|  |
| --- |
|  |
|  |

Healthcare Coalition of Northern Maine

**All Hazards Coalition Response Plan**

March 2019



Healthcare Coalition of Northern Maine

*A Maine CDC Partner*

**Approval and Implementation Document**

**Healthcare Coalition of Northern Maine**

**All Hazards Coalition Response Plan**

This Plan is hereby approved for implementation.

This Plan supersedes any and all previous editions.

**Date Response Plan Approved:**

**APPROVAL OF COALITION RESPONSE PLAN: The Plan is adopted with a review by coalition membership.**

**Healthcare Coalition of Northern Maine**

**All Hazards Coalition Response Plan**

**Record of Changes to Base Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Revision** | **Recommended Change** | **Revision Number** | **Initials** |
| 6/25/18 | Plan is created | 1 | GM |
| 6/26/18 | Plan is formatted and additional content added | 1 | JM |
| 3/27/19 | Plan is revised, used the HCCCM Format | 2 | MM |
| 3/31/19 | Draft Plan submitted to the ASPR | 2 | MM |
| 4/17/19 | Reviewed with Coalition members | 3 | MM |
| 5/8/19 | Reviewed with Coalition members | 4 | MM |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Healthcare Coalition of Central Maine**

**All Hazards Coalition Response Plan**

**Record of Distribution**

|  |  |  |
| --- | --- | --- |
| **To Whom: Person/Title/Agency** | **Method of Delivery** | **Date** |
| William Jenkins, Maine CDC | Email | 3/31/19 |
| CAT Program | CAT | 4/1/19 |
| HCCNM members | Email | 4/10/19 |
| HCCNM members | Email | 5/1/19 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Section I: Base Plan 5

Introduction 5

Purpose 5

Scope 5

Roles and Responsibilities 6

Situation Overview 9

Planning Assumptions 10

Healthcare Coalition Assistance Team (HCCAT)…………………………………………………………………………………. 11

Emergency Activation………………………………………………………………………………………………..………………….…. 12

Stage 1: Incident Recognition and Activation of the EOP…………………………………….…..………………………… 12

Levels of Activation………………………………………………………………………………………………………………………. 13

Response Structure………………………………………………………..……………………………………………………….……. 14

**Stage 2: Notifications**…………………………………………………………………………………………………………………….……. 14

**Notification Types……………………………………………………………………………………………………………………….. 15**

**Notification Priorities………………………………………………………………………………………………………………….. 16**

**Stage 3: Mobilization…………………………………..………………………………………………………………………………….. 16**

**Stage 4: Incident Operations……………………………………………………………………………….………………………….. 16**

**Managing the HCCCM’s Emergency Response…………………………………………………………………………….. 17**

**Stage 5: Demobilization………………………………………………………………………………………………………………….. 17**

Stage 6: Transition to Recovery and Return to Readiness………………………….………………………………………….. 18

**Plan Development and Maintenance………………………………………………………………………………………………. 19**

Authorities and References 19

Section II Annexes: Record of Revision 23

Functional Annexes 23

Communications Plan 23

Medical Surge 23

Responder Health and Safety 23

Volunteer Management 23

Hazard Specific Annexes 23

TBD 23

Support Annexes 23

Appendix 24

A. List of Acronyms 25

B. HCCAT ICS Form 207 27

C. Resource Request Form 29

D. Volunteer Request Form 32

E. Important Contact Information 43

F. Helpful Links 44

Section III: Annexes Listing 45

Section I Base Plan

# Introduction

This plan describes the roles and responsibilities of the Healthcare Coalition of Northern Maine (HCCNM) in responding to a healthcare emergency that spans primarily within northern Maine including the counties of Aroostook, Piscataquis, Penobscot, Washington, Hancock, Waldo, Knox counties, and most of Somerset county. The coalition can further support response in other regions of the state if needed. When effectively implemented, the Healthcare Coalition provides the mechanisms for individual healthcare organizations to coordinate information sharing and other response capabilities using efficient response processes and procedures. Further, this plan describes how key preparedness and response activities are coordinated with medical resources, healthcare services and other preparedness and response partners.

# Purpose

The HCCNM All Hazards Coalition Response Plan (EOP) establishes and describes the emergency response framework which will guide the HCCNM as it activates to protect the health, safety and well-being of Maine residents and visitors in areas impacted by a natural or manmade health emergency or disaster. Functional Annexes describe how the basic emergency functions will be managed. Hazard Specific Annexes describe management functions that are unique to specific hazards.

# Scope

The Coalition Response Plan describes how the HCCNM will respond to disasters that cause severe illness, injury and/or fatalities that affect participating healthcare organizations and the local jurisdiction, the region, and/or state that may overwhelm healthcare capabilities. The response plan provides an overview of the HCCNM and regional partner roles and responsibilities before, during and after emergencies in order to protect and restore the health of residents and visitors of northern Maine. Every attempt is made to assure that this response plan is compatible with Federal and State emergency response plans.

# Roles and Responsibilities

1. HCCNM

HCCNM’s primary role and responsibilities include:

* Facilitating information sharing among participating healthcare organizations and with jurisdictional authorities to promote common situational awareness.
* Facilitating resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members and supporting the request and receipt of assistance from local, State, and Federal authorities.
* Facilitating the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response.
* Facilitating the interface between the Healthcare Coalition (HCC) and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge.

1. Healthcare Coalition Coordinator

The Healthcare Coalition coordinator is responsible for coordinating and leading the HCCCM in planning for, responding to and recovering from a regional healthcare disaster.

Coordinators provide the primary hub for facilitating regional HCC response and recovery operations including:

* facilitating communications
* providing medical surge support
* coordinating regional medical equipment and supplies
* providing and receiving healthcare situational awareness and information with the Maine CDC, the Maine Emergency Management Agency and other key agencies during a disaster or emergency.

1. Healthcare Coalitions of Southern and Central Maine

Coordination between the three regional HCCs is integral to forming a common operating picture across the entire state and to providing support to one another. The HCCs will facilitate the sharing of information collected from its member organizations and provide support to actions taking place in the Northern Maine region. Likewise, if an incident were to occur in either other region, the HCCNM will provide information sharing and assistance as needed.

1. Maine Center for Disease Control and Prevention (Maine CDC)

The Maine CDC is the lead state agency responsible for preparing for and responding to public health emergencies resulting from natural disasters that impact the public’s health, disease investigations and contact tracing for infectious disease outbreaks and laboratory testing of biological, technological, and chemical terrorism agents.

1. Public Health District Liaisons (includes Tribal Liaisons)

The District and Tribal Liaisons serve as the arm of the Maine CDC at the District and Tribal level. They participate in planning, response and recovery at the district level, coordinating with the Healthcare Coalitions (HCCs), county Emergency Management Agencies (EMA) and other local agencies. They facilitate communication between the state and local agencies.

1. Public Health Nursing

Public Health Nurses are responsible for helping to monitor the health status of residents in their regions, diagnosing and investigating health problems and health hazards, and assisting with providing medical countermeasure dispensing at Strategic National Stockpile (SNS), Point of Dispensing (POD) sites.

1. Health and Environmental Testing Laboratory (HETL)

The Health and Environmental Testing Laboratory is responsible for rapidly identifying, tracking, and containing outbreaks through isolating, identifying, analyzing and monitoring any biological, chemical, or radiological hazards capable of causing harm.

1. Environmental Health

The Division of Environmental Health is responsible for ensuring the safety and security of public drinking water systems, responding to food-borne illnesses, ensuring the safety of radiological devices and materials, environmental toxicology response and monitoring occupational disease reporting.

1. Infectious Disease Epidemiology

The Infectious Disease Epidemiology Program is responsible for containing the spread of infectious diseases, conducting trace investigations and contact investigations, implementing non-pharmaceutical interventions such as isolation and quarantine and expert consultation to members of the public and healthcare practitioners.

1. Disaster Behavioral Health (DBH)

The Maine CDC Disaster Behavioral Health Response Team (DBHRT) is responsible for providing direct mental and behavioral health support and services to victims and response personnel during and after a disaster or emergency. DBHRT also provides mental/behavioral health support to families impacted by a disaster or emergency through the activation of a Family Assistance Centers (FAC), which are managed jointly with the American Red Cross, Medical Examiners, religious leaders and others to help families during times of crisis.

