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The RHCP is an overall coordination plan among participating entities that describes how:

- Medical (both acute care and non-acute care hospitals), emergency medical services (EMS), public health, emergency managers, and other first responders will coordinate and communicate during a disaster.
- Medical and healthcare resources will be coordinated, shared, and prioritized among healthcare facilities.
- Patient allocation will be coordinated among participating hospitals during an emergency.
- Regional decisions affecting medical and healthcare issues will be made.

The RHCP does not supersede existing facility, local, regional, or state level emergency response operational plans; rather, it supports these existing plans and serves as a tool for coordination among participating organizations and the first responder community.

The RHCP establishes the St. Louis Medical Operations Center (SMOC). The SMOC is composed of healthcare professionals who understand the operations, capabilities, and needs of hospitals and medical issues that may arise during an emergency incident. At the present time, healthcare professionals supporting the SMOC are volunteers who may or may not be reimbursed for their time. Additional expertise from other disciplines, including public health, poison control, HazMat, or public information may be brought in as needed.

When activated, the SMOC operational staff will consist of:

- SMOC Lead Coordinator (who also serves as the initial point-of-contact for County Dispatch)
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- Two hospital representatives, one from the clinical side and one from hospital operations/administration.

- One public health representative, or one EMS representative, or other subject matter expert(s) based upon the incident. An additional hospital coordinator may also be placed in this position if the situation warrants additional assistance.

The SMOC provides the analytical, coordination, and communication capability needed for hospitals and other healthcare organizations to be able to effectively respond to any type of emergency event. When activated, the SMOC operates out of the St. Louis County EOC. The EOC provides the infrastructure and technology needed to support emergency response operations and assists the SMOC with gathering accurate information about the incident.

All members of the SMOC team will collaborate in good faith to make decisions that are in the best interests of the region, and will not take into account solely their own hospital affiliation. Working in coordination with emergency management and other first responders, the SMOC will make decisions based on the following criteria:

- The first priority for all decisions will be life-saving measures.

- The primary consideration when making decisions regarding transportation and patient placement must be what is best for patients and residents.

- All decisions and protective actions will support regional response operations, regardless of discipline or jurisdiction, as decided upon in coordination with affected incident commanders/EOCs, usually through an ESF 8 representative or a public health liaison.

During an emergency, the SMOC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. In the future, the SMOC will hopefully operate as a non-profit entity that can be activated by a jurisdictional authority to serve as a response resource. If authorized to activate, the SMOC may be given purchasing authority, which will allow it to directly procure the resources needed to support healthcare response and recovery operations.

The SMOC will serve as a central point of contact between healthcare facilities and other governmental and non-governmental response agencies as necessary.

Resource requests between healthcare organizations will follow the rules and guidelines established in the Hospital Mutual Aid Agreement Memorandum of Understanding and the Hospital Mutual Aid Agreement Memorandum of Understanding Between Hospitals in the St. Louis Region and Hospitals Operated by The Missouri Department Of Mental Health in the St. Louis Region.

The SMOC will also communicate and coordinate with Belleville Memorial Hospital to reach out to Illinois Region 4 hospitals, as specified in the State of Illinois Region IV Southwestern Illinois Emergency Medical Services Medical Disaster Plan.
For the RHCP to be operationally viable, a comprehensive training and outreach program is required to identify and prepare SMOC team members and other first responders on the roles and responsibilities of the SMOC. Supporting policies, procedures, and plans must be developed or revised to reflect the concepts of coordination, alert and notification, and response and recovery processes described in this RHCP. Senior leadership support from healthcare organizations is essential to the successful implementation of this plan and the future emergency response and recovery capabilities of the region.
The overarching goal of the Regional Healthcare Coordination Plan (RHCP) is to mitigate the medical and healthcare consequences of any disaster affecting the St. Louis region.

The RHCP is an overall coordination plan among participating entities that describes how:

- Medical (both acute care and non-acute care hospitals), emergency medical services (EMS), public health, emergency managers, and other first responders will coordinate and communicate during a disaster.
- Medical and healthcare resources will be shared and prioritized among healthcare facilities.
- Patient allocation will be coordinated among participating hospitals during an emergency.
- Regional decisions affecting medical and healthcare issues will be made.

The RHCP does not supersede existing facility, local, regional, or state level emergency response operational plans; rather, it supplements these existing plans and serves as a tool for coordination among participating organizations and the first responder community.

- The RHCP is an annex of the St. Louis Area Regional Response System Regional Resource Coordination System Plan.
- The policies and procedures described in the RHCP work within the concept of operations described in county and city Emergency Operations Plans (EOPs), the Region IV- Southwestern Illinois Emergency Medical Service Medical Disaster Plan, the State of Missouri EOP, and the State of Illinois EOP.
- The RHCP supports the concepts and operations detailed in the individual jurisdiction EOPs and the emergency operations plans for the hospitals included in the following counties:

1. Franklin County, Missouri  
2. Jefferson County, Missouri  
3. Lincoln County, Missouri  
4. Madison County, Illinois  
5. Monroe County, Illinois  
6. Perry County, Missouri  
7. Pike County, Missouri  
8. St. Charles County, Missouri
The RHCP supports regional response efforts by providing a centralized location that response agencies (such as emergency management and/or emergency operations centers (EOC)) and hospitals can contact to obtain information on the status of hospitals and the medical community and their resources, as well as to obtain advice on medical and healthcare issues.

1.1 Need for Coordinated Approach

All emergencies require a coordinated approach where multiple disciplines and organizations work together to protect life, public safety, the economy, and the environment. The level of coordination and the number of organizations affected by and/or required to effectively respond to an emergency increases as an emergency crosses jurisdictional boundaries. Additionally, the number of organizations and disciplines involved may be expanded or contracted based upon the incident.

Most disasters have some level of medical and healthcare consequences. Historically, emergencies that have been dispersed geographically have widespread regional consequences for hospitals and healthcare providers. With this in mind, the St. Louis Region’s hospital, medical, EMS, public health, and emergency management communities have realized the need to work together to prevent, mitigate, respond to, and recover from emergencies that can potentially affect the region.

The hospitals in the St. Louis Region have a long history of working together. A regional committee of first responders and receivers began to meet in 1999 to coordinate on emergency preparedness efforts under the Metropolitan Medical Response System (MMRS) grant program. In 2001, a St. Louis Metropolitan Medical Response System (SLMMRS) Hospital Planning Committee was established to coordinate emergency preparedness activities between healthcare organizations in the St. Louis region. This original committee of healthcare representatives evolved into what is now the St. Louis Area Regional Response System (STARRS) Hospital Preparedness Committee.

STARRS is a regional organization developed to coordinate planning and response for large-scale critical incidents in the bi-state St. Louis metropolitan region. STARRS was formed as a result of the Urban Area Security Initiative (UASI) Grant Program for Homeland Security for Fiscal Years 2003 and 2004. STARRS formed an Advisory Council (originally known as the Safety and Security Council) to implement emergency response planning and preparedness throughout the region. The Advisory Council is composed of representatives from police and fire departments, EMS, schools, transportation agencies, utility companies, Local Emergency Planning Committees (LEPCs), the private sector, public health, hospitals, and emergency management agencies across the region. Its role is to bring together the experience and expertise of various disciplines to develop emergency preparedness and response plans.
for the entire region. The STARRS Hospital Preparedness Committee is a standing committee.

