

**[Organization Name]**

**Home Care and Hospice Comprehensive Emergency Management Plan Template**

Part II – Template

**2023**

[Organization Name]

[Organization Address]

[Organization Website]

# Instructions

The New York State Department of Health (DOH) Home Care and Hospice Comprehensive Emergency Management Plan (CEMP) Template is a tool to help home care and hospice providers develop and maintain organization-specific CEMPs. The plan template is designed to help organizations easily identify the information needed to effectively plan for, respond to, and recover from natural and man-made disasters. All content in this template should be reviewed and tailored to meet the needs of each organization.

Refer to *Part 1 – Instructions* for additional information about completion of this template.

Refer to *Part 3 – Toolkit* for supplementary tools and templates to inform CEMP development and implementation.

# Emergency Contacts

The following table lists contact information for public safety and public health representatives for quick reference during an emergency.

**Table 1: Emergency Contact Information**

|  |  |
| --- | --- |
| Organization | **Phone Number(s)** |
| Local Fire Department | [Placeholder – do not default to 911] |
| Local Police Department | [Placeholder – do not default to 911] |
| Emergency Medical Services | [Contact or N/A] |
| Fire Marshal | [Contact or N/A] |
| Local Office of Emergency Management | [Contact or N/A] |
| NYSDOH Regional Office (Business Hours)[[1]](#footnote-2) | [Contact or N/A] |
| NYSDOH Duty Officer | 866-881-2809 |
| New York State Watch Center (Warning Point) (After Business Hours) | 518-292-2200 |

# 

# Approval and Implementation

This Comprehensive Emergency Management Plan (CEMP) has been approved for implementation by:

[Name] [Date]  
[Title and Organization]

[Name] [Date]  
[Title and Organization]

# Record of Changes to the Emergency Plan

**Table 2: Record of Changes**

|  |  |  |  |
| --- | --- | --- | --- |
| Version # | **Implemented**  **By** | **Revision**  **Date** | **Description of Change** |
| *Example: 1.0* | *Jane Doe, Director of Nursing* | *May 1, 2020* | *Updated Section XYZ to reflect legislative changes.* |
|  |  |  |  |
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|  |  |  |  |

# Record of External Distribution of the Emergency Plan

**Table 3: Record of External Distribution**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | **Recipient Name** | **Recipient Organization** | **Format** | **Number of Copies** |
| *Example: May 1, 2020* | *Jim Doe* | *Local Office of Emergency Management* | *Digital (Email)* | *1* |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
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# Background

## Introduction

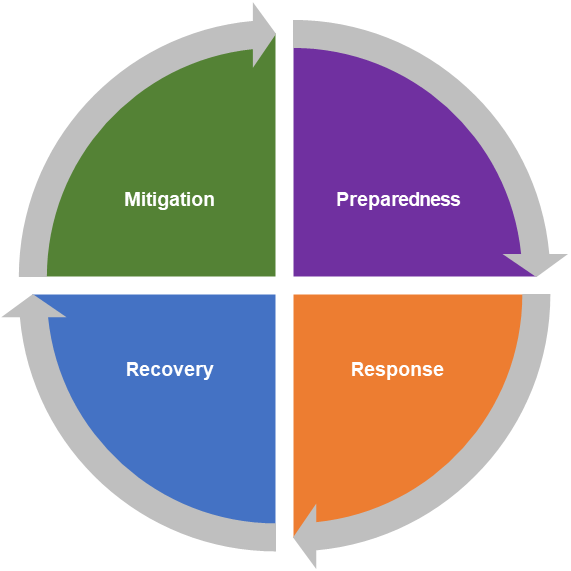
To protect the well-being of patients, families, staff, and visitors, the following all-hazards Comprehensive Emergency Management Plan (CEMP) has been developed. The CEMP is informed by organization-based and community-based risk assessments and pre-disaster collaboration with [organization-specific stakeholders such as Health Emergency Preparedness Coalitions, mutual aid partners, local emergency management agencies].

This CEMP is a living document that will be reviewed annually, at a minimum, in accordance with *applicable rules and regulations governing home care and hospice.*

## Purpose

The purpose of this plan is to describe the organization’s approach to mitigating the effects of, preparing for, responding to, and recovering from natural disasters, man-made incidents, and/or organization emergencies.

**Figure 1: Four Phases of Emergency Management**



**Preparation to address an emergency**

**Prevention of anticipated emergencies or minimizing their impact**

**Recovering in the short, intermediate, and long-term from an emergency**

**Responding efficiently and safely to an emergency**

## Scope

The scope of this plan extends to any event that disrupts, or has the potential to significantly disrupt, the provision of normal standards of care and/or continuity of operations, regardless of the cause of the incident (e.g., man-made or natural disaster).

The plan provides the organization with a framework for the organization’s emergency preparedness program and utilizes an all-hazards approach to develop organization capabilities and capacities to address anticipated events.

[If applicable, add description of how this plan relates to the plans of other related organizations and/or satellite offices)

## Situation

### Risk Assessment**[[2]](#footnote-3)**

The organization conducts an annual risk assessment to identify which natural and man-made hazards pose the greatest risk to the organization (e.g., human and economic losses based on the vulnerability of people, buildings, and infrastructure). The risk assessment should be reviewed at least annually to inform updates to the organization’s emergency plan, policy and procedures.

The organization conducted an organization-specific risk assessment on [Date] and determined the following hazards may affect the organization’s ability to maintain operations before, during, and after an incident:

* [Bulleted list of the organization’s primary hazards]

This risk information serves as the foundation for the plan—including associated policies, procedures, and preparedness activities.