1. Volunteer Management

The volunteer management program provides the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with medical preparedness and response to incidents and events.

1. County Emergency Management Agencies

Local emergency management activities are coordinated regionally by county EMAs, as applicable, in the HCCNM’s eight counties. County Directors provide support to cities and towns in Aroostook, Piscataquis, Penobscot, Washington, Hancock, Waldo and Knox Counties, and most of Somerset County as well as leadership in preparedness, response, recovery and mitigation to their local business and volunteer partners. County EMAs are integral in providing mutual aid and support to the HCCNM with deploying resources during an emergency.

1. Maine Emergency Management Agency (MEMA)

MEMA is responsible for coordinating the mitigation (risk reduction) preparedness, response and recovery from emergencies and disasters such as floods, hurricanes, earthquakes or hazardous materials spills. MEMA also provides guidance and assistance to county and local governments, businesses and nonprofit organizations in their efforts to provide protection to citizens and property and increase resiliency in the face of disaster. MEMA uses strategies such as planning, training, exercise and public education to carry out its mission.

1. Office of the Chief Medical Examiner (OCME)

The OCME is responsible for the investigation of sudden, unexpected and violent deaths resulting from mass fatality incidents and for implementing the state’s mass fatality plan in accordance with Title 22, Chapter 711, MEDICAL EXAMINER ACT.

1. Hospitals

Hospitals are responsible for providing definitive care to individuals resulting from a disaster or other medical emergency. Hospital emergency operation activities include preparing for medical surge incidents as well as activating and staffing alternate care sites and extended care sites.

1. Maine Emergency Medical Services (Maine EMS)

Maine EMS is responsible for providing rules, data collection, and treatment protocols for the transporting and non-transporting EMS agencies and pre-hospital care providers. Maine EMS works closely with HCCNM participating healthcare organizations, as well as Emergency Medical Dispatchers, on pre-hospital treatment and transport, medical surge, and mass casualty response operations.

# Situation Overview

Maine is a large, rural state, with a land mass of over 30,800 square miles, making it almost as large as the other 5 New England states combined. Maine has a population of 1.33 million residents and a limited sub-state public health infrastructure. Maine is also home to nearly 16,000,000 overnight visitors annually and nearly 19,000,000-day visitors annually. The majority of this influx of populous occupies the central and southern part of the State. Within Maine’s large geographic area and relatively low population are Maine’s 36 hospitals (4 are trauma centers) and a broad array of healthcare providers including 151 FQHCs, other health centers and private practitioners. Maine EMS is regulated by the Maine Bureau of Emergency Medical Services which provides rules, data collection, and treatment protocols for the 273 transporting and non-transporting EMS agencies and the roughly 5,500 pre-hospital care providers.

The Northern Maine Region is the largest geographical coalition area-wise among the three coalition regions. With approximately 25,500 square miles it is comprised of 21 separate Hospital Service Areas (HSA). The Northern Region spans all of Aroostook, Piscataquis, Penobscot, Washington, Hancock, Waldo, Knox Counties, and most of Somerset County. According to the 2010 US Census, approximately 452,000 people reside in the Northern region, the largest population of the three regions. Within the Northern region, Bangor is its largest city with approximately 33,039 residents followed by Presque Isle, Brewer, and Caribou with 9,692, 9,482, and 8,189 residents respectively. The varied geography of the area lends itself as a four-season tourist region. Industries include papermaking, technology, manufacturing and farming. The region includes 21 hospitals, 40 long term care facilities, 68 Federally Qualified Healthcare Centers as well as other healthcare centers form private practices to ambulatory surgical centers.

The HCCNM strives to improve an all-hazard medical response in the Northern Maine region through effective communication, planning, coordinated exercises, and collaboration between regional healthcare organizations, emergency responders, local/regional emergency management directors, public health and other emergency response planners.

The HCCNM updates their regional Hazard Vulnerability Analysis (HVA) annually taking into consideration many factors including corrective actions identified in previous After-Action Reports (AARs) assembled from exercises and real-life events from the preceding year.

# Planning Assumptions

The HCCNM will use the National Incident Management System (NIMS) as a basis for supporting, responding to, and managing activities.

Emergencies, disasters, and planned events affecting HCCNM organizations will be managed at the lowest possible geographic, organizational, and jurisdictional level using the Incident Management System. Response will also be conducted at the lowest applicable *activation level* to effectively and efficiently handle the situation.

Emergencies and disaster events may:

* Require significant communications and information sharing across jurisdictions and between the public and private sectors, as well as media management.
* Involve single or multiple geographic areas.
* Involve multiple varied hazards or threats on a local, regional, state, or national level.
* Involve widespread illness, casualties, fatalities, disruption of life sustaining systems, damage to essential health services and critical infrastructure and other impacts to the environment which will have an impact on statewide economic, physical and social infrastructures.
* Disrupt sanitation services and facilities, result in loss of power and require massing of people in shelters which can increase the potential for disease and injury.
* Produce urgent needs for mental health crisis counseling for victims and emergency responders.
* Overwhelm the capacity and capabilities of local and tribal governments or state agencies.
* Require short-notice asset coordination and response timelines.
* Require collaboration with non-traditional health partners (ex. massage therapist, medical interpreter, dental hygienist, nutritionist, lactation consultant, etc.).
* Require deployment of medical and lay volunteers.
* Require response operations including sustained incident management operations and support activities for an extended period of time as the emergency or disaster situation dictates.
* Require the evacuation of a facility to an alternate care site.
* Require the activation of an alternate care site.
* Disrupt the ability to provide day to day essential services.

This Emergency Response Plan reflects the additional assumptions and considerations below:

* The highest priorities of any incident management system are always life/safety for staff, responders, and the public health and safety of the public.
* Medical standards of care may be adjusted in a major incident or catastrophe where there are scarce resources, such as during an influenza pandemic.
* Participating organizations maintain their respective decision-making sovereignty during incident response, except in unusual circumstances that warrant the implementation of local or state health authorities (e.g., enactment of isolation or quarantine).
* Participating organizations determine individually how they will respond to an incident and whether they will activate any emergency response procedures. The Coalition does not supplant this responsibility.
* The HCC response organization may convene representatives (often virtually) from its member organizations to discuss response issues.
* Decisions made by the Coalition during incident response are made on a consensus basis or are recommendations only.
* HCC partners will work together for a common good despite day-to-day competition, especially if a fair platform with transparent decision-making is provided for this functional relationship.
* Support from the administrative leadership of each participating organization can be achieved with proper attention to the design and function of the Coalition.
* The use of NIMS-consistent concepts and procedures will promote integration with public sector response efforts; NIMS consistency is also required to be eligible for Federal funding.

**Healthcare Coalition Assistance Team (HCCAT)**

The HCCAT will function in a support and advisory position to manage complex coalition response under emergency and non-emergency situations. The HCCAT will not be used in a command role over any emergency situation but rather will support incident managers in their efforts to control the situation, whether the incident is based regionally or locally. The HCCAT will use the Hospital Incident Command System as a model for organization during a public health related incident.

Depending on the level of activation, positions will be filled with members of the HCCNM and volunteers of member organizations that are not directly affected by an emergency, essentially forming a healthcare specific incident management team.

**Emergency Activation**

**Activation Stages 1 - 6**

**Stage 1: Incident Recognition and Activation of the EOP**

If a situation exists within a healthcare facility or within a healthcare region that warrants activation of the coalition EOP the following steps will be taken:

* + - 1. Contact the Northern Coalition Emergency Line by dialing **207-200-3807**.
      2. An HCCAT member will answer and ask what situation exists.
      3. If the number is not answered, call the Healthcare Coalition of Northern Maine’s direct number at **207-747-9139** to speak to the coordinator.

The HCCAT member answering the call will grade the situation for severity level and issue the proper notifications.

