update the communication plan at least annually.	416.54 (C)				EM.12.02.01 (All EPs)- The hospital has a communications plan that addresses how it will initiate and maintain communications during an emergency.	6.4	12.5.3.3.6.1
As part of its communication plan include in its plan, names and contact information for staff; entities providing services under arrangement; patients' physicians and volunteers.	416.54 (C) (1)				EM.12.02.01 EP 2- The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals: - Staff, licensed practitioners, and volunteers (including individuals providing care at alternate sites) - Patients and family members, including people with disabilities and other access and functional needs - Community partners (such as, fire department, emergency medical services, police, public health department) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Media and other stakeholders	6.4.1	
Require contact information for Federal, State, tribal, regional, or local emergency preparedness staff and other sources of assistance.	416.54 (C) (2)				EM.12.02.01 EP 2- The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals: - Staff, licensed practitioners, and volunteers (including individuals providing care at alternate sites) - Patients and family members, including people with disabilities and other access and functional needs - Community partners (such as, fire department, emergency medical services, police, public health department) - Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff) - Media and other stakeholders	6.4.1	12.5.3.3.6.1(6)
Include primary and alternate means for communicating with staff and Federal, State, tribal, regional, and local emergency management agencies	416.54 (C) (3)					6.4.1	12.5.3.3.6.1
Include a method for sharing information and medical documentation for patients under the facility's care, as necessary, with other health care providers to maintain continuity of care.	416.54 (C) (4)						12.5.3.3.6.1(4)
Have a means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510.	416.54 (C) (5)					6.4.1	12.5.3.3.6.1(4)
Have a means of providing information about the general condition and location of patients under the facility's care, as permitted under 45 CFR 164.510(b)(4) 1.	416.54 (C) (6)						12.5.3.3.6.1(4)
Have a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee.	416.54 (C) (7)				EM.12.02.01 EP 3- The hospital's communication plan describes how the hospital will communicate with and report information about its organizational needs, available occupancy, and ability to provide assistance to relevant authorities.		12.5.3.3.6.1(2)(6)
Training and Testing	Training and Testing						

5.5 2022 Goals and Objectives

IHCC
Inter-Hospital
Coordinating Council
Est. 1994

2023 Resource & Gap Analysis
Inter-Hospital Coordinating Council

TOP PREPAREDNESS GAPS BY PROVIDER TYPE, AS IDENTIFIED THROUGH THE COALITION'S RESOURCE AND GAP ANALYSIS:

EMS/FIRE

1. MCI Plan Updates: ICS Integration, Individual Responsibilities and Communications
2. General MCI Plan Updates
3. Interagency Training with Law Enforcement

CLINIC/AMBULATORY SURGERY CENTER

1. COOP, Recovery/Business Continuity Planning
2. Staff and Resource Sharing Plan
3. Emergency Operations Planning
4. Staff and Resource Sharing Planning

HOSPITAL

1. Training and exercising the MAEA and MCI Plans
2. Decontamination

HOME HEALTH/HOSPICE

1. Information Sharing Plan/Communications Plan
2. Exercise Plan (more participation in exercises to maintain good knowledge and continuity of care, especially with staff turnover)

SKILLED NURSING/MEMORY CARE/ASSISTED LIVING

1. Evacuation Planning/Training
2. Staff and Resource Sharing Plan

PUBLIC HEALTH

1. Shelter Support Plan (medical services)
2. MAEA/MCI Updates

The following is a list of planned training activities relevant to identified risks, resource gaps, work plan priorities and corrective actions from prior exercises and incidents. Awareness and operational level training on all aspects of HCC functions focused on preparedness, response and recovery will also be conducted.

PREPAREDNESS ACTIVITIES

1. Medical Response & Surge Exercise (MRSE)
2. Communications Exercise
3. Coalition Plans/Guides updates
4. HVA/Gap and Resource Analysis
5. Workshops/Trainings
   a. WebEOC Training
   b. MAEA Training/Revisions
   c. MCIP Training/Revisions

5.6 Checklist of proposed activities

This checklist is a fluid document. Please reference the most up-to-date checklist for the status of the activities.