### Mitigation Overview

The primary focus of the organization’s pre-disaster mitigation efforts is to identify the organization’s level of vulnerability to various hazards and mitigate those vulnerabilities to ensure continuity of service delivery and business operations despite potential or actual hazardous conditions.

To minimize impacts to service delivery and business operations during an emergency, the organization has completed the following mitigation activities:

* Development and maintenance of a CEMP;
* Procurement of emergency supplies and resources;
* Establishment and maintenance of mutual aid and vendor agreements to provide supplemental emergency assistance;
* Instruction to staff on plans, policies, and procedures; and
* Validation of plans, policies, and procedures through exercises.[[3]](#footnote-4)

For more information about the organization’s fire prevention efforts (e.g., drills), safety inspections, and equipment testing, please refer to the building or unit fire plan.

## Planning Assumptions

This plan is guided by the following planning assumptions:

* Emergencies and disasters can occur without notice, any day, or at any time.
* Emergencies and disasters may be organization-specific, local, regional, or state-wide.
* Local, state, or federal authorities can declare an emergency.
* The organization may receive requests from other organizations for resource support (supplies, equipment, staffing, or to serve as a receiving organization).
* Organization security may be compromised during an emergency.
* The organization is expected to plan for extended emergencies (including triage and care for critical care patients in need) using all available resources within and outside the organization.
* Power systems (including emergency generators) could fail in facilities, offices, or residential locations.
* There may be a need to evacuate patients from their current locations.
* During an emergency, conditions may preclude travel thus affecting the ability to reach all assigned patients, and/or require stay in place orders.
* [Additional organization-specific assumptions]

# Concept of Operations

## Notification and Activation

### Hazard Identification

The organization may receive advance warning about an impending natural disaster (e.g., hurricane forecast) or man-made threat (e.g., law enforcement report), which will be used to determine initial response activities and the movement of personnel, equipment, and supplies. For no-notice incidents (e.g., active shooter, tornado), organizations will not receive advance warning about the disaster, and will need to determine response activities based on the impact of the disaster.

The Incident Commander may designate a staff member to monitor evolving conditions, typically through television news, reports from government authorities, and weather forecasts.

All staff have a responsibility to report potential or actual hazards or threats to their direct supervisor.

### Activation

Upon notification of hazard or threat—from staff, residents, or external organizations—the senior-most on-site organization official will determine whether to activate the emergency plan based on one or more of the triggers below:

* The provision of normal standards of care and/or continuity of operations is threatened and could potentially cause harm.
* The organization has determined the need to implement a protective action.
* The organization is serving as a receiving organization.
* The organization is testing the plan during internal and external exercises (e.g., fire drills).
* [Additional organization-specific triggers for plan activation]

If one or more activation criteria are met and the plan is activated, the senior-most on-site organization official—or the most appropriate official based on the incident—will assume the role of “Incident Commander” and operations proceed as outlined in this document.

### Staff Notification

Once a hazard or threat report has been made, an initial notification message will be disseminated to staff in accordance with the organization’s communication plan.

Department Managers or their designees will contact all personnel to indicate the emergency plan is being activated. Additional instructions and relevant incident information will continue to be disseminated regularly until the emergency resolves.

Emergency rosters will be used so personnel can contact all priority patients to determine status. (e.g., status of patients, power, supplies, and equipment).

All personnel are to follow instructions from Department Managers and assure lines of communication are open and available (i.e., cell phones and computers charged).

All personnel will provide status updates to management regarding both patients and staff availability in a timely manner.

### External Notification

Depending on the type and severity of the incident, the organization may also notify external parties (e.g., local office of emergency management, resource vendors, relatives, and responsible parties) utilizing established notification procedures to request assistance (e.g., guidance, information, resources) or to provide situational awareness.

The notification of NYSDOH Regional Office and other non-DOH parties may be mandatory depending on hazard type.

**Table 4: Notification by Hazard Type** offers a comprehensive list of mandatory and recommended external notification recipients based on hazard type for each organization to consider and document.

**Table 4: Notification by Hazard Type for Home Care and Hospice**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **M** = Mandatory **R** = Recommended | **Example Hazard** | **Cyber security** | **Active Threat[[4]](#footnote-5)** | **Blizzard/Ice Storm** | **Coastal Storm** | **Dam Failure** | **Water Disruption** | **Earthquake** | **Extreme Cold** | **Extreme Heat** | **Fire** | **Flood** | **CBRNE[[5]](#footnote-6)** | **Infectious Disease** | **Landslide** | **IT/Comms Failure** | **Power Outage** | **Tornado** | **Wildfire** |
| **Notification Recipient** | **NYSDOH Regional Office[[6]](#footnote-7)** | **M** | **M** | **M** | **R** | **M** | **M** | **R** | **M** | **R** | **R** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** |
| **Organization Senior Leader** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** |
| **Local Emergency Management** | **R** | **□** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** |
| **Local Law Enforcement** |  | **M** | **M** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **M** | **□** | **□** | **□** | **□** | **□** | **□** |
| **Local Fire/EMS** |  | **□** | **M** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **M** | **□** | **M** | **□** | **□** | **□** | **□** | **□** | **M** |
| **Local Health Department** | **R** | **□** | **□** | **□** | **□** | **□** | **R** | **□** | **□** | **□** | **□** | **□** | **M** | **M** | **□** | **□** | **□** | **□** | **□** |
| **Off Duty Staff** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** | **M** |
| **Relatives and Responsible Parties** |  | **□** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **M** | **R** | **R** | **R** | **R** | **R** |
| **Resource Vendors** |  | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **R** | **□** | **□** |
| **Authority Having Jurisdiction** |  | **□** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** | **R** |
| **Regional Healthcare Organization Evacuation Center** |  | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** | **□** |
|  | **Local Hospital** |  | **□** | **R** | **□** | **□** | **□** | **R** | **□** | **□** | **□** | **□** | **□** | **M** | **M** | **□** | **□** | **□** | **□** | **□** |

## Mobilization

### Incident Management Team

Upon plan activation, the Incident Commander will activate some or all positions of the Incident Management Team, which is comprised of pre-designated personnel who are trained and assigned to plan and execute response and recovery operations.