The following situations are examples of conditions that warrant activation of the Coalition EOP:

* Healthcare organizations reporting lack of necessary care resources
* Healthcare organizations reporting high rates of absenteeism for essential staff members to the point that it is impacting normal operations
* National vendors reporting that they are unable to fill supply request/resource request on back order
* Healthcare organizations reporting lack of surge capacity
* An organizational emergency causing a change in normal operations (ex. diversion)
* An organizational or geographical area emergency causing the need to evacuate or initiate the organization’s disaster plan (emergent notification required)

**Levels of Activation**

|  |  |
| --- | --- |
| Level 3: Monitoring & Assessment | This level is a monitoring and assessment phase where a specific threat, unusual event, or developing situation is actively monitored. Notification will be made to those who will need to take action as part of their everyday responsibilities. Activities will take place during working hours and will primarily be the responsibility of the HCCNM Coordinator. |
| Level 2:  Partial Activation | Partial activation is typically limited activation of the Coalition and the HCCAT team. HCCAT members with a role in incident response are activated and required to report virtually as part of the HCCAT. Notifications will be made to the HCCNM member organizations via the notification algorithm and conference calls will be scheduled to provide situational awareness. |
| Level 1:  Full Activation | HCCAT members will be notified and a conference call will be established to assign roles and discuss incident objectives. |

**Response Structure**

The coalition will respond to the situation within the following incident command structure. The incident will be managed at the lowest and smallest level possible so all stages of this chart may not be activated.

Maine

Governor

Maine

CDC

PHEOC

Maine

EMA

EOC

County EMA EOCs

CDC District Liaisons

HCCCM Coordinator

HCCAT Leader

EMA IMAT Teams

HCCAT Planning

HCCAT Logistics

HCCAT Operations

**Stage 2: Notifications**

Initial notification within the Coalition occurs in a relatively simultaneous fashion depending on the urgency required. “Notification” refers to the actions required to inform appropriate organizations within the response system about the onset of an incident or an important change in incident parameters. Notification conveys important details (if available) and may indicate whether the notified organizations should undertake response actions. An initial notification message accomplishes the following:

* Provides urgent information about a hazard occurrence or threat of a hazard occurrence
* Commonly suggests actionable guidance for the notified entity for protective and initial response actions
* Conveys the activation decision regarding the HCCAT

**Notification Types**

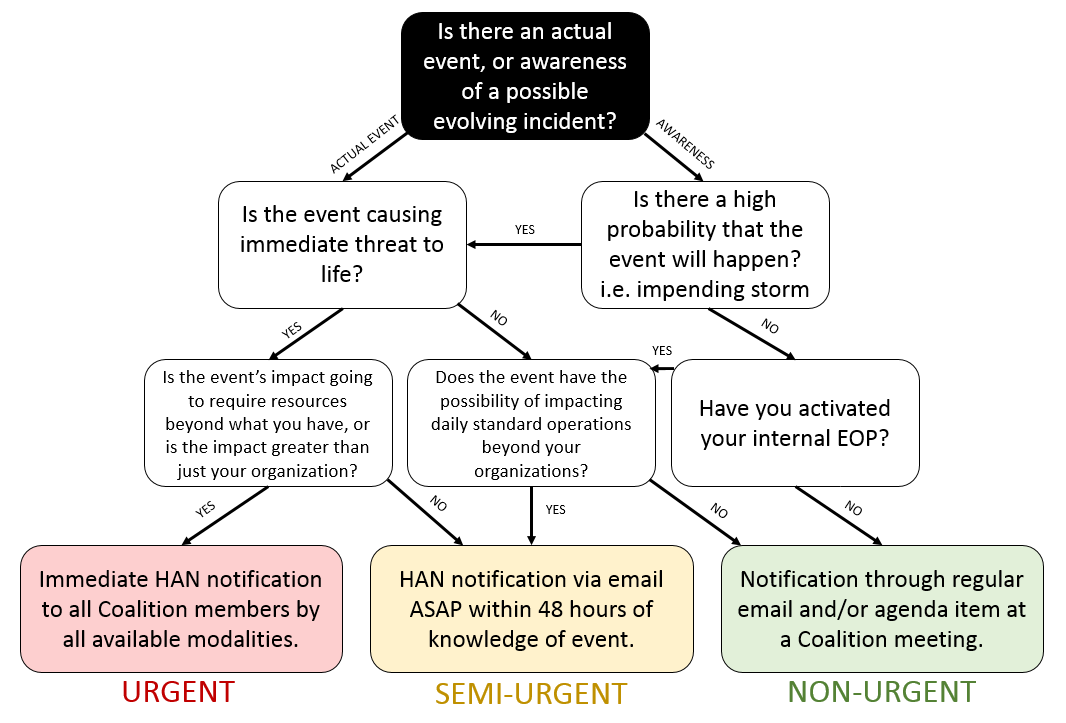
Notifications can be placed in the following categories:

|  |  |
| --- | --- |
| **Alert** | * Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. * An alert may also be used to notify Coalition member organizations that the HCCAT has been activated. * This category may also be used for ongoing notification during an emergency to convey urgent information and recommended actions from the HCCAT or incident command authorities. |
| **Advisory** | * Provides urgent information about an unusual occurrence or threat of an occurrence, but no action by the message recipient is expected. * An advisory may include actionable information for individual personnel at Coalition member organizations even though the organizations may not need to take emergency action (e.g., a weather advisory that includes travel precautions for individuals). |
| **Update** | * Provides non-urgent incident information and suggests no urgent actions. * This category is used in both emergency and non-emergency times (e.g., notification of a response action taking place at a member facility that does not require coalition support.) |

**Notification Priorities**

Based upon what conditions are reported to the HCCNM, the following algorithm will be followed to determine the urgency and modality of notification to HCCNM member organizations.

**Healthcare Coalition of Northern Maine Notification Algorithm**



**Stage 3: Mobilization**

This refers to the transition of the HCCAT from a state of inactivity or baseline operations to the designated response level. Each Coalition member organization mobilizes its own EOP independent of the HCCAT activation. Coalition members are only required to make available an Organizational Liaison to interface with the HCCAT.

**Stage 4: Incident Operations**

This stage refers to actions that address the Healthcare Coalition’s response objectives following activation of the Coalition’s EOP (other than mobilization and demobilization). Actions in this stage may be divided into “initial” (or “immediate”) and “on-going” categories.

**Managing the HCCNM’s Emergency Response**

The HCCAT Leader provides oversight and maintenance of the HCCAT. *Even during minimal HCCAT activation, it is mandatory to designate an HCCAT Leader.* It is expected that other traditional ICS Command staff positions will be unassigned during most HCCAT activations. The functions of these unstaffed positions are assumed by the HCCAT Leader.

Important initial management actions include the following:

* Conduct an initial situational assessment.
* Designate the structure of the HCCAT and which positions will be staffed for the emergency. (HCCAT ICS Form 207).
* Communicate this structure to other organizations as needed.
* Establish Initial Objectives
* Develop strategies to accomplish the objectives.
* Assign resources as applicable.

Incident Objectives

* Facilitate situational awareness for Healthcare Coalition member organizations
* Provide resource support to Coalition member organizations
* Facilitate coordination across participating Coalition organizations
* Facilitate the interface between jurisdictional authorities and Coalition member organizations

**Stage 5: Demobilization**

The time frame for this activity may vary by situation but planning for demobilization should begin from the outset of the response. The ultimate decision to move to demobilization will be made by the HCCAT Leader based on achievement of response objectives.

The criteria to implement demobilization will vary incident by incident, but fundamental considerations will be:

• The request for disaster support is declining to a manageable level using normal personnel and resources

• There is no subsequent rise in demand for disaster support expected

• Other responders are beginning their demobilization process

• Other critical community infrastructure is returning to normal operations

The HCCAT Leader will consult with the lead agency and other agencies including Maine CDC’s PHEOC (if activated), before making a final decision to demobilize.  As the HCCCM demobilizes elements from its response organization, a formal notification will be made to HCCNM’s members and the relevant jurisdictional agency(s).

Following an event, all supplies, equipment will be properly accounted for, recovered and/or reconstituted, and returned in preparation for a subsequent event or incident. When personnel are no longer needed, the HCCAT will ensure all staff are accounted for and checked off the log and have adequate travel arrangements to return home.

**Stage 6: Transition to Recovery and Return to Readiness**

This stage encompasses the Healthcare Coalition’s recovery activities and actions that return the Coalition to a state of readiness for the next emergency/event.