In keeping with STARRS’ mission to coordinate planning and response efforts, hospital representatives from twelve Missouri counties and three Illinois counties included in the regions’ jurisdictional boundaries came together with key emergency management and public health representatives to address the need for a coordinated regional medical and healthcare approach. This subcommittee to the STARRS Hospital Preparedness Committee developed this RHCP.

1.2 Purpose of the Regional Hospital Coordination Plan

The RHCP:

- Ensures a unified and coordinated incident management approach among the participating responding healthcare agencies and organizations in the region.

- Ensures a mechanism is in place for centralized coordination with local, regional, state, and federal emergency management organizations.

- Provides a mechanism for an integrated healthcare response with other disciplines.

- Establishes a mechanism for collecting and disseminating information regarding the availability of and need for healthcare resources, including but not limited to equipment, supplies, hospital bed capacity, personnel, specialty treatment capabilities, fatality management capabilities, transportation/evacuation capabilities, and alternate care site capabilities.

- Coordinates healthcare resources and personnel from outside the region to respond to or recover from the incident, if necessary.

- Provides a structure for healthcare agencies and organizations to communicate and coordinate response and recovery efforts.

- Facilitates the sharing of resources and personnel among healthcare agencies and organizations in the region.

1.3 Scope of Plan

This plan applies to all disasters, including those caused by technological, human, or natural agents of sufficient scale to overwhelm the normal medical response capabilities of a hospital and require assistance from other hospitals, hospital systems, public health resources (such as the Strategic National Stockpile (SNS)), or other first responder organizations (such as emergency management, law enforcement, fire, EMS, public works).
This plan applies to all hospitals within the counties provided in Section 1. However, other counties and hospitals from outside the jurisdictions listed in Section 1. Introduction may have to be engaged in incident response and recovery activities depending on the incident.

1.4 Situation

The St. Louis region is a bi-state area and thus has two state authorities with different rules, standards, and guidelines that must be followed. Healthcare facilities are geographically dispersed and separated by the Mississippi River. These healthcare facilities include level 1, level 2, and level 3 trauma hospitals, non-trauma hospitals, specialty hospitals (rehabilitation, mental health, etc.), and long-term acute care hospitals.

Each hospital has engaged in individual facility hazard vulnerability and risk threat assessments, which describe the probability and likely impact of various hazards. Many of the hazards faced in the region are no-notice types of threats (e.g., earthquakes, human-caused accidents, terrorist threats).

The medical and healthcare staff in the region are equally at risk from the effects of a disaster as the general public would be. Planning for the care and protection of health and medical staff is necessary.

1.5 Regional Coordination Assumptions

- All jurisdictions and entities supporting the RHCP, regardless of affiliation, will collaborate in good faith to make decisions that are in the best interest of the region at large.

- Effective response and recovery requires a coordinated effort among both public and private entities. Hospitals and healthcare facilities are critical during an emergency incident and thus must be active participants in emergency preparedness efforts, including partnering with emergency management, law enforcement, fire, and other entities.

- The St. Louis regional response structure promotes inter- and intra-jurisdictional cooperation and coordination, but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels.

1.6 Planning Assumptions

- The plan is intended to support and enhance the emergency plans and protocols maintained by the healthcare agencies and organizations in the region. This plan is not intended to supersede, usurp, or infringe upon any other preceding authorities, plans, or procedures of any jurisdiction, organization, or agency.
This plan works in coordination with the regional coordination and concept of operations described in the St. Louis Area Regional Response System Regional Resource Coordination System Plan.

Each jurisdiction has an EOP that describes roles and responsibilities and designates organizations to lead and provide assistance during any incident with medical consequences.

Local health departments will coordinate and execute their respective health, mental health, and medical authorities and program responsibilities before, during, and after the regional incident or emergency, as specified in their EOP.

Hospitals and other accredited facilities are responsible for development of an emergency operations plan specific to the facility. This plan will outline strategies for continuation of healthcare services to patients/residents, and identify and provide resources necessary to support operations for a recommended 96 hours.

### 1.7 Operational Assumptions

- Emergency incidents are managed by an Incident Commander from a designated jurisdictional authority in accordance with the National Incident Management System (NIMS) and the Incident Command System (ICS). A large-scale regional incident may warrant the activation of the STARRS Multi-Agency Coordination Group (MAC-G) to coordinate regional threats and/or incidents as described in the St. Louis Area Regional Response System Regional Resource Coordination System Plan.

- Timely, accurate, and credible information sharing at all stages of the regional incident is necessary for the timely response to and recovery from such a situation.

- An incident can happen with little to no notice and/or may only become apparent over time. Immediate resources to communicate, coordinate, and respond collaboratively are necessary.

- Victims of the incident may have pre-existing medical conditions that may be exacerbated by the emergency, or new medical and health care needs/problems may arise as a direct result of the incident.

- The medical response may overwhelm hospitals without an integrated cooperative response.

- A “host” EOC will provide physical space, communications support, and logistical support for the St. Louis Medical Operations Center’s (SMOC’s) regional healthcare response.
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The purpose of this section is to detail the concept of coordination for any incident that may have medical consequences beyond the capabilities of a hospital or healthcare facility. This section describes the process for bringing together key decision-makers, subject matter experts, and emergency responders to obtain situational awareness, develop initial recommendations and protective actions, and develop and assign response and recovery activities to meet the medical and healthcare needs of the region.

2.1 Purpose of the St. Louis Medical Operation Center

The St. Louis Medical Operations Center (SMOC) is a regional coordination entity supported by participating hospitals and response organizations that coordinates communication and decision-making (including resource allocation, resource tracking and coordination of resource needs) related to medical issues.

The SMOC is composed of subject matter experts (SMEs) from the medical and public health communities, including hospitals (both administrative and clinical), emergency medical services, and public health. Additional expertise, such as poison control, hazardous material (HazMat), fire, emergency management, and law enforcement will be brought in or consulted as necessary.

The SME’s that form the SMOC work together to:

- Share information on an incident that may have medical ramifications to healthcare providers
- Develop recommended protective actions and guidance
- Respond to questions and provide advice to hospitals and other response agencies regarding medical issues, capabilities, status, and capacity
- Identify, request, obtain, allocate, and track resources needed by hospitals
- Protect the healthcare infrastructure
- Provide a single point of data collection/dissemination for healthcare
- Provide healthcare situational awareness to other disciplines
2.2 SMOC Responsibilities

The Hospital Mutual Aid Agreement Memorandum of Understanding and the Hospital Mutual Aid Agreement Memorandum of Understanding Between Hospitals in The St. Louis Region and Hospitals Operated by The Missouri Department of Mental Health in the St. Louis Region (both hereafter referred to collectively as the St. Louis Hospital MOU) has designated SMOC\(^1\) as the communication center for the Hospital Mutual Aid System and as a regional coordination group for medical disaster planning and response. Additionally, participating RHCP hospitals have agreed to authorize the SMOC with the following responsibilities:

**SMOC Responsibilities Include:**

- Communicating and coordinating with other EOCs and first responders to provide advice and guidance on the operational status of hospitals and the needs and capabilities of hospitals and other healthcare facilities
- Providing information to hospitals regarding the incident and the needs and capabilities of other hospitals and response agencies
- Identifying and meeting the healthcare needs of the region
- Monitoring tracking resources
- Monitoring HEAR radio system
- Monitoring bed availability through HavBed and assisting in identification of patient destinations to equitably manage patient load
- Coordinating hospital staff and equipment under the St. Louis Hospital MOU
- Protecting and maintaining the medical infrastructure of all regional healthcare facilities
- Providing appropriate transfer to healthcare facilities based on both patient need and hospital capacity and capability
- Maintaining patient tracking records

2.3 SMOC Organization

The SMOC is a team of four appropriately trained individuals\(^2\) who have an in-depth understanding of hospital organizations, hospital operations, and regional hospital capabilities and resources. Each agency identified in the SMOC organizational structure will assign and provide a representative(s) to serve on the SMOC on a

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\(^1\) The Hospital MOU refers to MedComm, the precursor of SMOC.