Incident Management Team activation is designed to be flexible and scalable depending on the type, scope, complexity of the incident, and the agency’s staff resources. As a result, the Incident Commander will decide to activate the entire team or select positions based on the extent of the emergency.

**Table 5** outlines suggested organization positions to fill each of the Incident Management Team positions. The most appropriate individual given the event/incident may fill one or more different roles as needed.

**Table 5: Incident Management Team - Organization Position Crosswalk**

| Incident Position | **Organization Position Title** | **Description** |
| --- | --- | --- |
| Incident Commander | [Example positions include Administrator, Director of Patient Services, Senior Management] | Leads the response and activates and manages other Incident Management Team positions. |
| Public Information Officer | [Example positions include Public Relations Director, Communication Director, Administrator, other Senior Management | Provides information and updates to visitors, relatives and responsible parties, media, and external organizations. |
| Safety Officer | [Example positions include Maintenance Director, Emergency Response Coordinator, Director of Patient Services, Occupational Health and/or clinical staff)] | Ensures safety of staff, patients, and visitors; monitors and addresses hazardous conditions; empowered to halt any activity that poses an immediate threat to health and safety. |
| Operations Section Chief | [Example positions include Infection Control Practitioners, Registered Nurses, Licensed Nurses] | Manages tactical operations executed by staff (e.g., continuity of patient services, administration of first aid). |
| Planning Section Chief | [Example positions include Director of Patient Services, Clinical Management or designee] | Collects and evaluates information to support decision-making and maintains incident documentation, including staffing plans. |
| Logistics  Section Chief | [Example positions include Supplies Coordinator, Social Workers, Assistants] | Locates, distributes, and stores resources, arranges transportation, and makes alternate shelter arrangements with receiving organizations. |
| Finance/Admin Section Chief | [Example positions include Administrator, Finance Director or designee] | Monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses. |

If the primary designee for an Incident Management Team position is unavailable, **Table 6** should be completed to identify primary, secondary, and tertiary organization personnel that will staff Incident Management Team positions.

While assignments are dependent upon the requirements of the incident, available resources, and available personnel, this table provides initial options for succession planning, including shift changes.

**Table 6: Orders of Succession**

| Incident Position | **Primary** | **Successor 1** | **Successor 2** |
| --- | --- | --- | --- |
| Incident Commander | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Public Information Officer | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Safety Officer | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Operations Section Chief | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Planning Section Chief | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Logistics Section Chief | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |
| Finance/Admin Section Chief | [Organization Position Title] | [Organization Position Title] | [Organization Position Title] |

### Incident Command Center

The Incident Commander will designate a physical or virtual location to serve as the centralized location for incident management and coordination activities, also known as the “Command Center.”

Assure all staff are aware of the designated location for the Command Center and the secondary/back-up location.

## Response

### Assessment

The Incident Commander will convene activated Incident Management Team members in the Command Center and assign staff to assess the organization’s geographically impacted service areas to account for patient and employee safety as well as to identify potential or actual risks, including the following:

* Number of patients injured or affected;
* Status of patient care and support services;
* Extent or impact of the problem (e.g., hazards, life safety concerns);
* Current and projected staffing levels (clinical, support, and supervisory/managerial);
* Status of organization physical plant, utilities, and environmental services (e.g., power, access, air quality, etc.);
* Projected impact on normal organization operations;
* Organization patient occupancy and bed availability if pertinent;
* Need for protective action; and
* Resource needs.

### Protective Actions

Refer to CEMP Toolkit 8. Protective Action Decision Support for more information.

### Staffing

Based on the outcomes of the assessment, the members of the Incident Command Team and Planning Section Chief or designee will develop, execute, and monitor an effective staffing plan for each day for the duration of the emergency and recovery. The Finance/Administration Section Chief will manage the storage and processing of timekeeping and related documentation to track staff hours.

## Recovery

### Recovery Services

Recovery services focus on the needs of patients and staff and help to restore the organization’s pre-disaster physical, mental, social, and economic conditions.

Recovery services may include coordination with government, non-profit, and private sector organizations to identify community resources and services (e.g., employee assistance programs, state and federal disaster assistance programs, if eligible). Pre-existing organization- and community- based services and pre-established points of contact are provided in **Table 7 (see example in first row)**.

**Table 7: Pre-Identified Recovery Services**

| Service | **Description of Service** | **Point(s) of Contact** |
| --- | --- | --- |
| [Example: Mental Health and Trauma support] | Employee Assistance Contracted Support and Counseling | [Mr. John Doe at wwww.abc.com] |
| [Recovery service or program] | [Description of service and support provided] | [Contact information and/or link to website] |
| [Recovery service or program] | [Description of service and support provided] | [Contact information and/or link to website] |

Ongoing recovery activities, limited staff resources, as well as the incident’s physical and mental health impact on staff members may delay organization staff from returning to normal job duties, responsibilities, and scheduling.

Resuming pre-incident staff scheduling will require a planned transition of staff resources, accounting for the following considerations:

* Priority staffing of critical functions and services (e.g., patient care services, scheduling, administrative).
* Personal staff needs (e.g., restore private residence, care for relatives, attend memorial services, mental/behavioral health services).
* Continued use or release of surge staffing, if activated during incident.