**Managing the Healthcare Coalition through Recovery**

There are additional management considerations for the Healthcare Coalition as its response to an incident draws to a close, including:

* The HCCAT Leader should be the last position to demobilize.
* In addition to incident recovery objectives, the Coalition may find it useful to address mitigation or improvement in its response capabilities during recovery. Funding opportunities often arise after an emergency. The Coalition should be ready with targeted initiatives that will increase Coalition resiliency and/or improve its response capabilities.
* The HCCAT may assign personnel to assist with the Coalition’s AAR process or other organizational learning activities. When the HCCAT demobilizes, the supervision of the AAR process transitions to the Incident Commander

Reimbursement for Healthcare Coalition Response

The primary cost for operating the HCCAT is usually personnel time, which is often donated by the Coalition member organizations. However, it is still important to keep records of personnel time (or other Coalition expenses), since reimbursement mechanisms may be available.

# Plan Development and Maintenance

This EOP was developed, reviewed, and approved by the members of HCCNM including hospitals, EMS organizations, and emergency management and public health agencies, and approved by the Coalition Membership. The EOP will be reviewed by the HCCNM annually and revised as needed once an agreed upon version is reached. Lessons learned as they emerge from After Action Report/ Improvement Plans following real events or planned training exercises will be incorporated into the EOP.

# Authorities and References

**Federal Authorities**

Centers for Medicare and Medicaid Services (CMS), Regulations and Guidance. Accessed February 3, 2016 at: <http://www.cms.hhs.gov/home/regsguidance.asp>.

Centers for Medicare and Medicaid Services (CMS), Emergency Medical Treatment and Labor Act (EMTALA). Accessed February 3, 2016 at: <http://www.cms.hhs.gov/emtala/>.

Homeland Security Act, Department of Homeland Security Act, 2002

Homeland Security Presidential Directives (HSPD) # 5, Management of Domestic Incidents, Office of the President, 2003

Homeland Security Presidential Directives (HSPD) # 8, National Preparedness Goal, Office of the President, 2003

National Incident Management System, Department of Homeland Security, 2009

National Response Framework, Department of Homeland Security, 2009

U.S. Department of Health and Human Services, Health Insurance Portability and Accountability Act (HIPAA), “Understanding HIPAA Privacy.” Accessed February 3, 2016 at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, “Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies.” Accessed December 10, 2015 at: <http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/executivesummary.aspx>.

National Fire Protection Agency Standard 1600, 2007 Edition: Standard on Disaster/Emergency Management and Business Continuity Programs. Accessed February 3, 2016 at: <http://www.nfpa.org/assets/files/PDF/NFPA1600.pdf>.

## State Authority

**Legal Authority: Title 22 M.R.S.A. Chapter 250, Subchapter II-A, Extreme Public Health Emergencies**

The Maine CDC is the lead state agency responsible for the protection of public health in the event of a public health emergency. Situated within the Maine CDC is the Emergency Public Health Preparedness unit, responsible for development and implementation of public health emergency planning and coordination of public health interventions in the State of Maine. The Maine CDC has broad statutory and regulatory authority, in the event of a public health emergency, to establish and implement procedures to identify persons exposed to communicable, environmental or occupational diseases, or toxic agents, and impose appropriate educational, counseling or treatment programs to prevent the transmission of communicable disease. The Center may designate facilities appropriate for the quarantine, isolation and treatment of persons exposed to or at significant risk of exposure to notifiable conditions, environmental hazards or toxic agents and to initiate court actions to secure involuntary disease control measures if necessary.

The Department may, with the approval of the Attorney General, issue administrative subpoenas to access health information relevant to any public health threat. If necessary, to avoid a clear and immediate public health threat, the Department may obtain ex parte orders to place individuals into emergency temporary custody and seek court ordered public health measures to compel individuals to participate in medical examinations, health counseling, treatment, quarantine, isolation, and other public health measures. Quarantine, isolation and treatment of persons exposed or at significant risk of exposure to notifiable conditions, environmental hazards or toxic agents and to initiate court actions to secure involuntary disease control measures if necessary. In this regard, the Department may impose administrative emergency public health orders, exclude infected persons from school, and conduct investigations necessary to address any public health threat. The statutory procedures for the processing of public health measures are established in Title 22 M.R.S.A. Chapter 250, Subchapter II.

In the event the Governor declares an extreme public health emergency, the Department has enhanced powers necessary to collect additional health information from medical providers, pharmacists, and veterinarians and place persons into prescribed care, including involuntary examination, vaccination, treatment, quarantine and isolation. In periods of extreme public health emergency, the Department may impose prescribed care upon individuals without court order if necessary, to prevent disease transmission. The statutory procedures for the processing of control measures in periods of declared extreme public health emergency are established in Title 22, Chapter 250, Subchapter II-A.

The Maine Department of Health and Human Services has adopted rules, which establish public health control measures to address public health threats, public health emergencies and extreme public health emergencies. The rules establish procedures governing the Departments’ investigation and intervention into potential public health threats. In the event persons are unable or unwilling to cooperate in the Department’s disease control programs, the rules establish step-wise interventions depending upon the characteristics of the suspected disease entity and the risk of disease transmission. The interventions available to the Department include counseling, treatment, disease control measures, administrative orders and court ordered examination, treatment and confinement. The rules also establish departmental protocol governing the investigation and response to outbreaks of communicable disease, epidemic investigation and intervention. In the event the Governor has declared an extreme public health emergency, the Department may also impose additional control measures, including the management of persons, control of property, commandeering of private property to provide emergency healthcare, the seizure and destruction of contaminated property, and the disposal of human and animal remains.

The Governor may assume direct operational control over all or any part of the civil emergency preparedness or public safety functions of the State and directly, or through the Adjutant General, cooperate with federal agencies and the offices of other states and foreign governments and private agencies in all matters relating to the civil emergency preparedness of the State. Furthermore the Governor may declare a state of emergency and thereby activate a host of extraordinary powers, including the authority to suspend regulatory legislation, direct the evacuation of affected geographical regions, control traffic to and from affected areas, exercise control over private property, enlist the aid of emergency personnel and undertake all other measures necessary to mitigate or respond to the disaster emergency. The Governor’s powers in this regard are complimentary to the powers of the Department of Health and Human Services in responding to a public health emergency. It is noteworthy, however, that among the enumerated powers of the Governor in a period of disaster emergency is the power to transfer the direction, personnel, or functions of state government for the purpose of performing or facilitating emergency services. Hence the Governor can effectively exercise all the authority of the Maine DHHS Commissioner in a period of public health emergency.

In order for the Department to exercise the extraordinary public health powers vested in it pursuant to Title 22, chapter. 250, subchapter II-A, the Governor must have declared an extreme public health emergency pursuant to his or her authority under Title 37-B, chapter 13, subchapter 11.

**Volunteer Liability Protections**

Federal and Maine laws contain protections for individuals from liability for performance of certain emergency management activities. The applicable provisions of the laws are:

1.  **Title 37-B M.R.S.A. § 784-A**.  This section of Maine law provides that MEMA and local emergency management organizations may employ any person considered “necessary to assist with emergency management activities”.  The statute states that a healthcare worker, licensed in Maine, who is designated by MEMA to perform emergency management or health activities in Maine in a declared disaster or civil emergency pursuant to Title 37-B M.R.S.A. §742 is deemed to be an employee of the state for purposes of immunity from liability and workers compensation.  Title 37-B M.R.S.A. § 822, provides that any person who is called out pursuant to Section 784-A and while engaged in emergency management activities is not liable for the death or injury to any person, or for damage to any property as a result of such activities.  However, a disaster or civil emergency under Title 37-B M.R.S.A. § 742 and 742-A, requires a proclamation by the Governor that such an emergency exists.

2.  **Title 22 M.R.S.A. § 816**.  This section of Maine law provides immunity to private institutions, their employees and agents from civil liability to the extent provided by the Maine Tort Claims Act for engaging in any prescribed care as defined by the statue in support of the State’s response to a declared extreme public health emergency.  An extreme public health emergency is defined in Title 22 M.R.S.A. § 2-A and requires a proclamation by the Governor that such an emergency exists.

3. **VOLUNTEER PROTECTION ACT OF 1997**

In 1997 the United States Congress passed the Volunteer Protection Act (VPA). The stated purpose of this Act was to encourage volunteers to continue to volunteer without fear of liability. It established a minimum level of protection that pre-empted state law unless the state provides greater protections under its own laws than the VPA. The VPA also does not apply in a state where the state has enacted a statute expressly declaring the VPA provisions will not apply. Maine has not enacted this type of a statute, so the VPA does apply.