\(^2\) All SMOC representatives must complete training on SMOC operations.
rotational basis. The assigned individuals representing the hospitals may be members of a hospital emergency preparedness or security staff, administration, or clinical/medical staff. (Please see Appendix C: St. Louis Medical Operations Center Team Member Form for a list of training requirements required for all SMOC team members.)

When activated, the SMOC operational staff will consist of:

- SMOC Lead Coordinator (who also serves as the initial point-of-contact for County Dispatch)
- Two hospital representatives, one from the clinical side and one from hospital operations/administration.
- One public health representative, or one EMS representative, or other subject matter experts based upon the incident. An additional hospital coordinator may also be placed in this position if the situation warrants additional help.

### 2.4 Activation Levels

There are four increasing levels of activation:

- **Level 1 – Normal Operations** – During this phase, the focus is on general situational awareness. The SMOC Duty Officer monitors external intelligence information and shares accordingly. The SMOC is not activated at this point.

- **Level 2 – Significant Incident** – During this phase, an incident has occurred that could affect the SMOC regional response agencies. The primary focus is on gathering more information about the incident. The SMOC duty officer...
periodically contacts other first response agencies (e.g., public health and/or emergency management) or affected healthcare facilities to obtain additional information to determine if the situation has escalated and/or if further SMOC action is warranted. The SMOC duty officer may request periodic conference calls with the four other SMOC members and other first response agencies to get more information on the incident (see Steps 4–6 below) and share situational awareness with healthcare providers.

- **Level 3 – Partial Activation** – During this phase, the threat of a regional medical emergency is imminent and hospitals or first response agencies are submitting initial requests for support/information from the SMOC. The SMOC duty officer notifies the three other SMOC members who are also on call and coordinates a process to respond to initial requests, to provide advice and recommendations to healthcare facilities, and/or to assess current hospital capabilities and anticipated needs/gaps. During a partial activation, the four team members of the SMOC may operate virtually from their individual locations (using all communication methods available), from an appropriate EOC, or some combination thereof.

- **Level 4 – Full Activation** – During this phase, the SMOC will coordinate and implement actions to aid healthcare facilities and support response operations in the region. If the emergency warrants, the SMOC will assist with coordination of resource requests between hospitals and to/from hospitals to other response agencies. During this stage, the SMOC requires the support and communication capabilities of an appropriate “host” EOC.

### 2.5 Alert and Notification

The SMOC Duty Officer is notified to activate the SMOC by a jurisdiction of authority. The SMOC Duty Officer may be notified of an event by: (1) Central County Dispatch; (2) receiving a message directly from a member of the response community, such as emergency management, law enforcement, fire, etc.; (3) through a hospital/healthcare facility; and/or (4) becoming aware of an incident from another source (e.g., news media, etc.).

#### 2.5.1 Triggers or Incidents That May Activate the SMOC

The SMOC may be initiated or triggered when an incident occurs that has or will have substantive impact to the hospital or medical community in the St. Louis Region. Substantive impact is defined as any consequence or activity that overwhelms or has the potential to overwhelm the day-to-day operational capacity of any hospital or medical facility.

Regional incidents that initiate the notification of the SMOC Duty Officer include:

**Fire/EMS incidents**

- An Alert 2 or 3 at Lambert International Airport, Spirit Airport, Mid-America Airport or Scott Air Force Base
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- A plane crash anywhere in St. Louis City, St. Louis County, Franklin County, Jefferson County, St. Charles County or any other area where there is a possibility that patients could be brought into one of the St. Louis Area regional hospitals
- HazMat Team Operations
- Fire Mutual Aid Region C/HSRT activation
- A Level 2 Mass Casualty Incident
- Upon the tasking of county or state EOC

Police/FBI incidents:
- Code 1200 (St. Louis City Police Department)
- Code 1000 (St. Louis County Police Departments)
- Change in status of Homeland Security or Local Threat Condition
- Any suspected terrorist activity confirmed by local law enforcement
- At the request of an Office of Emergency Management (OEM) or Emergency Management Agency (EMA)

Hospital incidents:
- Any incident or internal crisis at a hospital in the St. Louis Area region that impacts the hospital’s capacity or capabilities (e.g., HazMat contamination, power outage, water problem, etc.)

Public Health Department incidents:
- Response to or investigation of any biological incident
- Investigation of increased incidences or a possible trend developing in one particular area of the St. Louis region.
- Any obvious health hazards (e.g., water contamination, unhealthy air conditions, food contamination, etc.)

National Disaster Medical System (NDMS) Activation – Scott Federal Coordinating Center (375 Medical Group):
- Activation of NDMS to move patients from an incident and a Casualty Collection Point is set up in St. Louis, including but not limited to Scott Air Force Base, Mid-America Airport and Lambert International Airport

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3 Code 1200 and Code 1000 are used by the St. Louis City and St. Louis County Police Departments to obtain law enforcement mutual aid assistance. When these codes are used, dispatch conducts an organized and rapid call out of on duty law enforcement assets to respond to imminent or actual threat or hazard. These codes are rare and usually used for large incident. During large incidents there is a greater likelihood of individuals needing medical assistance and thus notifying the SMOC of a Code 1200 or a Code 1000 is a sound precautionary measure.
Section 2

Other incident or event (expected or planned)

- Notification and possible activation for special and/or planned regional incidents that require coordination of more than one jurisdiction
- Any incident that the dispatch supervisor feels is significant

When any of these incidents occur, Central County Dispatch will contact the SMOC Duty Officer.

2.6 Medical Operations Center: Actions Following Initial Alert and Notification

During any incident that may have a medical impact on the region, it is important to gain situational awareness, identify the status of hospitals and other medical assets, identify medical needs, anticipate gaps, develop recommendations, and assign protective actions. The following process describes how hospitals and other response agencies will coordinate and communicate with each other after initial notification.

1. The SMOC Duty officer is made aware of an incident that has/may have a potential medical and healthcare impact.

2. The SMOC may be notified through Central County Dispatch, receive a message directly from a member of the response community or through a hospital/healthcare facility, or become aware of an incident from another source (for example, television news is often the first to become aware of incident.)

3. The SMOC Duty officer alerts and notifies the SMOC team (via a mass notification system such as E-Sponder or any available communication mechanism) and arranges for a conference call or other discussion between SMOC team members and other response agencies as appropriate.

4. The STARRS Conference Bridge will be the primary conference line. If this is not available, any other SMOC members’ conference bridge may be used. The SMOC duty officer will provide the conference line information and time of call to the SMOC team.

5. The SMOC Duty officer will contact SMOC team members using a mass notification system. If the Duty Officer is unable to contact the on-call SMOC team members within 30 minutes, the SMOC duty officer will notify the backup members. There are two backup members for each SMOC member. The SMOC will also invite the emergency manager and/or public health agencies for the affected jurisdictions. Through the emergency manager(s) (via the EOC(s)), other response agencies should be invited to participate in this conference call as applicable. The SMOC duty officer will notify other SMOC team members and other response agencies using mass notification systems or by all communications methods available.