### Demobilization

****As the incident evolves, the Incident Commander will begin to develop a demobilization plan that includes the following elements:

* Activation of re-entry/repatriation process if evacuation occurred;
* Deactivation of surge staffing;
* Replenishment of emergency resources;
* Reactivation of normal services and operations; and
* Compilation of documentation for recordkeeping purposes.

### Infrastructure Restoration

Once the Incident Commander has directed the transition from incident response operations to demobilization, the organization will focus on restoring normal services and operations to provide continuity of care and preserve the safety and security of patients.

**Table 8** outlines entities responsible for performing infrastructure restoration activities and related contracts/agreements.

**Table 8: Infrastructure Restoration Activities**

| Activity | **Responsible Entity** | **Additional Resources** |
| --- | --- | --- |
| Internal assessment of electrical power. | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Clean-up of organization grounds (e.g., general housekeeping, removing debris and damaged materials). | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Internal damage assessments (e.g., structural, environmental, operational). | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Clinical systems and equipment inspection. | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Strengthen infrastructure for future disasters (if repair/restoration activities are needed). | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Communicate restoration efforts to staff and patients. | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |
| Inspection/ Recurring inspection of restored structures as needed (Building Safety). | [responsible party for performing activity (e.g., organization department, company] | [Brief description of resource to assist in activity completion] |

### Resumption of Full Services

Department Managers will conduct an internal assessment of the status of patient care services delivery and advise the Incident Commander and/or organization leadership on the prioritization and timeline of recovery activities.

Special consideration will be given to patients who require equipment, supplies, and utilities for the safe resumption of services.

Staff, patients, and relatives/responsible parties will be notified of any patient care services that are not available, and as possible, provide updates on timeframes for resumption. The Planning Section Chief will develop a phased plan for resumption of pre-incident staff scheduling to help transition the organization from surge staffing back to regular staffing levels.

### Resource Inventory and Accountability

Full resumption of services involves a timely detailed inventory assessment and inspection of all equipment, devices, and supplies to determine the state of resources post-disaster and identify those that need repair or replacement.

All resources, especially patient care equipment, devices, and supplies, will be assessed for health and safety risks. Questions on resource damage or potential health and safety risks will be directed to the vendor or manufacturer for additional guidance.

# Information Management

## Critical Organization Records

Critical organization records that require protection and/or transfer during an incident include:

* [Organization-specific records and information (e.g., patient roster, staff information)]

[Describe organization’s Business Continuity Plan for maintaining electronic records (e.g., off-site servers, cloud-based systems) and/or protections for paper-based systems (e.g., storage in durable containers in locations designated as least vulnerable)]

If computer systems are interrupted or non-functional, the organization will utilize paper-based recordkeeping in accordance with internal organization procedures.

## Patient Tracking and Information-Sharing

### Tracking Evacuated Patients

**Patient Confidentiality**

The organization will ensure patient confidentiality throughout the evacuation process. The Health Insurance Portability and Accountability Act Privacy Rule allows patient information to be shared to assist in emergency relief efforts. Providers and health plans covered by the Privacy Rule can share patient information in the following ways:

* Health care providers can share patient information as necessary to provide treatment.
* Coordinating patient care with others (such as emergency relief workers).
* Providers can share patient information to seek payment for services.
* Notification of the individual’s location, general condition, or death.
* Providers can share patient information with anyone to prevent or lessen a serious and imminent threat to the health and safety of a person.

When a health care provider shares information with disaster relief organizations authorized by law or by their charters to assist in disaster relief efforts, it is unnecessary to obtain a patient’s permission to share the information if doing so would interfere with the organizations’ ability to respond to the emergency.

## Staff Tracking and Accountability

### Staff Accountability

Staff accountability enhances site safety by allowing the organization to track staff locations and assignments during an emergency. Staff accountability procedures will be implemented as soon as the plan is activated.

The organization will utilize [organization-specific system] to track staff condition and availability to meet operational and clinical needs.

If an individual becomes injured or incapacitated during response operations, Department Managers or designees will notify the Incident Commander/designee to ensure the staff member’s status change is reflected in [organization-specific system tracking system].

### Non-Organization Personnel

The Incident Commander—or Logistics Section Chief, if activated— or designee will ensure that appropriate credentialing and verification processes are followed. Throughout the response, the Incident Commander—or Planning Section Chief, if activated— or designee will track non-organization personnel providing surge support along with their respective duties and the number of hours worked.

# Communications

## Organization Communications

As part of CEMP development, the organization conducted a communications assessment to identify existing organization communications systems, tools, and resources that can be leveraged during an incident and to determine where additional resources or policies may be needed.

Primary (the best and intended option) and alternate (secondary back-up option) methods of communication are outlined in **Table *9*.**

**Table 9: Methods of Communication**

| Mechanism | **Primary Method of Communication** | **Alternate Method of Communication** |
| --- | --- | --- |
| Landline telephone |  |  |
| Cell Phone |  |  |
| Voice over Internet Protocol (VOIP) |  |  |
| Text Messages |  |  |
| Email |  |  |
| News Media |  |  |
| Radio Broadcasts |  |  |
| Social Media |  |  |
| Runners/Messengers |  |  |
| Weather Radio |  |  |
| Emergency Notification Systems[[7]](#footnote-8) |  |  |
| [Additional organization-specific mechanism] |  |  |

### Communications Review and Approval

[Identify Organization-specific approval process and/or policy reference for the approval and dissemination of communications materials (e.g., pre-scripted messages)]

Upon plan activation, the Incident Commander may designate a staff member as the Public Information Officer to serve as the single point of contact for the development, refinement, and dissemination of internal and external communications.