4. **Good Samaritan Law**

In Maine, any person who renders first aid, emergency treatment or rescue assistance voluntarily, without expecting any type of compensation (monetary or otherwise) from the person they assist, is not liable for any damages for injuries sustained by that person or for damages for that person’s death because of the aid, treatment, or assistance. An exception to this rule applies if the injuries or death is caused willfully, wantonly, recklessly, or by gross negligence on the part of the person giving the aid, treatment, or assistance.

This law applies to members or employees of nonprofit volunteer or governmental ambulance, rescue or emergency units – whether or not a fee is charged for the services by the nonprofit or governmental entity and whether or not the members or employees receive salaries or other compensation from the nonprofit or governmental entity. The law does not apply if the aid, treatment, or assistance is given on the premises of a hospital or clinic.

**References**

**General References**

* ASPR, Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness, January 2012
* CDC, Public Health Preparedness Capabilities: National Standards for State and Local Planning, March 2011
* FEMA, Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, November 2012
* NACCHO, 2010 PPHR Criteria for Local Health Departments, All Hazards Preparedness Planning, 2012

**State Plans**

* Connecticut Department of Public Health, Public Health Emergency Response Plan, September 2005
* Florida Emergency Operations Plan, v 2.2, March 2009
* Lane County Oregon, Public Health Services Emergency Operations Plan, Version 1, May 2008
* Maine Emergency Operations Plan, June 2015
* Minnesota DOH All Hazards Response and Recovery Base Plan, v 2011
* Montana, Department of Public Health and Human Services, Emergency Operations Plan, December 2010
* Wyoming Department of Health, Emergency Operations Plan, revision #3, November 2010
* Maine CDC, Hazards Vulnerability Analysis Report, May 2, 2012
* MEMA, Maine State Hazard Mitigation Plan, 2010

Section II Annexes: Record of Revision

|  |  |  |
| --- | --- | --- |
| Functional Annexes | **Date of Revision** | **Revision Number** |
| Communications Plan |  |  |
| Medical Surge |  |  |
| Responder Health and Safety |  |  |
| Volunteer Management |  |  |
| Hazard Specific Annexes | **Date of Revision** | **Revision Number** |
| TBD |  |  |
| Support Annexes | **Date of Revision** | **Revision Number** |
| TBD |  |  |
|  |  |  |

Appendix

* + 1. List of Acronyms
    2. HCCAT ICS Form 207
    3. Resource Request Form
    4. Volunteer Request Form
    5. Important Contact Information
    6. Helpful Links

# A. List of Acronyms

|  |  |
| --- | --- |
| AAR | After Action Report |
| AHOC | After Hours on Call |
| AOC | Administrator on Call |
| ARC | American Red Cross |
| ASPR | Assistant Secretary for Preparedness and Response |
| BPH | Bangor Public Health |
| CBRN | Chemical, Biological, Radiological, Nuclear Threat |
| CDC | Center for Disease Control and Prevention |
| CEMA | County Emergency Management Agency |
| HCC | Healthcare Coalition |
| HCCAT | Healthcare Coalition Assistance Team |
| HCCCM | Healthcare Coalition of Central Maine |
| HCCNM | Healthcare Coalition of Northern Maine |
| HCCSM | Healthcare Coalition of Southern Maine |
| CMS | Center for Medicaid and Medicare Services |
| CONOPS | Concept of Operations |
| COOP | Continuity of Operations Plan |
| CPG | Capabilities Planning Guide |
| CSC | Coalition Steering Committee |
| DBH | Disaster Behavioral Health |
| DBHRT | Disaster Behavioral Health Response Team |
| DEH | Department of Environmental Health |
| DEP | Department of Environmental Protection |
| DHHS | Department of Health and Human Services |
| DHS | Department of Homeland Security |
| DMAT | Disaster Medical Assistance Team |
| DMORT | Disaster Mortuary Operational Response Team |
| DOA | Department of Agriculture |
| DOE | Department of Education |
| DOT | Department of Transportation |
| DLs | District Liaisons |
| EMA | Emergency Management Agency |
| EMS | Emergency Medical Service |
| EOC | Emergency Operations Center |
| EOP | Emergency Operations Plan |
| EPI | Epidemiology |
| FAC | Family Assistance Center |
| FEMA | Federal Emergency Management Agency |
| FQHC | Federally Qualified Health Center |
| HAN | Health Alert Network |
| HAvBED | Hospital Available Beds for Emergencies and Disasters (software) |
| HCC | Healthcare Coalition |
| HCCCM | Healthcare Coalition of Central Maine |
| HCCNM | Healthcare Coalition of Northern Maine |
| HCCSM | Healthcare Coalition of Southern Maine |
| HCCAT | Healthcare Coalition Assistance Team |
| HETL | Health and Environmental Testing Laboratory |
| HICS | Hospital Incident Command System |
| HVA | Hazard Vulnerability Analysis |
| IAP | Incident Action Plan |
| IC | Incident Commander |
| ICS | Incident Command System |
| ID | Infectious Disease |
| IMATS | Inventory Management Tracking System |
| IMT | Incident Management Team |
| IZ | Immunizations |
| JAS | Job Action Sheet |
| JIC | Joint Information Center |
| MAA | Mutual Aid Agreement |
| MAC | Multiagency Coordination System |
| Maine CDC | Maine Center for Disease Control and Prevention |
| MEMA | Maine Emergency Management Agency |
| MENG | Maine National Guard |
| MFDA | Maine Funeral Directors Association |
| MOU | Memoranda of Understanding |
| MPCA | Maine Primary Care Association |
| MRC | Medical Reserve Corps |
| NACCHO | National Association of County and City Health Officials |
| NIMS | National Incident Management System |
| NNEPCC | Northern New England Poison Control Center |
| NWS | National Weather Service |
| OCME | Office of the Chief Medical Examiner |
| OIT | Office of Information Technology |
| PHEOC | Public Health Incident Command Center |
| PHEP | Public Health Emergency Preparedness |
| PHN | Public Health Nursing |
| PIO | Public Information Officer |
| POC | Point of Contact, Person of Contact, Plan of Correction |
| POD | Point of Dispensing |
| PPE | Personal Protective Equipment |
| PPH | Portland Public Health |
| PSC | Planning Section Chief |
| RAD | Radiation Control |
| SME | Subject Matter Expert |
| SMT | Senior Management Team |
| SNS | Strategic National Stockpile |
| SOP | Standard Operation Procedure |
| WebEOC | Web based incident management software |
| US CDC | United States Center for Disease Control and Prevention |

# 

# B. HCCAT ICS Form 207

|  |  |  |
| --- | --- | --- |
| HCCAT ORGANIZATIONAL CHART | | HCCAT 207  REV. 11/16/2016 |
| Use this form to document personnel assigned to positions in the Healthcare Coalition Assistance Team (HCCAT). Initial assignments may change, and this form should be updated as necessary (even within an operational period). | | COMMAND STAFF  GENERAL STAFF |
| 1. INCIDENT NAME: | 2. DATE/TIME PREPARED: | 3. OPERATIONAL PERIOD: |
| 4. ORGANIZATIONAL STRUCTURE: | | |
| HCCAT Operations Chief:  Home Organization:  Cell/Contact:    HCCAT Leader:  Home Organization:  Cell/Contact:    Organizational Liaisons: | HCCAT Logistics Chief:  Home Organization:  Cell/Contact:    HCCAT Planning Chief:  Home Organization:  Cell/Contact: |  |

**Public Health Resource Request Form Instructions**

**Purpose:** The Resource Request (ICS 213 RR) is used to order resources and track resource status.

**Preparation:** The ICS 213 RR is initiated by the resource requestor, who will complete the “Requestor” section highlighted in light blue. Once the requestor section is completed, the form is sent to the appropriate agency (e.g. Healthcare Coalition Coordinator, Public Health Emergency Operations Center, etc.) to be completed by the Logistics or Command Staff. After the form is finalized, the requestor will be notified of the action taken and provided a copy of the form.