6. During this initial conference call, the SMOC team members gain situational awareness of the incident, develop initial recommendations and protective actions,
respond to medical inquiries from other response agencies, and start to coordinate between hospitals, healthcare facilities, and other response agencies as necessary.

The SMOC duty officer will lead the call and facilitate a discussion of the following agenda (for more information, see Appendix A - Initial Conference Call Agenda below):

i. Gain regional situational awareness

ii. Determine response status

iii. Review status of initial protective actions

iv. Consider additional protective actions

v. Evaluate public information needs

vi. Determine next steps

vii. Determine SMOC status (identify if virtual or physical activation of an EOC is needed)

viii. Develop a message to alert and notify other hospitals and healthcare facilities/organizations

Coordination with EOCs and other response agencies is critical to a well coordinated response. Every effort should be made to ensure that a representative from affected EOCs participates in this initial call. In most cases, the EOC representative(s) will be part of an ESF 8 – Public Health and Medical or a public health liaison to an EOC. This EOC representative(s) is responsible for reporting on SMOC issues to the EOC Incident Commander.

1. The SMOC duty officer, in coordination with other SMOC team members, will determine if the SMOC should be activated. If activated and the SMOC requires the resources and equipment of an EOC, the SMOC Duty Officer will contact the County EOC to request space be made available. If the County EOC is unavailable, the City EOC will serve as a backup location. The SMOC Duty Officer will then contact the City EOC to request that space be made available.

2. After the SMOC team has convened, the SMOC duty officer (or designee) should develop a message for hospitals and other healthcare facilities. Information should be shared with the public in accordance with the St. Louis Regional Response System Regional Resource Coordination Plan and follow NIMS and ICS procedures for a joint information center. (See Appendix B - Sample SMOC Communication Messages for more details on the structure and content of messages.)

a. The EMResource is the primary mechanism used to notify hospitals and other healthcare organizations. Backup radio communications include the

4 The conditions under which the County and the City EOC will make space available to the SMOC will be outlined in a formal memorandum of agreement.

5 Please note that EMSSystem has been renamed EMResource.
HEAR and MERCI Radio Systems. HAM radios and satellite phones are redundant communications that can all be used to notify hospitals if phone lines and Internet connections are down.

b. The messages should be written in plain English without the use of codes (e.g., level 2, code orange). For more information on what the message should contain, see Exhibit 2.1 below and Appendix B for sample message templates.

2.7 Medical Operations Center: Emergency Response Actions During a Partial or Full Activation

This section describes the establishment of the SMOC and the response activities that will be implemented to support regional response missions and objectives during Level 3 or Level 4 activation.

2.7.1 Regional Approach to Decision-Making on Healthcare and Hospital Resources

All members of the SMOC team will collaborate in good faith to make decisions that are in the best interests of the region, and will not take into account solely their own hospital affiliation.

To create additional surge capacity within any medical system, there must be some redistribution of medical care and resources within regional healthcare. To achieve this redistribution, it is essential that available options are understood and accepted by all stakeholders. The proper use of medical resources changes from one disaster to another. Proper resource allocation, whether it is people, supplies, transport vehicles, or available treatment modalities, must be coordinated and geared to providing the most care for the most individuals, without regard to financial capabilities or deficiencies.

*Individuals needing placement into healthcare facilities will be determined based on hospital capacity and capability matched with the patients’ healthcare needs.* Long-term care facilities and specialty hospitals will be included in the surge capacity matrix. By using this approach, acute care facilities will not become overwhelmed with non-acute patients, resulting in the most medically fragile individuals being treated in the most appropriate facility, thereby eliminating the need for further transfer of the patient for appropriate or specialized care.

2.7.2 Direction, Control, and Coordination

While the SMOC has no jurisdictional oversight or authority over the region, the SMOC will work with governing entities, such as the Incident Commander, EOCs, emergency management, and public health, in coordinating response, mitigation of adverse effects, preparedness, and planning to ensure emergency incidents do not
adversely affect the quality, capacity, and continuity of healthcare operations for the region. The SMOC will follow NIMS and ICS principles and interact with local, state, and federal response agencies through the affected county EOCs. In most cases, the SMOC will communicate with an EOC through an ESF 8 representative or through a public health/medical liaison.

The SMOC recognizes its unique role and responsibilities to the general public and the medical community, and will respond to community and regional medical emergencies by providing regional coordination for many aspects of medical response. This includes but is not limited to transportation, medical surge capacity and capabilities, notifications, updates, patient tracking, and facility requests for resources.

2.7.2.1 Decision-Making Criteria

The SMOC and all healthcare facilities in the region do not discriminate on patient placement, transportation, care, or services based on minority status, race, religion, age, or country of origin. The SMOC team will make decisions using the following criteria:

- The first priority for all decisions will be life-saving measures.
- The primary consideration when making decisions regarding transportation and patient placement must be what is best for patients and residents.
- All decisions and protective actions will support regional response operations, regardless of discipline or jurisdiction, as decided upon in coordination with affected incident commanders/EOCs, usually through an ESF 8 representative or a public health liaison.

2.7.2.2 Integrating with Local Regional, State, and/or Federal Response Efforts

During a regional incident warranting the activation of the SMOC, healthcare facilities in the region will need to work with other response agencies, potentially at all levels of government (local, regional, state, and federal). This is especially true if non-hospital-owned assets are needed.

The ability of the SMOC and healthcare facilities to obtain local, state, or federal assistance is dependent on the activation of the local emergency response system and/or declaration of an emergency by local, state, and/or federal authorities.

In accordance with NIMS, the SMOC will coordinate all requests for additional assistance with the local jurisdiction, such as the county EOC. If the local jurisdiction cannot fulfill the request, the county will submit the request to the state. Consequently, if the state cannot fulfill the request by using its own resources or through the Emergency Mutual Aid Compact (EMAC), a request should be submitted to FEMA. The SMOC will attempt to fulfill the requests locally if possible, first looking within the regional healthcare systems and then to local municipalities such as cities and counties. Requesting resources from the state and/or FEMA will usually take several days, which may be too late to meet the needs of the affected healthcare facilities.
2.7.3 Communication and Coordination

For an effective regional medical response, the SMOC must maintain situational awareness, have an understanding of the common operational picture, and be able to provide accurate and accessible information to stakeholders in a rapid, user-friendly manner.

At the onset of an incident, the SMOC will assess the situation, identify and prioritize requirements, establish incident objectives (in accordance with the affected EOC to support regional response efforts), and activate available resources and capabilities to support healthcare facilities.

Upon activation, the SMOC will send out a request for information on the current status of healthcare facilities in the region. This request for information will be disseminated to all healthcare facilities as soon as there is the threat or potential threat of an incident. Healthcare facilities will need to update this information on a frequent basis. The SMOC will determine the schedule the healthcare facilities will follow to update the information based on incident requirements.

Appendix D - St. Louis Hospital Status is an example request form that will be disseminated to all healthcare facilities. This document may be disseminated and completed using all available communication technologies, with a preference for electronic mediums such as EMResource. If these systems are not available, healthcare facilities may submit their status via fax or phone. As a last resort, couriers/runners/messengers may be used.