Key Public Information Officer functions include:

* Develop and establish mechanisms to rapidly receive and transmit information to local emergency management;
* Develop situational reports/updates for internal audiences (staff and patients) and external audiences;
* Develop coordinated, timely, consistent, and reliable messaging and/or tailor pre-scripted messaging;
* Conduct direct patient and relative/responsible party outreach, as appropriate; and
* Address rumors and misinformation.

## Internal Communications

### Staff Communication

The organization maintains a list of all staff members, including emergency contact information, at [virtual and/or physical location]. To prepare for impacts to communication systems, the organization also maintains redundant forms of communication with on-site and off-site staff. The organization will ensure that all staff are familiar with internal communication equipment, policies, and procedures.

During and after an incident, the Incident Commander—or Public Information Officer or designee, if activated—will establish a regular method and frequency for delivering information to staff, patients, and caregivers/responsible parties, recognizing that message accuracy is a key component influencing staff/patient trust in the organization and in perceptions of the response and recovery efforts.

### Patient Communication

Upon admission and prior to any recognized threat, the organization will educate patients and/or responsible parties on the organization’s preparedness efforts. In addition to the required admission materials patient communication may include [organization-specific (e.g., newsletters, emails, patient- caregiver group meetings, etc.).

During and after an incident, the Incident Commander—or Public Information Officer or designee, if activated—will establish a regular method and frequency for delivering information to staff, patients, and caregivers/responsible parties, recognizing that message accuracy is a key component influencing staff/patient trust in the organization and in perceptions of the response and recovery efforts.

Communication will be adapted, as needed, to meet population-specific needs, including primary language, individuals with vision and/or hearing impairments, and individuals with other access and functional needs.

## External Communications

Under no circumstances will protected health information be released over publicly accessible communications or media outlets. All communications with external entities shall be in plain language without the use of codes or ambiguous language.

### Corporate/Parent Organization

[Remove section 4.3.1 if organization is not part of a multi-organization system]

The organization will coordinate all messaging with [corporate/parent organization] to ensure external communications are in alignment with corporate policies, procedures, and brand standards. Prior to an incident, the organization will coordinate with [corporate/parent organization] to ensure an on-site organization staff member(s) has authorization and approval to disseminate messages.

### Caregivers and/or Responsible Parties

The organization maintains a list [location of list] of all identified caregivers’ and responsible parties’ contact information, including phone numbers and email addresses if possible. Caregivers and responsible parties will have access to the organization’s emergency preparedness plan via patient admission information.

During an organization’s declared emergency situation, the organization will notify caregivers and responsible parties about the incident, and status of the organization’s services by [organization-identified primary method(s) of communication]. Additional updates may be provided on a regular basis to keep patients, caregivers and/or responsible parties apprised of the incident and the response.

The initial contact to patients or their primary point of contact (e.g., caregiver or responsible party) will include the following:

* Nature of the incident;
* Status of organization’s services;
* Inquiry to patient status and immediate needs
* Restrictions on visitation if applicable; and
* Estimated duration of emergency actions
* [Additional organization-specific information]

When incident conditions do not allow the organization to contact caregivers, or responsible parties, the organization will utilize local and/or state emergency officials, the organization website, and/or a recorded outgoing message, among other methods, to provide information on the status of the organization’s services. (Hospice inpatient units include status and location of patients).

During and after an incident, the Incident Commander—or Public Information Officer or designee, if activated—will establish a regular method and frequency for delivering information to staff, patients, and caregivers/responsible parties, recognizing that message accuracy is a key component influencing staff/patient trust in the organization and in perceptions of the response and recovery efforts.

### Media and General Public

During an emergency, the organization will utilize traditional media (e.g., television, newspaper, radio) and social media (e.g., Facebook, Twitter) to keep relatives and responsible parties aware of the situation and the organization’s response posture.

During and after an incident, the Incident Commander—or Public Information Officer or designee, if activated—will establish a regular method and frequency for delivering information to staff, patients, and caregivers/responsible parties, recognizing that message accuracy is a key component influencing staff/patient trust in the organization and in perceptions of the response and recovery efforts.

The Incident Commander—or Public Information Officer, if activated—may assign a staff member to monitor the organization’s social media pages and email account to respond to inquiries and address any misinformation.

# Administration, Finance, Logistics

## Administration

### Preparedness

As part of the organization’s preparedness efforts, the organization conducts the following tasks:

* Identify and develop roles, responsibilities, and delegations of authority for key decisions and actions including the approval of the CEMP;
* Ensure key processes are documented in the CEMP;
* Ensure training requirements are met
* Conduct annual CEMP review with update as needed; and
* Ensure CEMP is in compliance with local, state, and federal regulations.
* [Additional organization-specific tasks]

## Finance

### Incident Preparedness and Response

Financial functions during an incident include tracking of personnel time and related costs, initiating contracts, arranging for personnel-related payments such as Workers’ Compensation, ensuring continuation of accounts payable and billing functions, and tracking of response and recovery costs.

The Finance/Administration Section Chief or designee will account for all direct and indirect incident-related costs from the outset of the response, including but not limited to:

* Personnel (especially overtime and supplementary staffing)
* Event-related patient care and clinical support activities
* Incident-related resources
* Equipment repair and replacement
* Costs for event-related organization operations
* Transportation expenses
* Vendor services
* Room and board expenses, food, or other emergent needs
* Personnel illness, injury, or property damage claims
* Loss of revenue-generating activities
* Cleanup, repair, replacement, and/or rebuild expenses
* [Additional organization-specific costs]

## Logistics

### Preparedness

Logistics functions prior to an incident may include identifying and monitoring emergency resource levels, and executing mutual aid agreements, resource service contracts, and memorandums of understanding. These functions will be carried out pre-incident by the Administrator or their designee.