**Distribution:** This form is maintained in order to track resource status.

| **Box Number** | **Box Title** | **Instructions** |
| --- | --- | --- |
| **1** | **Requester Name/Organization** | Enter the name and organization of the requestor |
| **2** | **Requester Phone/Email** | Enter a phone number and email address for the requestor |
| **3** | **Order** | Specify quantity, Unit of Measure (UOM), and item description. Examples of UOM include box, case, single, bottle, etc. |
| **4** | **Resource Status (complete after resource received/returned)** | Enter date (m/dd/yy) and time (HH:MM – 24-hour clock) received/returned and condition received/returned |
| **5** | **Requested Delivery Location/Address** | Enter location and address for delivery/reporting |
| **6** | **24 Hour Point of Contact Name/Phone** | Enter a POC name and a phone number where they can be reached 24 hours |
| **7** | **Suitable Vendor and/or Item Substitutes** | Enter possible substitute vendors and/or items in case exact requested resource is not available |
| **8** | **Approval Name** | Enter the name of the official authorizing the request on behalf of the requesting organization |
| **9** | **Date/Time** | Enter the date (m/dd/yy) and time (HH:MM – 24-hour clock) for request approval |
| **10** | **Incident/Facility Name** | Enter the name assigned to the incident or facility |
| **11** | **Date/Time** | Enter the date (m/dd/yy) and time (HH:MM – 24-hour clock) the request was received |
| **12** | **Resource Request Number** | Generate a unique number (the first request should be 1) |
| **13** | **Order Number** | Enter a unique order number (e.g. from inventory management system) |
| **14** | **Suggested Source(s) of Supply** | Enter source(s) for the resource requested |
| **15** | **Supplier Phone/Email** | Enter contact information for source of supply suggested in Box 14 |
| **16** | **Notes** | Enter any relevant notes regarding the request |
| **17** | **Approval Name** | Enter the name of the official recognizing the request (e.g. logistics section chief or command staff) |
| **18** | **Date/Time** | Enter date (m/dd/yy) and time (HH:MM – 24-hour clock) for request recognition |
| **19** | **Action Taken** | Check “accepted” or “rejected” based on decision by command staff |
| **20** | **Reason** | Enter reason for action taken if “rejected” in Box 19 |
| **21** | **Requestor Notified** | Enter the date and time the requester was notified of the action taken in Box 19 |

Public Health Resource Request Form (ics 213 RR)

| **Requestor** | **1. Requestor Name/Organization:** | | | | **2. Requestor Phone/Email:** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3. Order (Use additional forms when requesting different resource sources of supply)** | | | | | | | | | | |
| Qty | UOM | Detailed Item Description (Vital characteristics, brand, specs, experience, size, etc.) | | | | | **4. Resource Status (complete after resource received/returned)** | | | |
| Received  Date/Time | Condition  Received | Returned  Date/Time | Condition  Returned |
|  |  |  | | | | |  |  |  |  |
|  |  |  | | | | |  |  |  |  |
|  |  |  | | | | |  |  |  |  |
|  |  |  | | | | |  |  |  |  |
|  |  |  | | | | |  |  |  |  |
| **5. Requested Delivery Location/Address:** | | | | | **6. 24 Hour POC Name/Phone:** | | | | | |
| **7. Suitable Vendor and/or Item Substitutes:** | | | | | | | | | | |
| **8. Approval Name:** | | | | | | **9. Date/Time:** | | | | |
| **Logistics or Command** | **10. Incident/Facility Name:** | | | **11. Date/Time:** | | | **12. Resource Request Number:** | | | | |
| **13. Order Number:** | | | | | | **15. Supplier Phone/Email:** | | | | |
| **14. Suggested Source(s) of Supply:** | | | | | |
| **16. Notes:** | | | | | | | | | | |
| **17. Approval Name:** | | | | | | **18. Date/Time:** | | | | |
| **19. Request Accepted: Request Rejected:** | | | | | **20. Reason:** | | | | | |
| **21. Requestor Notified (Date/Time):** | | | | | |

# D. Volunteer Request Form

Maine CDC Public Health Emergency Preparedness

Request for Volunteers

*Standard Operating Procedures*

PURPOSE: To provide the Healthcare Organizations, County Emergency Management Agencies (EMA) and Healthcare Coalition Coordinators with guidance when healthcare volunteers have been requested to respond to a disaster or public health emergency incident.

CONTENTS: This Standard Operating Procedures (SOP) document is divided into several sections:

Section I: Identification of Healthcare and Emergency Management Agency Volunteer Coordinators, Healthcare Coalition Coordinators and Public Health Emergency Preparedness (PHEP) Volunteer Management Coordinators

Section II: Requesting PHEP Healthcare Volunteer Resources

* Form A: Maine CDC PHEP Healthcare Volunteer Request Form

Section III: Regional Resource requests for PHEP Healthcare Volunteer Resources

* Form B: Acknowledgement of Status as an Agent under Sec. 15. 37-B MRSA §784-A

Section IV: Requesting Out-of-State Healthcare Volunteer Resources

**Section I. Identification of Healthcare and Emergency Management Agency Volunteer Coordinator(s), Regional Resource Director (or Designee), and Public Health Emergency Preparedness Volunteer Coordinator(s)**

It is important for each organization to identify a Healthcare and Emergency Management Agency Volunteer Coordinator by name, title, contact phone number and fax number prior to a request for healthcare volunteer resources. Please complete the Table 1.1 Identification of Volunteer Coordinators with your organization’s information.

Send a copy of the completed Table 1.1 to the Public Health Emergency Preparedness Volunteer Management Coordinator, Edward Molleo at email: [edward.Molleo@maine.gov](mailto:edward.Molleo@maine.gov) or by fax number 207-287-4082.

*Table 1.1 Identification of Volunteer Coordinators*

|  |  |  |
| --- | --- | --- |
| **Healthcare Organization and EMA Volunteer Coordinator** | **Regional Resource Director or Designee** | **Public Health Emergency Preparedness Volunteer Coordinator and DHHS/CDC Staff** |
| Healthcare Organization:  Volunteer Coordinator Name:  Title:  Phone 1:  Phone 2:  FAX:  Email: | Healthcare of Northern Maine Coordinator:  Megan Melville  Phone: 207-747-9139  Email: meganm@allclearemg.com | *PHEP* Volunteer Management Coordinator  Name: Edward Molleo  Phone office: 287-4072  Phone cell: 441-2638  Fax: 207-287-4082  [edward.molleo@maine.gov](mailto:Jared.mccannell@maine.gov) |
| Emergency Management Agency  Volunteer Coordinator Name:  Title:  Phone 1:  Phone 2:  FAX:  Email: | DHHS/CDC Disaster Behavioral Health Director  Name: Kathleen Wescott  Phone office: 287-3796  Phone cell: 441-5466  Fax: 207-287-4082 [Kathleen.wescott@maine.gov](mailto:Kathleen.wescott@maine.gov) | CDC/EOC Logistics  Name: Patrick Furey  Cell phone: 441-2638  [Patrick.J.Furey@Maine.gov](mailto:Patrick.J.Furey@Maine.gov)  . |
| Additional Contacts: | Additional Contacts: |  |

**Section II. Requesting *PHEP* Healthcare Volunteer Resources**

*Healthcare Organizations and local Emergency Management Agencies are encouraged to process their healthcare volunteer requests through the Regional Resource Directors to ensure coordination and to avoid duplication of efforts; and to establish a systematic tracking of volunteers.*

**Standard Operating Procedures:**

*The requesting organization’s volunteer coordinator will contact the Healthcare Coalition Coordinator listed on Table 1.1 Identification of Volunteer Coordinators to request healthcare volunteer assistance:*

1. Requesting healthcare organizations and local Emergency Management Agencies will complete the Maine CDC *PHEP* Healthcare Volunteer Request Form with essential information; *(refer to Form A)*:

* 1. Name of Volunteer Coordinator: requesting organization
  2. Organization Name and address
  3. Contact information: both business and cell phones, fax number, email address
  4. Organization Authority Approval: Name and Title of Authorizing Person who will be responsible for healthcare volunteers (*different from Volunteer Coordinator*)
  5. Authorizing person’sphone number and contact information
  6. Relevant information regarding the Event

1. Name of Logistics Chief for incident
2. Volunteer Staging Location: provide address where volunteers will check-in including the county name and zip code
3. Description of event for healthcare needs: describe the specifics about the incident and where healthcare volunteers would be needed, i.e. clinic, point of dispensing, Emergency Dept., shelter, EOC etc.
   1. Information on number and type of Healthcare Volunteers
4. The number of volunteer types needed
5. The type of skills, experience, credentials, training, license, etc.
6. Requesting Organization volunteer coordinator will forward the Maine CDC *PHEP* Healthcare Volunteer Request Form to their Healthcare Coalition Coordinator by email or fax.
7. The Healthcare Coalition Coordinator will contact their Healthcare Coalition partners to determine if the volunteer request can be fulfilled within the region.
8. The Healthcare Coalition Coordinator will notify the requesting organization if the request can be completed.