<table>
<thead>
<tr>
<th>Healthcare Facility Status Information Needed by the SMOC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Bed capacity</td>
</tr>
<tr>
<td>■ Staffing levels</td>
</tr>
<tr>
<td>■ Facility capabilities</td>
</tr>
<tr>
<td>■ Epidemiological projections, if applicable</td>
</tr>
<tr>
<td>■ Casualty estimates</td>
</tr>
<tr>
<td>■ Speciality services available or needed</td>
</tr>
</tbody>
</table>

2.7.3.1 Communication Tools

The SMOC will use all available communication tools during an incident. EMResource and web-based/Internet computer technology (such as web-based disaster management systems) should be used to communicate and coordinate if the Internet and connectivity are available. These systems help provide greater visibility of status and needs among all healthcare facilities, the SMOC, and other response organizations.

The tools (such as the conference call lines and the web-based disaster management system) and how to access/use them are described in the Communication section of
the St. Louis Area Regional Response System Regional Resource Coordination System Plan. These systems include, but are not limited to:

- EMResource
- Landline telephones
- Dedicated telephone lines
- HEAR or MERCI radios
- Fax
- E-mail

2.7.3.2 Notification Procedures for SMOC Team

As described in Section 2.5 above, the SMOC Duty Officer may be notified of an incident that may activate the SMOC by: (1) Central County Dispatch; (2) receiving a message directly from a member of the response community; (3) a hospital/healthcare facility; and/or (4) becoming aware of an incident from another source (e.g., news media).

The SMOC Duty Officer and other SMOC team members should be notified using appropriate mass notification systems such as E•SPONDER or EMResource. If these systems are degraded or not functional, notification should take place by all communication means available, as the effects of the incident may selectively degrade communication across the region. Other communications mechanisms include landline or cellular telephones, pagers, electronic mail, and courier message (either a private company or a law enforcement officer, as arranged via an EOC).

Methods of Emergency Notification (in no particular order of preference):

- Mass notification systems such as E•SPONDER, E Team, EMResource
- Cell phone call to SMOC team members
- Text message or page to cell phones of all members and their designated alternates
- Activation notice posted on EMResource
- Broadcast e-mail to all members and their designated alternates
- Broadcast fax to all SMOC members
- Radio message via HEAR or MERCI
- External TV and radio station media alert

A list of contact information for each method of communication will be developed and maintained. This contact information should be shared with other SMOC members, County Dispatch, and EOCs. An alert and notification test will be conducted at least once per quarter using all means except external television and radio station media alert.
2.7.3.3 Information Collection and Dissemination

During an emergency, there is a strong likelihood that communications will be degraded and various locations will have varying levels of capability. All available forms of communication should be used. The SMOC will specify how information should be submitted back to the SMOC when making a request for information. The SMOC will disseminate information using as many communication methods as available to ensure receipt of information.

2.7.3.4 Sharing Information with EOCs and Other First Responders

The SMOC will submit information and requests to EOCs using standard NIMS and ICS forms unless otherwise directed by a specific EOC to do otherwise. The SMOC will serve as a consolidated communication and coordination center to share information bi-directionally with local emergency management offices, healthcare facilities, EMS agencies, public health, and other appropriate organizations.

2.7.4 Administration Finance and Logistics

The SMOC will complete and track all time, expenses, and resources used during response to the incident in accordance with NIMS procedures and submit the request for reimbursement, as directed in the tasking.

The SMOC Duty Officer and the individuals supporting the SMOC during the activation will work with the requesting jurisdiction to identify and submit the forms for reimbursement.

Hospitals and supporting organizations should follow SMOC procedures for tracking resources to ensure that the necessary documentation is available should reimbursement opportunities become available.

The Hospital Preparedness committee will work with appropriate jurisdictional organizations such as STARRS and local emergency management agencies to develop a process to help facilitate reimbursement.
During an emergency incident, the availability of resources for life saving measures, medical transportation, and protection of the public and the environment are in high demand. Basic supplies (e.g., water, ice, food, fuel) may also be scarce. The St. Louis Hospital MOU facilitates the sharing of resources, equipment, and personnel necessary to provide emergency medical care during a disaster. A copy of this mutual aid agreement is attached in Appendix E.

During an emergency, the SMOC will serve as a center for collecting and disseminating current information about healthcare resources and needs (including equipment, bed capacity, personnel, supplies, etc.), developing priority allocations, tracking disbursement of resources, and other relevant healthcare response matters. In the future, the SMOC will hopefully operate as a non-profit entity that can be activated by a jurisdictional authority to serve as a response resource. If authorized to activate, the SMOC may be given purchasing authority, which will allow it to directly procure the resources needed to support healthcare response and recovery operations.

The SMOC will serve as a central point of contact between healthcare facilities, state and local emergency management agencies, and other governmental and non-governmental agencies as necessary.

All participating healthcare facilities will provide updated relevant information on resource requests, including available and needed resources, at the request of the SMOC.

3.1 Requesting Resources

Pursuant to the St. Louis Hospital MOU, only the hospital command center (HCC) or designee of a healthcare facility needing assistance has the authority to initiate a request for resources. This request can be made through the SMOC using the incident-specific established resource request mechanism(s). In most cases, verbal telephone requests and electronic requests (submitted using EMResource, E•SPONDER, or e-mail) are acceptable. All verbal requests must be followed up with a written request within 24 hours of the initial request.

**NOTE: Verbal requests are NOT recommended unless other methods of communication and documentation are unavailable.**

The SMOC will communicate the request to the other healthcare facilities directly and to other response agencies via EOCs, and conduct the ongoing communication and coordination needed to obtain the resource.

The healthcare facility requesting and receiving the resource, referred to as the recipient hospital, will assume direction and control of the resource (e.g., personnel, equipment, and supplies) during the time the resource is at the recipient hospital.
As specified in the St. Louis Hospital MOU, if the resource is obtained from another healthcare facility, the recipient hospital will reimburse the transferring hospital (the hospital that provides the resource) for all of the transferring hospital's costs as determined by the transferring hospital’s established regular rates. Reimbursable costs include salary and benefits for personnel; all use, breakage, damage, replacement and return costs of equipment and supplies; and management and administration costs. Reimbursement will be made within ninety (90) days following receipt of the invoice.

When requesting resources or assistance from Illinois hospitals, the SMOC will communicate the request through the Illinois Region 4 POD Hospital/Regional Hospital Control Center (RHCC), which is Memorial Hospital in Belleville.

### 3.1.1 Request of Resources

Facilities should first utilize all internal avenues to fulfill their needs prior to contacting the SMOC. Individual facilities that are part of healthcare system should contact their hospital command center/EOC via their ICS structure, as described in their individual hospital emergency plans. The hospital command center/EOC will submit the request to the SMOC.

When a facility is requesting resources, the SMOC will require the following information:

- Type and number of requested resource
- Estimate of how quickly the request is needed
- Location and point of contact person where the resource is to report
- Estimate of how long the resource will be needed

The request for resources should be submitted in writing, preferably electronically, in the format and forms as described by the SMOC. If available, electronic resource request forms in disaster management systems such as E•SPONDER should be used.

### 3.1.2 Request of Personnel

In the event the request is for personnel and the transferred personnel are required to work in a facility greater than 50 miles from their home facility, the requesting facility will be responsible for housing and feeding the transferred personnel. Documentation, credentialing, and liability will be in compliance with the guidelines stipulated in the St. Louis Hospital MOU.

### 3.1.3 Transfer/Evacuation of Patients

When a facility is not able to carry out its transfer/evacuation plans, the request for transfer of patients may be made via the SMOC. In making a request to transfer through the SMOC, a transferring hospital must specify the number of patients who need to be transferred, the general nature of their illnesses or conditions, and whether specialized services or placement is required. To the extent that is practicable in the context of the disaster, the participating hospital requesting transfer of one or more of
its patients will provide copies of the patient’s pertinent medical records, registration information, and other information necessary for continued care at the receiving hospital. Additionally, to the extent possible under the circumstances, and at the request of the receiving hospital, the transferring hospital will provide any extraordinary drugs or other special patient needs (e.g., equipment, blood products).