### Incident Response

To assess the organization’s logistical needs during an incident, the Logistics Section Chief or designee will complete the following:

* Regularly monitor supply levels and anticipate resource needs during an incident.
* Identify multiple providers of services and resources to have alternate options in case of resource or service shortages.
* Ensure all resource and service costs are being tracked.
* Restock supplies to pre-incident preparedness levels.
* Coordinate distribution of supplies to service areas.
* [Additional organization-specific activities]

# Plan Development and Maintenance

To ensure plans, policies, and procedures reflect organization-specific needs and capabilities, the organization will conduct the following activities:

**Table 10: Plans, Policies, and Procedures**

| Activity | **Responsible Party** | **Frequency** |
| --- | --- | --- |
| Review and update the organization’s risk assessment. | [Example positions include Administrator] | Annually |
| Review and update contact information for response partners, vendors, and receiving organizations. | [Example positions include Business Office Manager] | Annually or as response partners, vendors, and host organizations provide updated information. |
| Review and update contact information for staff members emergency contacts. | [Example positions include Human Resources Manager] | Annually or as staff members provide updated information. |
| Review and update patient contact information | [All staff] | Immediately upon notification of change |
| Review and update contact information for patients’ caregivers/ responsible parties. | [All Staff] | Immediately upon notification of change |
| Maintain electronic versions of the CEMP in folders/drives that are accessible by others. | [Example positions include Administrator] | Annually |
| Revise CEMP to address any identified gaps. | [Example positions include Administrator] | Annually and Upon completion of an exercise or real-world incident with identified gaps. |
| Inventory emergency supplies (e.g., potable water, food, patient care supplies, communication devices, batteries, flashlights). | [Example positions include Administrator, Facility Designee] | Recommended Quarterly |

# Authorities and References

This plan may be informed by the following authorities and references:

**Authorities and Emergency Preparedness (EP) Requirements for Certified Home Health Agencies (CHHA), Long Term Home Health Care Providers (LTHHCP), Licensed Home Care Services Agencies (LHCSA), and Hospices.**

***Federal Conditions of Participation*** ***(Hospice and CHHA) and other federal authorities:***

* CFR Title 42, Chapter IV, Subchapter G, Part 418 and 484
* 42 CFR - Emergency Preparedness Conditions of Participation § 418.113 for Hospices and § 484.102 for HHA: including all codes and standards incorporated by reference with the same force and effect as if fully set forth at length therein.
* CMS EP Rule update for Hospices: [Hospice Requirements (hhs.gov)](https://files.asprtracie.hhs.gov/documents/aspr-tracie-cms-ep-rule-hospice-requirements.pdf)
* Title 44 of the Code of Federal Regulations, Emergency Management and Assistance
* Homeland Security Act (Public Law 107-296, as amended, 6 U.S.C. §§ 101 et seq.) TITLE V-EMERGENCY PREPAREDNESS AND RESPONSE § 505 CONDUCT OF CERTAIN PUBLIC HEALTH-RELATED ACTIVITIES
* Presidential Policy Directive 8: National Preparedness, 2011
* Homeland Security Presidential Directive 5, 2003
* National Response Framework, January 2016
* National Disaster Recovery Framework, Second Edition, 2016
* National Incident Management System, 2017
* Health Insurance Portability and Accountability Act (HIPAA) of 1996, Privacy Rule
* Homeland Security Act (Public Law 107-296, as amended, 6 U.S.C. §§ 101 et seq.) TITLE V-EMERGENCY PREPAREDNESS AND RESPONSE § 505 CONDUCT OF CERTAIN PUBLIC HEALTH-RELATED ACTIVITIES
* Public Health Service Act (codified at 42 USC §§ 243, 247d, 247d-6b, 300hh-10(c)(3)(b), 311, 319)
* Cybersecurity Information Sharing Act of 2015 (Pub. L. No. 114-113, codified at 6 U.S.C. §§ 1501 et seq.)
* Pandemic and All-Hazards Preparedness Act (PAHPA) of 2006
* Post-Katrina Emergency Management Reform Act of 2006

***New York State Emergency Preparedness Regulations:***

* DAL DHCBS 16-11 issued 12/1/16 - Regulations found in 10 NYCRR require that providers have an emergency preparedness plan that includes agency specific procedures to be followed to assure the health care needs of patients continue to be met:
* 10 NYCRR 794.1(m) for Hospices (Article 40)
* 10 NYCRR 763.11(a)(10) for CHHAs
* Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM)

***Applicable NYS Statutes, Regulations (Minimum Standards) and other Authorities:***

* 10 NYCRR Parts 400 and 415
* 10 NYCRR Part 402 – Criminal History Record Check
* NYS Exec. Law, Article 2-B
* Robert T. Stafford Disaster Relief and Emergency Assistance Act (Public Law 93-288, as amended, 42 U.S.C. 5121-5207
* NYSDOH Healthcare Organization Evacuation Center Manual
* NYSDOH Healthcare Organization Evacuation Center Metropolitan Area Regional Office Region Organization Guidance Document for the 2017 Coastal Storm Season
* NFPA 99 – Health Care Organizations Code, 2012 edition and Tentative Interim Amendments 12-2, 12-3, 12-5, and 12-6
* NFPA 101 – Life Safety Code, 2012 edition and Tentative Interim Amendments 12-1, 12-2, 12-3, and 12-4
* NFPA 110 – Standard for Emergency and Standby Power Systems, 2010 edition and Tentative Interim Amendments to Chapter 7
* CHHA: 10 NYCRR 763.11(a)(10) and 763.1 – 763.14
* LHCSA: 10 NYCRR Part 766, Sections: 766.1- 766.12 and NY Public Health Law § 3605