Provider Type	Top Priorities	Activities	Person Responsible	Agency	Anticipated Completion Date	Date Completed
EMS/Fire	MCI Plan Updates: ICS Integration, Individual Responsibilities and Communications					
	General MCI Plan Updates					
	Interagency Training with Law Enforcement					
Hospital	Training and exercising the MAEA and MCI Plans					
	Decontamination					
Skilled Nursing/Memory Care/Assisted Living	Evacuation Planning/Training					
	Staff and Resource Sharing Plan					
Public Health	Shelter Support Plan (medical services)					
	MAEA and MCI Updates					
Clinics/Ambulatory Surgery Center	COOP, Recovery/Business Continuity Planning					
	Emergency Operations Planning					
	Surge Capacity Planning					
	Staff and Resource Sharing Planning					
Home Health/Hospice	Information Sharing Plan/Communication Plan					
	Exercise Plan (more participation in exercises to maintain good knowledge and continuity of care, especially with staff turnover)					

5.7 Social Vulnerability Index 2018 – Washoe County

Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters to human-caused threats. The CDC/ATSDR SVI ranks each tract on 16 social factors, including poverty, lack of vehicle access, and crowded housing, and groups them into four related themes.[2] Data such as below is encouraged to be incorporated into planning and exercises.

Washoe County, Nevada Overall SVI Score: 0.6744 (Moderate to High Level of Vulnerability)

HOUSEHOLD CHARACTERISTICS THEME SVI SCORE: 0.38 (LOW TO MODERATE LEVEL OF VULNERABILITY)		
MEASURE	**ESTIMATE**	**PERCENT**
Aged 65 or older	75,922	16.4
Aged 17 or younger	100,439	21.6
Civilian with a Disability	55,580	12.0
Single-Parent Households	11,246	6.0
English Language Proficiency	14,576	3.3

SOCIOECONOMIC THEME SVI SCORE: 0.61 (MEDIUM TO HIGH LEVEL OF VULNERABILITY)		
MEASURE	**ESTIMATE**	**PERCENT**
Below 150% Poverty	88,863	19.4
Unemployed	13,021	5.2
Housing Cost Burden	54,852	29.5
No High School Diploma	35,877	11.1
No Health Insurance	44,990	9.8

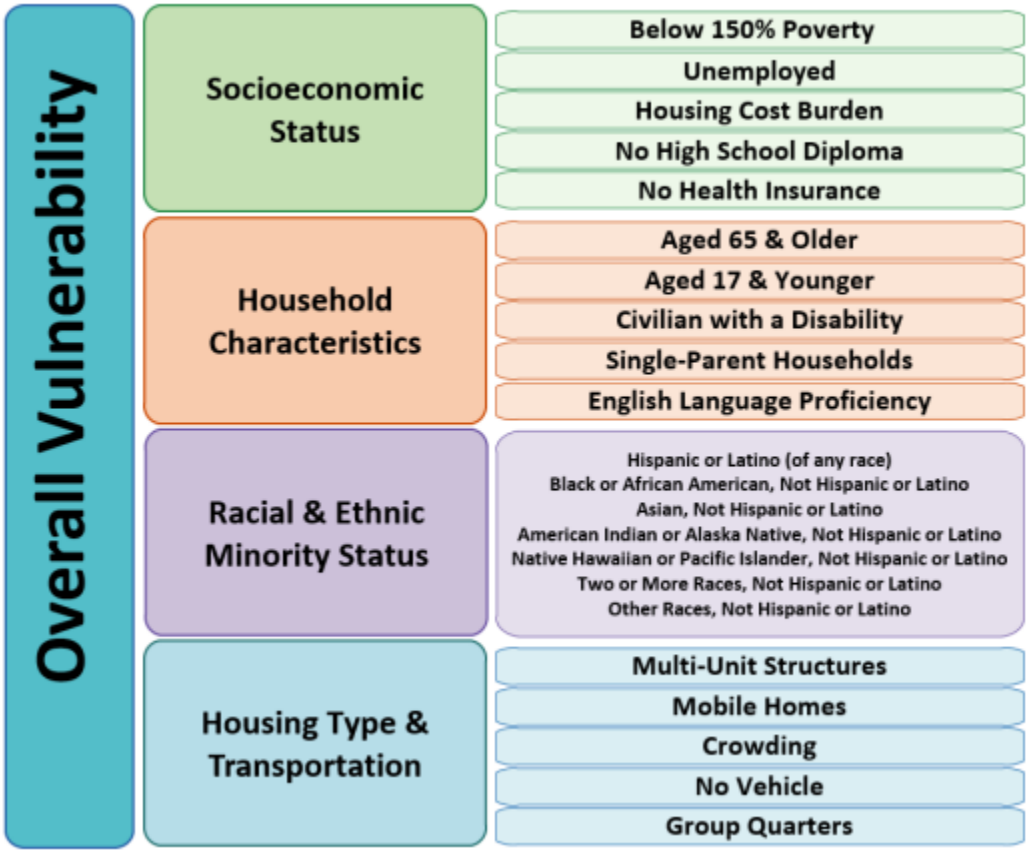
HOUSING AND TRANSPORTATION THEME SVI SCORE: 0.77 (HIGH LEVEL OF VULNERABILITY)		
MEASURE	**ESTIMATE**	**PERCENT**
Multi-Unit Structures	30,211	15.0
Mobile Homes	10,773	5.3
Crowding	7,909	4.2
No Vehicle	12,159	6.5
Group Quarters	6,010	1.3