The SMOC will coordinate the placement and transportation needs of the patients. Admission, notification, financial liability, and legal liability will be conducted in compliance with the St. Louis Hospital MOU.

3.1.4 Request for Pharmaceuticals, Supplies, or Equipment

If a facility is unable to obtain necessary resources, supplies, or equipment from its regular vendors, the SMOC will facilitate acquisition of and coordination for the request of pharmaceuticals, supplies, and/or equipment. The SMOC will use standard order requisition forms for hospitals as documentation of the receipt of the requested materials. The SMOC is responsible for tracking the resource to the recipient hospital and back during the recovery phase.

As specified in the St. Louis Hospital MOU, the recipient hospital will reimburse the transferring hospital for any consumable supplies or pharmaceuticals at actual cost, including a fee for management and administration associated with the transfer that shall be an amount of ten percent (10%) of the base costs of the supplies or pharmaceuticals.

The recipient hospital will pay for all reasonable transportation fees to and from the transfer site. The recipient hospital is responsible for appropriate tracking, use, and necessary maintenance of all borrowed pharmaceuticals, supplies, and equipment during the time such items are in the custody of the recipient hospital in accordance with law, and shall be responsible for risk of loss and may insure or self-insure risk of loss with the right of subrogation reserved.

3.2 Regional Resources

Through several grants, the Region has procured regional assets that may be used for emergency response and recovery efforts. These regional assets are owned by the Region and any hospital or healthcare facility within the Region that is a signatory to the St. Louis Hospital MOU may request these resources.

Even though these resources are stored at individual hospital facilities, the agreement does not give this hospital any priority to use these resources. Use of these resources should be coordinated through the SMOC, if the SMOC is activated. Use of the regional assets and replacement of materials are governed by grant agreement as well as the St. Louis Hospital MOU.

6 Special attention must be given to ensure transfer and maintenance of records is coordinated and the process is well established and understood by all stakeholders. The St. Louis Hospital Preparedness Committee will work on clarifying the record process.
Appendix F is a series of maps that show the location of regional assets.

### 3.3 Escalation of Response

During a widespread catastrophic disaster, resources may need to be requested from outside the region. Resource requests for emergency supplies should be made from the healthcare facility to the SMOC. If the SMOC is unable to fulfill the request locally (directly or through coordination), the SMOC will submit the request to the County EOC from which the request was made. If the County EOC is unable to fulfill the request, the County EOC may escalate the resource request to the State. The State EOC, if unable to fulfill the resource request, may seek assistance via EMAC agreements and/or escalate the request to federal agencies.
Section 4
PLAN TRAINING, DEVELOPMENT AND MAINTENANCE

The RHCP will be managed and maintained by the SMOC Duty Officer, under the authority of the Hospital Preparedness Committee. Participating hospitals, emergency management agencies, EMS agencies, and public health departments are responsible for updating their respective EOPs. The SMOC Duty Officer will update this plan following an exercise or at least once annually. The RHCP will be reviewed and accepted by the STARRS and a copy will be made available to all participating healthcare facilities and jurisdictional EOCs.

4.1 Test, Training, and Exercise

The development of a comprehensive, on-going test, training, and exercise program to inform and educate decision makers, hospitals, and other response stakeholders is essential. An initial orientation and training session for all participating hospitals will be held following the adoption of this plan. Additional training sessions for senior leadership within healthcare facilities and other response agencies will be scheduled through the Hospital Preparedness Committee.

The SMOC and all participating hospitals will conduct periodic exercises to test and validate the concept of coordination described in this plan. Following the conclusion of each exercise, the SMOC Duty Officer will update and disseminate changes to this plan to reflect lessons learned and corrective actions.

Table 4.1
Regional Evacuation Plan Test, Training, and Exercise Schedule

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Purpose (Test, Train, Exercise)</th>
<th>Frequency</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a drill to test the communication tools used for alert and notification</td>
<td>Exercise</td>
<td>Monthly</td>
<td>Central County 9-1-1 Dispatch to conduct in coordination with monthly radio test</td>
</tr>
<tr>
<td>All Stakeholder RHCP Awareness Training: Distribute a 2-page fact sheet on the RHCP that describes the roles and responsibilities of stakeholders so they are aware of expectations during an emergency incident.</td>
<td>Train</td>
<td>Upon approval of this RHCP and biannually thereafter</td>
<td>Hospital Preparedness Committee</td>
</tr>
</tbody>
</table>
### Program Description

<table>
<thead>
<tr>
<th>Program Description</th>
<th>Purpose (Test, Train, Exercise)</th>
<th>Frequency</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Senior Leadership Training Seminar: Using a realistic scenario, conduct a briefing for hospital senior staff to train them on the RHCP and their roles and responsibilities.</td>
<td>Train</td>
<td>Upon approval of this plan and annually thereafter</td>
<td>Hospital Preparedness Committee and Hospital Designated Disaster Coordinator</td>
</tr>
<tr>
<td>Exercise/Drill: Exercise this plan during the next annual Regional Exercise.</td>
<td>Exercise</td>
<td>As soon as possible following approval of this plan and annually thereafter</td>
<td>Hospital Preparedness Committee, STARRS, participating facility representatives, participating jurisdiction EOCs, EMS, Public Health and Missouri Hospital Association</td>
</tr>
</tbody>
</table>
INITIAL CONFERENCE CALL AGENDA

Once the SMOC has been activated for a situation or potential situation that may have an impact on hospitals or the ability of the region to provide medical services, the SMOC duty officer will convene the other on-call members of the SMOC team and appropriate subject matter experts. The SMOC team and other subject matter experts from other emergency response disciplines (e.g., public health, law enforcement, fire, emergency management, hazardous materials, poison control) will coordinate via conference call. The group will discuss and obtain answers to the following questions:

i. Obtain Situational Awareness
   - What is the current information known about the incident?
   - Who is leading the response or investigation?
   - What jurisdictions are affected? Projected?
   - Has incident/area command been established? If yes, where? Contact info?
   - What role is foreseen by hospitals, public health and other healthcare facilities?
   - What assets/agencies are on scene, available or needed?
   - What are the medical needs and symptoms being demonstrated by victims and responders?
   - What is the threat status and/or emergency declarations status (federal, state, local)?

ii. Review Initial Protective Actions
   - Have first responders (fire, police, public health) issued/implemented any initial protective actions (e.g., lockdown) for hospitals or other types of facilities, such as nursing homes, schools, community centers, etc.?
   - Have first responders (fire, police, public health) issued/implemented any initial protective actions for citizens and the workforce (e.g., shelter in place)?
   - How have special needs populations been addressed?
   - Have any initial protective actions occurred for transportation (e.g., public transit operational, high-occupancy vehicle (HOV)/carpool restrictions lifted)?

iii. Consider Additional Protective Actions
   - What protective actions are recommended to be implemented by hospitals and other medical facilities?
Appendix A

- Is there a need for establishment of shelters? If so, what is the location and capability/capacity?
- What information should be provided to the community regarding any medical issues?

iv. **Determine Next Steps to Coordinate and Implement Protective Actions**
- What response actions need to be coordinated regionally among healthcare facilities and other response agencies? (Please note: all protective actions must be coordinated through incident command/EOCs.)
- What resources are needed?