***Additional NYS Authorities for Hospice:***

* CFR Title 42, Chapter IV, Subchapter G, Part 483, Subpart B, Section 483.73, 2016
* N.Y. Public Health Law, Sections 4000 - 4015
* 10 NYCRR 702.7 and 700.2
* 10 NYCRR 794.5 - Short-term Inpatient Service
* Part 14 of the Sanitary Code
* 10 NYCRR Part 717, sections 717.1-717.4

By reference:

* Guidelines for Design and Construction of Hospital and Health Care Facilities, 1996 edition. The American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Department of Health and Human Services.
* Guidelines for Design and Construction of Health Care Facilities, 2010 edition. The American Society for Healthcare Engineering, with assistance from the U.S. Department of Health and Human Services.
* Design standards for the disabled including The Americans with Disabilities Act of 1990 (ADA) the regulations which implement it. Title 28 of the Code of Federal regulations, Public Health Parts 35, Non-Discrimination on the Basis of Disability in State and Local Government Services

[Additional organization-specific authorities and references]



**Annexes**

# 

# Resource Management

## Hospice In-patient Unit Preparedness

The organization maintains an inventory of resources and corresponding suppliers/vendors, sufficient for emergency use including:

[Organization to modify items in list below to remove those that are not applicable and add additional items as needed]

* Generators
* Fuel for generators and vehicles
* Propane tanks
* Food and water for a minimum of 72 hours for staff and patients
* Disposable dining supplies and food preparation equipment and supplies
* Medical and over-the-counter pharmaceutical supplies
* Personal protective equipment, as determined by the organization
* Emergency lighting, cooling, heating, and communications equipment
* Patient movement equipment (e.g., stair chairs, bed sleds, lifts)
* Durable medical equipment (e.g., walkers, wheelchairs, oxygen, beds)
* Linens, gowns, privacy plans
* Housekeeping supplies, disinfectants, detergents
* Patient specific supplies (e.g., identification, medical records, physician orders, Medication Administration Records, Treatment Administration Records, Contact Information Sheet, progress notes, , most recent History and Physical (H&P), clothing, footwear, and hygiene supplies)
* Administrative supplies

The organization’s resource inventory will be updated as needed to ensure that adequate resource levels are maintained, and supplier/vendor contact information is current.

## Resource Distribution and Replenishment

During an incident, the Incident Commander—or Logistics Section Chief, if activated—will release emergency resources to support operations. The Incident Commander—or Operations Section Chief, if activated—will ensure the provision of subsistence needs.

The Incident Commander—or Planning Section Chief, if activated—will track the status of resources used during the incident. When defined resource replenishment thresholds are met, the Planning Section Chief will coordinate with appropriate staff to replenish resources, including:

* Procurement from alternate or nontraditional vendors
* Procurement from communities outside the affected region
* Resource substitution
* Resource sharing arrangements with mutual aid partners
* Request for external stockpile support from the state

## Resource Sharing

In the event of a large-scale or regional emergency, the organization may need to share resources with mutual aid partners or healthcare organizations in the community, contiguous geographic area, or across a larger region of the state and contiguous states as indicated.

## Emergency Staffing

* 1. Off-Duty Personnel

If off-duty personnel are needed to support incident operations and/or patient care, the organization will conduct the following activities in accordance with organization-specific employee agreements: [Modify table to reflect organization-specific processes for notifying and recalling off-duty personnel]

**Table 11: Off-Duty Personnel Mobilization Checklist**

|  |  |
| --- | --- |
| **Off-Duty Personnel Mobilization Checklist** | |
|  | The most senior-on-site organization official will confirm that mobilization of off-duty personnel is authorized and indicate which personnel may be activated (e.g., overtime pay). |
|  | Once approved, Department Managers will be notified of the need to mobilize off-duty personnel. |
|  | Off-duty personnel will be notified of the request and provided with instructions including:   * Time and location to report * Assigned duties * Safety information * Resources to support self-sufficiency (e.g., water, flashlight) |
|  | Once mobilized, off-duty staff will report for duty as directed. |
|  | If staff are not needed immediately, staff will be requested to remain available by phone. |
|  | To mobilize additional off-duty staff, the organization may consider providing additional staff support services (e.g., childcare, respite care, pet care). These services help to incentivize staff to remain available, but also need to be carefully managed (e.g., reduce liability, manage expectations). |
|  | [Additional organization-specific activities] |

* 1. Other Job Functions

An employee may be called upon to aid with work outside of job-prescribed duties, work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) their normal schedule. Employees may not be asked to function out-of-scope of certified or licensed job responsibilities.

The Incident Management Team will request periodic updates on staffing levels (available and assigned). In addition to deploying clinical staff as needed for patient care activities, non-medical assignments may include:

* Security augmentation
* Runners / messengers
* Switchboard support
* Clerical or ancillary support
* Transportation
* Patient information, monitoring, and one-on-ones, as needed
* Preparing and/or serving meals, snacks, and hydration for patients, staff, visitors, and volunteers
* Cleaning and disinfecting areas, as needed
* Laundry services
* Recreational or entertainment activities
* Providing information, escorts, assistance, or other services to relatives and visitors
* Other tasks or assignments as needed within their skill set, training, and licensure/certification.
* [Additional organization-specific tasks]

* 1. Surge Staffing

If additional surge staffing cannot be met via contract staffing, requests should be made via local OEM request process.

If unmet needs remain, regional DOH should be notified for further assistance and appropriate escalation.

# Emergency Power Systems

## Capabilities

1. In the event of an electrical power disruption causing partial or complete loss of the organization’s primary power source to the office, the organization should implement their emergency response/business continuity plan to assure continued operations and communication to staff.
2. In the event of an electrical power disruption at a Hospice In-patient facility, the organization would assure generator operation in accordance with the organization’s plans, policies, and procedures,[[8]](#footnote-9) the organization will ensure provision of the following subsistence needs:

* Maintain temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;
* Emergency lighting;
* Fire detection and extinguishing, and alarm systems; and
* Sewage and waste disposal.