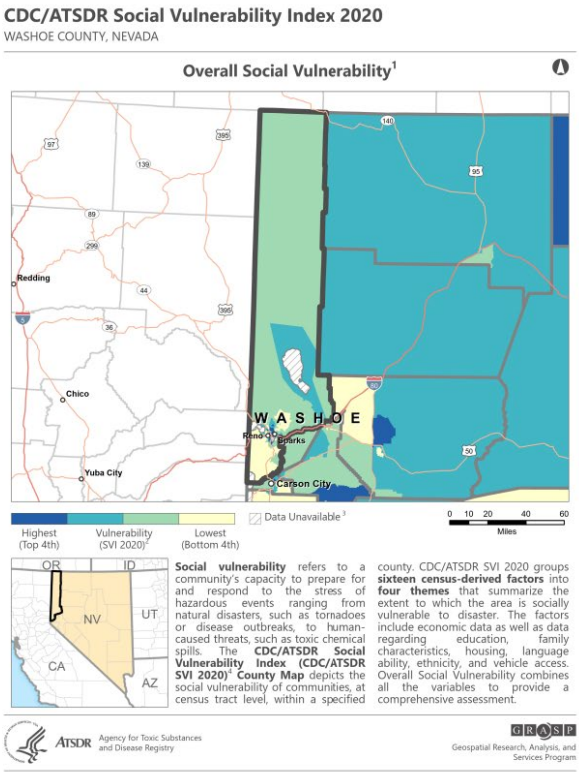
RACIAL & ETHNIC MINORITY STATUS THEME SVI SCORE: 0.77 (HIGH LEVEL OF VULNERABILITY)		
MEASURE	**ESTIMATE**	**PERCENT**
Hispanic or Latino (of any race); Black and African	175,379	37.8

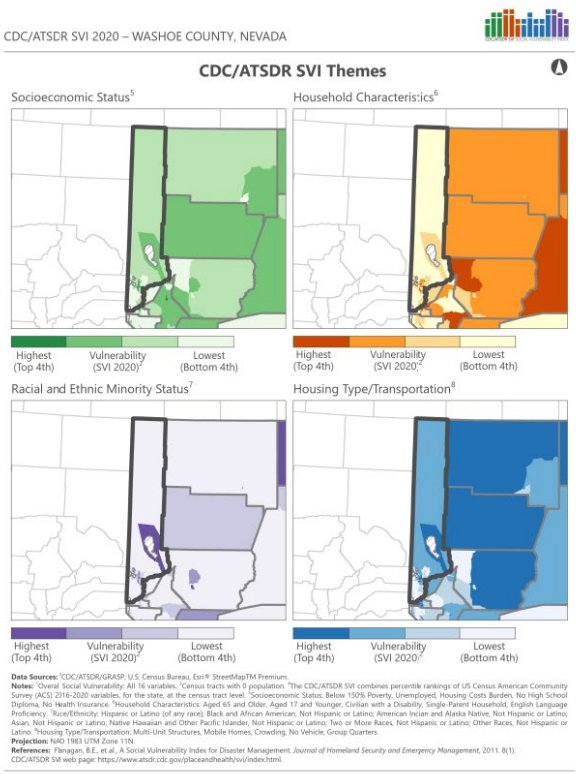
[2] Centers for Disease Control and Prevention/ Agency for Toxic Substances and Disease Registry/ Geospatial Research, Analysis, and Services Program. CDC/ATSDR Social Vulnerability Index 2020. Database Washoe County. https://www.atsdr.cdc.gov/placeandhealth/svi/data_documentation_download.html. Accessed on March 13, 2023.

American, Not Hispanic or Latino; American Indian and Alaska Native, Not Hispanic or Latino; Asian, Not Hispanic or Latino; Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino; Two or More Races, Not Hispanic or Latino; Other Races, Not Hispanic or Latino		

American Community Survey (ACS), 2016-2020 (5-year) data for the following estimates:







5.8: Communications Plan

The Communications Plan is located within the Response Plan.