After Healthcare Volunteers are deployed to requesting organizations:

1. The healthcare organization and local Emergency Management Agency will provide regular updates to the Healthcare Coalition Coordinator on the number of deployed volunteers by type using the Activity Log (ICS/ HICS 214).
2. The Incident’s Logistics Chief is responsible for tracking the deployment of volunteers and will be kept up‐to‐date regarding volunteer deployment or demobilization.
3. The Requesting Organizations will need to notify the Healthcare Coalition Coordinator if:
4. It appears healthcare volunteer resources have been exhausted and additional volunteer resources from other areas of the state will be needed.
5. Volunteers are no longer needed and are being sent home or turned away at the site.

Demobilization of Healthcare Volunteers:

1. The Healthcare Coalition Coordinator will remain in continual communication with the requesting organizations regarding demobilization of volunteers.

2. It is recommended that requesting organizations solicit and encourage volunteer feedback and evaluations when conducting deployment out-processing.

3. Upon demobilization of the assigned healthcare volunteers, the healthcare organization and local Emergency Management Agencies will complete a Demobilization Checkout Form (ICS/HICS 221) before releasing the healthcare volunteer.

4. The completed Demobilization Checkout Form (ICS/HICS 221) will be sent to the Healthcare Coalition Coordinator *within one business day* upon demobilization of the healthcare volunteers that had been assigned to their organization.

**FORM A: Maine CDC *PHEP* Healthcare Volunteer Request Form**

(Please print legibly to ensure accuracy)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Requesting Organization Information** | **Volunteer Coordinator name:** | |  | | | | |
| **Organization Name:** | |  | | | | |
| **Organization Address:** | |  | | | | |
| **Contact phones/fax:** | |  | | | | |
| **Organization**  **authority approval** | **Name/Title:** | |  | | **Date/Time:** | |  |
| **Phone Number(s):** | |  | | | | |
| **Relevant Information on Event** | **Logistics Chief:** | |  | | | | |
| **Volunteer Staging Location:** | |  | | | | |
| **Description of Event for healthcare needs:** | |  | | | | |
| **Information on the Number and Types of Healthcare Volunteers** | | | | | | | |
| **Relevant Job Action Sheets/Skills/License Requirements** | | | | **Number of Volunteers requested by Type** | | **Estimated Shift Duration** | |
|  | | | |  | |  | |
|  | | | |  | |  | |
|  | | | |  | |  | |
|  | | | |  | |  | |
| **TOTAL NUMBER OF VOLUNTEERS REQUESTED BY TYPE:** | | | |  | |  | |
| **Anticipated Date(s) of Service:** | | **Start date:**  **End date:** | | | | | |

***PHEP Volunteer Office Only:***

|  |  |  |  |
| --- | --- | --- | --- |
| PHEP Volunteer Coordinator | Name/Title | | Contact Info: |
|  |  | |  |
| ***Requesting Organization Logistics Chief:*** |  | |  |
|  |  | |  |
| ***Transportation/Meals Coordination:*** |  | |  |
|  |  | |  |
| ***Environmental Health Protections*** | **Concerns:**  **1.**  **2.**  **3.**  **4.** | | **Mitigation:**  **1.**  **2.**  **3.**  **4.** |
|  | **Time/Date Received** | **Time/Date**  **Processed** | ***PHEP Volunteer Coordinator Signature*** |
| ***PHEP Request Process:*** |  |  |  |
|  |  | |  |
| ***Volunteer Demobilization Forms:*** | ***Time/Date Received:*** | | **Demobilization Referrals:**  **1.**  **2.**  **3.**  **4.** |
| ***Volunteer Deployment Evaluations:*** | ***Time/Date Received*** | | ***MEMA/Maine Responds Entry/Initials:*** |

**Section III. Regional Resource requests for *PHEP* Healthcare Volunteer Resources**

*If the Regional Resource Director determines that local and regional healthcare volunteer resources are inadequate, overwhelmed or unavailable:*

1. The Healthcare Coalition Coordinator will send a copy of the requesting organization’s *PHEP* Healthcare Volunteer request form to the *PHEP* Volunteer Management Coordinator by scanned email or fax for action.
2. The *PHEP* Volunteer Management Coordinator, in coordination with *PHEP* Logistics Chief, will review the Maine CDC *PHEP* Healthcare Volunteer Request Form and:
3. Identify and send a *Maine Responds* communication within one hour to registered healthcare volunteers, i.e. Maine Responds, Medical Reserve Corps (MRC), and Disaster Behavioral Health Response team (DBHRT). The communications to the volunteers will contain relevant information on the event with a description of healthcare needs, type of healthcare volunteer requested, estimated shift durations, and anticipated dates of service, and environmental health and safety issues.
4. Volunteers will respond via email or phone call to the *PHEP* Volunteer Management Coordinator regarding their availability to respond to the request.
5. The *PHEP* Volunteer Management Coordinator will complete the Acknowledgement of Status as an Agent (see attached Form B) under Sec. 15. 37-B MRSA §784-A. and will submit within one hour the completed form to the *PHEP* Incident Commander and/or *PHEP* Logistics Chief for review; then to the MEMA Director or their designee by contacting the MEMA Duty Officer at (207) 624-4400.
6. After the MEMA Director or their designee signs the Acknowledgement of Status as an Agent under Sec. 15. 37-B MRSA §784-A. and returns a signed copy within 2 hours. The *PHEP* Volunteer Management Coordinator will confirm the availability of the authorized healthcare volunteers.
7. If the volunteer is still available, the *PHEP* Volunteer Management Coordinator will provide the volunteers with information on the volunteer staging location, name of organization’s volunteer coordinator, and environmental health and safety mitigation needs; and to expect a phone call, email or other message from the requesting organization volunteer coordinator.
8. The *PHEP* Volunteer Management Coordinator will advise the volunteers to bring any necessary equipment, i.e. GO Bag, overnight items, resource manuals, ID Badges, etc.
9. The *PHEP* Volunteer Management Coordinator will send a list of authorized healthcare volunteers with their contact information to the requesting organizations with a copy to the Healthcare Coalition Coordinator/s.
10. The requesting organization will need to contact the healthcare volunteers directly to provide information on their assignment, shift duration and the name of their direct supervisor at the organization; and environmental health and safety mitigation needs depending on available resources a phone call, email or other message can be sent to each volunteer listed on the Acknowledgement of Status (Form B).
11. The *PHEP* Volunteer Management Coordinator will post the number and type of volunteers, without including volunteer names, with the anticipated deployment locations on *EM Resource* for information sharing with emergency partners *within 2 hours of receipt*.

*At this point, the Healthcare Organization and local Emergency Management Agencies will coordinate the necessary steps to prepare for the arrival of requested healthcare volunteers.*

1. Requesting organizations should be prepared to manage volunteers in the following ways:
2. The organization should have a designated staging area where volunteers are being directed for check-in.
3. The organization will be responsible for checking-in and identifying volunteers as they arrive. The volunteer’s driver’s license or Maine Responds Identification Badge will confirm that the healthcare volunteer identification matches the names on the list received from the *PHEP* Volunteer Management Coordinator.
4. An incident briefing and safety briefing will be provided to volunteers by the organization.
5. Any necessary *Just-in-Time* training will be provided to volunteers by the organization.
6. As healthcare volunteers arrive, the requesting organization is responsible for notifying the *PHEP* Volunteer Management Coordinator about the status of the volunteer:
7. An Incident Command System Form Assignment List (ICS/HICS 204) should be completed and prepared by the organization requesting the volunteers.
8. The Assignment List (ICS/HICS 204) will be faxed to the PHEP Volunteer Management Coordinator within the same business day to (207) 287-4082.
9. The healthcare organization and the local Emergency Management Agency volunteer coordinator will need to remain in regular communication with the *PHEP* Volunteer Management Coordinator with updates using the Activity Log (ICS/HICS 214) on their volunteer situation.