1. In the event of an electrical power disruption causing partial or complete loss of the organization’s primary power source to patients under care of the organization, the organization will assist in maintaining subsistence needs following all organization’s plans, policies, and procedures.

## Resilience and Vulnerabilities

Any onsite generators and associated equipment and supplies are located, installed, inspected, tested, and maintained in accordance with the National Fire Protection Association’s (NFPA) codes and standards. In extreme circumstances, incident-related damages may limit generator and fuel source accessibility, operability, or render them completely inoperable. In these instances, emergency plans and policies should be followed which may require an urgent or planned evacuation be considered.

# Training and Exercises

## Training

To empower organization personnel and external stakeholders (e.g., emergency personnel) to implement plans, policies, and procedures during an incident, the organization will conduct the following training activities:

**Table 12: Training**

| Activity | **Led By** | **Frequency** |
| --- | --- | --- |
| Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. | [Organization Department or Position] | Orientation held within [XX] days of employment. |
| Incorporate into regular educational training schedule to ensure that all staff are trained and updated on the use of the CEMP and core preparedness concepts. | [Organization Department or Position] | [Minimum At Least Every 2 years] |
| Maintain records of staff completion of training. | [Organization Department or Position] | [Placeholder] |
| Ensure that patients and caregivers receive information and are aware of the CEMP, including what to expect of the organization before, during, and after an incident. | [Organization Department or Position such as  Director, Resident Services] | [Placeholder]  (e.g., At least Admission Information) |
| Identify specific training requirements for individuals serving in Incident Management Team positions. | [Organization Department or Position] | [Placeholder] |
| [Additional organization-specific activities] | [Organization Department or Position] | [Placeholder] |

## 

## Exercises

To validate plans, policies, procedures, and trainings, the organization will conduct exercise activities as required by their licensure type:

**Table 13: Exercises**

| Activity | **Led By** | **Frequency** |
| --- | --- | --- |
| Conduct one community-wide full-scale or functional exercise. [[9]](#footnote-10) | [Organization Department or Position] | Based on Licensure and Policy |
| Conduct one discussion-based exercise (e.g., tabletop exercise). | [Organization Department or Position] | Based on Licensure and Policy |
| Conduct one operations-based exercise (e.g., full-scale or functional exercise). | [Organization Department or Position] | Based on Licensure and Policy |
| Other | [Organization Department or Position] | Based on Licensure and Policy |

## Documentation

## Participation Records

In alignment with industry best practices for emergency preparedness, the organization will maintain documentation and evidence of course completion through [organization-specific system such as sign-in sheets, feedback forms, or printed or digital certificates of completion].

## After Action Reports

The organization will develop After Action Reports to document lessons learned from tabletop and full-scale exercises and real-world emergencies and to demonstrate that the organization has incorporated any necessary improvements or corrective actions.

After Action Reports will document what was supposed to happen; what occurred; what went well; what the organization can do differently or improve upon; and corrective action/improvement plan and associated timelines.

1. During normal business hours (non-holiday weekdays from 8:00 am – 5:00 pm), contact the NYSDOH Regional Office for your region or the NYSDOH Duty Officer. Outside of normal business hours (e.g., evenings, weekends, or holidays), contact the New York State Watch Center (Warning Point). [↑](#footnote-ref-2)
2. The Hazard Vulnerability Analysis (HVA) is the industry standard for assessing risk to healthcare organizations. Organizations may rely on a community-based risk assessment developed by public health agencies, emergency management agencies, and Health Emergency Preparedness Coalitions or in conjunction with conducting its own organization-based assessment. If this approach is used, organizations are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the organization’s emergency plan is in alignment. [↑](#footnote-ref-3)
3. Refer to the “Training and Exercises” section of this plan for additional information about pre-incident trainings and exercises. [↑](#footnote-ref-4)
4. “Active threat” is defined as an individual or group of individuals actively engaged in killing or attempting to kill people in a populated area. Example attack methods may include bombs, firearms, and fire as a weapon. [↑](#footnote-ref-5)
5. “CBRNE” refers to “Chemical, Biological, Radiological, Nuclear, or Explosive” [↑](#footnote-ref-6)
6. To notify NYSDOH of an emergency during business hours (non-holiday weekdays from 8:00 am – 5:00 pm), the Incident Commander will contact the NYSDOH Regional Office [region-specific phone number]. Outside of normal business hours (e.g., evenings, weekends, or holidays), the Incident Commander will contact the New York State Watch Center (Warning Point) at 518-292-2200. The Watch Command will return the call and will ask for the type of emergency and the type of organization (e.g. hospital, nursing home, adult home) involved. The Watch Command will then route the call to the Administrator on Duty, who will assist the organization with response to the situation. [↑](#footnote-ref-7)
7. An emergency notification system is a one-way broadcast, sometimes coordinated by a third-party vendor, and is not required by NYSDOH. [↑](#footnote-ref-8)
8. CMS requires healthcare organizations to accommodate any additional electrical loads the organization determines to be necessary to meet all subsistence needs required by emergency preparedness plans, policies, and procedures. It is up to each organization to make emergency power system decisions based on its risk assessment and emergency plan. [↑](#footnote-ref-9)
9. If an organization activates its CEMP due to a disaster, the organization is exempt from the operational exercise for the year ending November 15. An organization is only exempt if the event is fully documented, a post-incident after action review is conducted and documented, and the response strengths, areas for improvement, and corrective actions are documented and maintained for three (3) years. However, the secondary requirement for a tabletop exercise still applies. [↑](#footnote-ref-10)