v. **Determine SMOC Operational Status**
- Depending on the incident, the SMOC team will collaborate with the affected jurisdictional authority and/or Incident Commander to determine the SMOC Operational Status.
- **Level 1 – Normal Operations** – During this phase, the focus is on general situational awareness. The SMOC Duty Officer monitors external intelligence information and shares accordingly. The SMOC is not activated at this point.
- **Level 2 - Significant Incident** – During this phase, an incident has occurred that could affect the SMOC regional response agencies in the future. The primary focus is on gathering more information about the incident. The SMOC duty officer periodically contacts other first response agencies (e.g., public health and/or emergency managers) or affected healthcare facilities to obtain additional information to determine if the situation has escalated and/or if further SMOC action is warranted. The SMOC duty officer may request periodic conference calls with the four other SMOC members and other first response agencies to get more information on the incident (see Steps 4–6 below) and share situational awareness with healthcare providers.
- **Level 3 – Partial Activation** – During this phase, the threat of a regional medical emergency is imminent and hospitals or first response agencies are submitting initial requests for support/information from the SMOC. The SMOC duty officer notifies the three other SMOC members who are also on call and coordinates a process to respond to initial requests, to provide advice and recommendations to healthcare facilities, and/or to assess current hospital capabilities and anticipated needs/gaps. During a partial activation, the four team members SMOC may operate virtually from their individual locations (using all communication methods available), from an appropriate EOC or some combination thereof.
- **Level 4 – Full Activation** – During this phase, the SMOC will coordinate and implement actions to aid healthcare facilities and support response operations in the region. If the emergency warrants, the SMOC will assist with coordination of resource requests between hospitals and to/from hospitals to
other response agencies. During this stage, the SMOC requires the support and communication capabilities of an appropriate “host” EOC.

vi. Develop a message to alert and notify other hospitals and healthcare facilities/organizations.

- The message for hospitals should include the following information in this specific order (please note that pager messages are limited to 230 characters):
  - State that the message is from SMOC
  - State the general status of the message. Is the message for the recipient’s general awareness or is a response activity required? Consider using terms like “awareness”, “FYI”, “response required” or “action needed”.
  - Succinctly describe the type of incident. Describe the type of threat or hazard that has occurred and the magnitude or number of people affected (e.g., “small plane crash” or “large plane crash”).
  - Describe the affected areas. Note the cities or counties affected by the hazard or threat. Specify the state (IL or MO) if appropriate.
  - Explain where to get more information. For example, “See EMResource for recommendations on protective actions.”
  - Include contact information for SMOC (phone, e-mail and fax) as appropriate.
  - Develop recommendations on initial protective actions that hospitals should implement.
  - Describe the status of any affected hospitals.
  - Provide links to any additional references (e.g., Material Safety Data Sheets (MSDS) or chemical agent briefing sheets).

**NOTE: Text and other lateral messaging systems should be used to facilitate access to clear and appropriate information, which may be provided in other formats (e.g., EMResource, E•SPONDER, web-sites, etc.).**
Appendix B
SAMPLE SMOC COMMUNICATION MESSAGES

The following are sample pager messages that could be used during an incident that requires the St. Louis Regional Hospital Coordination System. These messages should be followed by a more detailed EMResource message that describes the incident, the type of assistance or response requested, recommendations or initial protective actions, and links to any other reference materials. The initial message is limited to 230 characters.

The message for hospitals should include the following information in this specific order (please note that pager messages are limited to 230 characters):

- State that the message is from SMOC
- State the general status of the message. Is the message for the recipient’s general awareness or is a response activity required? Consider using terms like “awareness”, “FYI”, “response required” or “action needed”.
- Succinctly describe the type of incident. Describe the type of threat or hazard that has occurred and the magnitude or number of people affected (e.g., “small plane crash” or “large plane crash”).
- Describe the affected areas. Note the cities or counties affected by the hazard or threat. Specify the state (IL or MO) if appropriate.
- Explain where to get more information. For example, “See EMResource for recommendations on protective actions.”
- Include contact information for SMOC (phone, e-mail and fax) as appropriate.
- Develop recommendations on initial protective actions that hospitals should implement.
- Describe the status of any affected hospitals.
- Provide links to any additional references (e.g., Material Safety Data Sheets (MSDS) or chemical agent briefing sheets).

Sample Pager/Text Messages

- SMOC Alert: No action required. FYI ONLY. 10-person plane crash in St. Charles Co., MO. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.
- SMOC Alert: Immediate action required. 500-person plane crash in St. Charles Co., MO. Medical staff needed at incident site. Go to EMResource for details. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.
Appendix B

- SMOC Alert: Response required. Power out @ 10 hospitals in St. Louis, St. Charles Co., MO & Madison Co., IL. Hospitals need supplies & evac help. Go to EMResource for details. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

- SMOC Alert: Response required. Potential HazMat threat for all St. Louis Area hospitals. Recommend lock down of ER. Go to EMResource for details. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

Sample Full EMResource Messages

The following are sample messages:

- SMOC Alert: Response Required. MO DHSS requests daily reporting of emergency department volume and flu-like illness (Influenza Like Illness (ILI)) presentations. Please report to the SMOC the past calendar day (midnight to midnight) ED volume and ILI presentations daily by 11:00 a.m. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

- SMOC Alert: No action required. FYI ONLY. MO DHHS has requested the attached guidance be posted for all healthcare facilities. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

- SMOC Alert: Response required. MCI: Explosion with chemical exposure at 456 First St. Please report to the SMOC via EMResource the number of available burn beds and decontamination capability. The latest affected areas and projections are attached. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

- SMOC Alert: Response required. MCI: Multi-vehicle crash with more than 50 patients at 123 Main St. Please report all available emergency department capacity using EMResource. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.

- SMOC Alert: Response required. Please report all unmet needs (e.g., staff, supplies, medications, etc.) by 10:00 am daily using the resource request form on E•SPONDER. Contact SMOC Duty Officer at XXX-XXX-XXXX for more info.
Appendix C

ST. LOUIS MEDICAL OPERATIONS CENTER TEAM
MEMBER FORM

Please complete the following form to sign up to become a member of the St. Louis Medical Operations Center (SMOC).

Name:

Hospital:

Title

Healthcare System:

Phone:

E-mail:

Cell Phone:

Pager:

Notification system used at your hospital:

Are you part of the clinical or administrative staff at your hospital? Please select one.

Please describe your role at your hospital:

Do you have an operational understanding of the hospital incident command system (HICS)? Yes No

Please describe your emergency management training. Check all that apply. If you have taken an equivalent course, please provide a description and title of the course.

<table>
<thead>
<tr>
<th>Course</th>
<th>Comment</th>
<th>Date Last Taken (Month, Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IS.100.a – Introduction to Incident Command System or equivalent course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS.100.HC – Introduction to Incident Command System from Healthcare/Hospitals or equivalent course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS. 200 – ICS for Single Resource and Initial Action Incidents or equivalent course</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IS.200.HC – Applying ICS to Healthcare Organization or equivalent course</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To create additional surge capacity within any medical system, there must be some redistribution of medical care and resources within regional healthcare facilities. To achieve this redistribution, it is essential that available options are understood and accepted by all stakeholders. The proper use of medical resources changes from one disaster to another. Proper resource allocation, whether it is people, supplies, transport vehicles or available treatment modalities, must be coordinated and geared to providing the most care for the most individuals, without regard to financial capabilities or deficiencies.

I, _____________________________, certify that as a member of the SMOC team, I will collaborate in good faith to make decisions that are in the best interests of the region and will not take into account my hospital affiliation.