*After Healthcare Volunteers are deployed to requesting organizations:*

1. The healthcare organization and local Emergency Management Agency will provide regular updates to the *PHEP* Volunteer Management Coordinator on the number of deployed volunteers by type using the Activity Log (ICS/ HICS 214).
2. The *PHEP* Logistics Chief is responsible for tracking the deployment of volunteers and will be kept up‐to‐date regarding volunteer deployment or demobilization.
3. The Requesting Organizations will need to notify the *PHEP* Volunteer Management Coordinator if:
4. It appears healthcare volunteer resources have been exhausted and additional volunteer resources from other areas of the state will be needed.
5. Volunteers are no longer needed and are being sent home or turned away at the site.

*Demobilization of Healthcare Volunteers:*

1. The *PHEP* Volunteer Management Coordinator, in coordination with the Healthcare Coalition Coordinator, will remain in continual communication with the requesting organizations regarding demobilization of volunteers.
2. It is recommended that requesting organizations solicit and encourage volunteer feedback and evaluations when conducting deployment out-processing.
3. Upon demobilization of the assigned healthcare volunteers, the healthcare organization and local Emergency Management Agencies will complete a Demobilization Checkout Form (ICS/HICS 221) before releasing the healthcare volunteer.
4. The completed Demobilization Checkout Form (ICS/HICS 221) will be sent to the *PHEP* Volunteer Management Coordinator by email to: Edward Molleo at [edward.molleo@maine.gov](mailto:jared.mccannell@maine.gov) or fax to (207) 287-4082 *within one business day* upon demobilization of the healthcare volunteers that had been assigned to their organization.
5. The *PHEP* Logistics Chief will notify the MEMA Duty Officer immediately at 624-4400 when authorized *Maine Responds* volunteers have been demobilized, upon receipt of the Demobilization Checkout Form (ICS/HICS 221) from the organization where deployed healthcare volunteers had been assigned.

 FORM B

**Acknowledgement of Status as an Agent under Sec. 15. 37-B MRSA §784-A.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Agent** | **Address** | **DOB** | **Agent Telephone** | **Email** | **Organization/ Affiliation** | **Employer** | **License #** | **Expire Date** | **Date Lic. Verified** | **Back-ground Check** | **Clinic Date & Hours of Operation** | **Clinic Location** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

The Maine Emergency Management Agency hereby acknowledges that the following individual(s) are authorized to act as its agent under the provisions of Title 37-B, §784-A. to assist the Maine Center for Disease Control and Prevention in responding to a declared or non-declared public health incident. The individual(s) status as an agent will not continue beyond the duration set forth unless a new acknowledgement is issued which sets forth a new duration

All of the provisions of Title 37-B §784**-**A shall apply to the above-named individual(s) for the duration of time that the individual(s) are acting as the Department’s agent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEMA Director or Designee Date

MEMA Duty Officer: 1-800-452-8735 (toll-free)

FAX: 207-287-3178

**Section IV: Requesting Out-of-State Healthcare Volunteer Resources**

*Once it has been determined that Maine healthcare volunteer resources are insufficient to cover the event; volunteer resources can be requested through the EMAC outside the state of Maine.*

1. The requesting organizations will submit the *PHEP* Volunteer Healthcare Resource Request form to the RHCC Coordinator.
2. If the regional Healthcare Volunteer resources are exhausted, the RHCC Coordinator will forward the request to the *PHEP* Volunteer Management Coordinator.
3. The *PHEP* Volunteer Management Coordinator will determine that the *Maine Responds* volunteer resources are inadequate, overwhelmed or unavailable.
4. The *PHEP* Volunteer Management Coordinator, in coordination with the Incident Commander and *PHEP* Logistics Chief, will discuss if an EMAC request for volunteer healthcare resources will need to be submitted and authorized by MEMA.
5. The *PHEP* Logistics Chief will contact the Duty Officer with the Maine Emergency Management Agency (MEMA):

Maine Emergency Management Agency

24/7 Duty Officer:

**207-624-4400**

800-452-8735 (toll-free, in state only)

TTY: Maine Relay 711

FAX: 207-287-3178

1. The *PHEP* Logistics Chief will direct the *PHEP* Volunteer Management Coordinator to advise the requesting healthcare organization or local Emergency Management Agency that MEMA will be sent their Maine CDC PHEP Healthcare Volunteer Request Form by email, fax, or other communication methods to determine if EMAC resources are available.
2. Requesting healthcare organizations and local Emergency Management Agencies may be asked to provide the Incident Commander and Logistics Chief with a situation briefing including all local volunteer activity to that point.

*MEMA will notify PHEP Volunteer Management Coordinator if an EMAC partner can fulfil the Maine CDC PHEP Healthcare Volunteer Request:*

1. The EMAC partner will provide a list of qualified healthcare volunteers to MEMA who would be able to respond to the healthcare volunteer request.
2. MEMA will authorize the EMAC healthcare volunteers under Acknowledgement of Status as an Agent under Sec. 15. 37-B MRSA §784-A. within one hour and fax a copy of the authorization form to the PHEP Volunteer Management Coordinator.
3. The *PHEP* Volunteer Management Coordinator will receive a list of the MEMA-authorized EMAC healthcare volunteers and their contact information.
4. The *PHEP* Volunteer Management Coordinator will provide requesting healthcare organizations and local Emergency Management Agencies, and a copy to the RHCC Coordinator, with information on the EMAC healthcare volunteers being deployed to their unit.
5. The requesting organizations will follow up with the EMAC healthcare volunteers directly to provide information on the location of the volunteer staging area, shift durations and anticipated dates of service, and environmental health and safety concerns; and the necessary equipment to bring to the response.
6. The *PHEP* Volunteer Management Coordinator will post the type and number of volunteers, excluding their names and personal contact information, with the deployment information on Resource for information sharing with response partners.
7. There should be regular updates between the healthcare organization and local Emergency Management Agencies with the *PHEP* Volunteer Management Coordinator regarding volunteer activities, deployment and demobilization using the Activity Log (ICS/HICS 214)
8. Upon demobilization, the healthcare organization and local Emergency Management Agencies will notify the *PHEP* Volunteer Management Coordinator:
9. Upon demobilization of the assigned healthcare volunteers, the healthcare organization and local Emergency Management Agencies will complete a Demobilization Checkout Form (ICS/HICS 221) before releasing the EMAC volunteer.
10. The completed Demobilization Checkout Form (ICS/HICS 221) will be faxed to the *PHEP* Volunteer Management Coordinator at (207) 287-4082 within two hours upon demobilization of the EMAC healthcare volunteers assigned to their organization.
11. The *PHEP* Logistics Chief will notify the MEMA Duty Officer immediately by phone or fax when assigned EMAC Healthcare Volunteers have been demobilized; or upon receipt of the Demobilization Checkout Form (ICS/HICS 221) from the requesting healthcare organizations and local Emergency Management Agencies.
12. The *PHEP* Volunteer Management Coordinator will notify the RHCC Coordinator and requesting organization when the demobilization process has been completed, and as part of the After-Action Report (AAR).

# E. Important Contact Information

24/7 Healthcare Coalition of Central Maine HCCAT Team

Emergency Phone Number: 207-200-3807

HCCNM Conference Line

Phone Number: 1-605-313-4162

Access Code: 794935

Maine HCC Website:

<https://www.mainehccs.com/>

Maine Healthcare Coalition Coordinators:

Healthcare Coalition of Southern Maine

Allyssa Caron of Southern Maine

207-747-9546 Direct Line

207-358-0345 Emergency Number (Google Number)

Healthcare Coalition of Central Maine

Michael Hatch

207-747-8100 Direct Line

207-200-6905 Emergency Number (Google Number)

Healthcare Coalition of Northern Maine

Meagan Melville

207-747-9139 Direct Line

207-200-3807 Emergency Line (Google Number)

Maine Healthcare Coalitions

Hannah James

207-747-9318 Direct Line

# F. Helpful Links

Maine Healthcare Coalition

<https://www.mainehccs.com/>

Maine CDC Health Resource Request Form ICS 213 RR

(<http://cmrrc.org/wp-content/uploads/2015/07/ICS-213-PH-Resource-Request-Form-FINAL.pdf>).

Maine CDC Public Health Emergency Preparedness Request for Volunteers (<http://cmrrc.org/wp-content/uploads/2015/07/SOP-Request-for-PHEP-Volunteers-FINAL-AUG-2015-2.pdf>).

Section III. Annexes Listing