Signature

Date

Title

Hospital

Because of the time commitment associated with being a SMOC team member, please obtain senior-level approval from either a department director or vice president,
I, _____________________________, acknowledge and support the efforts of ____________________________
to serve as a SMOC team member of behalf of ____________________________ hospital.

Signature

Date

Title
HEALTHCARE FACILITY STATUS REPORT

The following resource management chart identifies the current regional healthcare facility status and resource availability. This form should be submitted to the St. Louis Medical Operations Center using the methods listed below in order of preference. The SMOC will designate the preferred methods of communications and provide specific contact information. The technology noted with a numeric “1” is the most preferred means of communication.

<table>
<thead>
<tr>
<th>Communication Preference</th>
<th>Additional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The SMOC will rank the preferred means of receiving the data from the healthcare facilities and provide contact information (i.e., the telephone, fax, email address, radio channels) that hospitals should use to submit the requested information.</td>
<td></td>
</tr>
<tr>
<td>___ EMResource</td>
<td></td>
</tr>
<tr>
<td>___ E•SPONDER</td>
<td></td>
</tr>
<tr>
<td>__ E-mail</td>
<td></td>
</tr>
<tr>
<td>___ Fax</td>
<td></td>
</tr>
<tr>
<td>(___) ______ - _______</td>
<td></td>
</tr>
<tr>
<td>Hand deliver to</td>
<td></td>
</tr>
<tr>
<td>Satellite Phone</td>
<td></td>
</tr>
<tr>
<td>(___) ______ - _______</td>
<td></td>
</tr>
<tr>
<td>HAM Radio</td>
<td></td>
</tr>
<tr>
<td>___________</td>
<td></td>
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<tr>
<td>___________</td>
<td></td>
</tr>
<tr>
<td>_____Other</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix D

Date: _____________
Time: _______________
Facility: ________________________________
Submitted By: ___________________________
Telephone/Cell: __________________________
E-mail address: __________________________

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>STATUS* (Y, U, S, or M)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beds or cots</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-essential medical supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communications equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs other than antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antibiotics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quinolones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracyclines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aminoglycosides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cipro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anti-virals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tamiflu/Relenza</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve Agent Chem Pack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal Protective Equipment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N95 masks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular masks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gowns</td>
<td></td>
<td></td>
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<tr>
<td>Gloves</td>
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<tr>
<td>Goggles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RESOURCE</td>
<td>STATUS* (Y, U, S, or M)</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Blood and Blood Products</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Equipment and Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portable generators</td>
<td>Each facility has backup generator power.</td>
<td></td>
</tr>
<tr>
<td>Fuel</td>
<td>Dependent upon notification time.</td>
<td></td>
</tr>
<tr>
<td>Fans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heaters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning supplies/gel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other________________________</td>
<td></td>
<td></td>
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<tr>
<td>Other________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y1 = Sufficient on hand for the next 12 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y2 = Sufficient on hand for the next 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y3 = Sufficient on hand for the next 36 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y4 = Sufficient on hand for the next 48 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y5 = Sufficient on hand for the next 60 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y6 = Sufficient on hand for the next 72 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y7 = Sufficient on hand for the next 84 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Y8 = Sufficient on hand for the next 96 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>U = Unmet need; depending on other resources for supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S = Resource on hand and will share if not needed*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M = Resource on hand and may share depending upon situation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table D-1
Contact Information/Internal Communications

<table>
<thead>
<tr>
<th>NAME</th>
<th>PHONE</th>
<th>PAGER</th>
<th>E-MAIL</th>
<th>FAX</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</table>

### Table D-2
External Communications (insert additional rows as necessary)

<table>
<thead>
<tr>
<th>ID</th>
<th>PHONE</th>
<th>FAX</th>
<th>E-MAIL</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local EOC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Health Dept.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Health Dept.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Emergency Mgmt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Louis Medical Operations Center (SMOC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poison Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FBI</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dispatch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media Contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TV: ______________</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radio: ____________</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Appendix E
HOSPITAL MUTUAL AID AGREEMENT
MEMORANDUM OF UNDERSTANDING BETWEEN HOSPITALS IN THE ST. LOUIS REGION AND HOSPITALS OPERATED BY THE MISSOURI DEPARTMENT OF MENTAL HEALTH IN THE ST. LOUIS REGION

The following is a copy of the Hospital Mutual Aid Agreement Memorandum of Understanding and the Hospital Mutual Aid Agreement Memorandum of Understanding Between Hospitals in the St. Louis Region and Hospitals Operated by The Missouri Department of Mental Health in the St. Louis Region.
Appendix E

HOSPITAL MUTUAL AID AGREEMENT
MEMORANDUM OF UNDERSTANDING

I. INTRODUCTION

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

II. THIS MUTUAL AID AGREEMENT

The purpose of the Hospital Mutual Aid Agreement established by this Memorandum of Understanding (MOU) is to establish a coordinated system in which hospitals in the St. Louis Region will provide mutual aid to each other as necessary in order to provide emergency medical care needed in a medical disaster. The hospitals that are parties to this agreement are collectively referred to as “Participating Hospitals” or individually a “Participating Hospital” and are listed on Exhibit “A” attached hereto and incorporated herein.

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

This MOU:

1. addresses the relationships between and among hospitals and is intended to augment, not replace, each facility’s disaster plan;
2. describes the relationship between the Participating Hospitals and the St. Louis Area Regional Response System (“STARRS”) through its committee structure and area-wide Medical Communication Center (“MedComm”); and,
3. provides the framework for hospitals to coordinate through MedComm with the relevant local emergency management agencies, local public health departments, municipal governments and state emergency management agencies in the region.

This MOU does not replace but rather supplements the rules and procedures governing interaction between Participating Hospitals with external organizations during a disaster such as law enforcement agencies, local emergency medical services, local public health departments, fire departments, American Red Cross, etc.
III. MAINTENANCE OF INDIVIDUAL HOSPITAL'S DISASTER PROGRAM

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

Each Participating Hospital, as part of its individual disaster planning agrees to participate in this Mutual Aid Agreement and to participate in periodic training exercises conducted to prepare for implementation of this agreement.

IV. HOSPITAL PARTICIPATION IN THE STARRS ADVISORY COUNCIL

Each Participating Hospital will designate a representative to participate on STARRS Advisory Council subcommittees charged with planning and developing operational procedures for medical disasters and coordinating mutual aid initiatives.

V. COMMUNICATION

In the event of a medical disaster MedComm will serve as a center for collecting and disseminating current information about Participating Hospital resources and needs including equipment, bed capacity, personnel, supplies and other relevant matters. MedComm will serve as a point of contact between Participating Hospitals, state and local emergency management agencies, other governmental and non-governmental agencies as necessary. Each Participating Hospital will provide and update relevant information during drills or disasters to MedComm.

To accomplish this in the event of interruption of the telephone system, each Participating Hospital agrees to use, maintain, and upgrade when necessary the equipment necessary to participate in the following communication systems:

A. HEAR/MERCI NETWORK – the Hospital Emergency Administrative Radio Network, operating on VHF radio frequencies 155.340 (hospital to hospital), 155.220 (ambulance to hospital), and 155.400 (incident command).

B. EMSYSTEM – an internet-based hospital status system used by all St. Louis Metropolitan Hospitals to report open/closed/divert status in real-time. Messaging functions via EMSYSTEM can reach all hospitals simultaneously.

C. ROUTINE COMMUNICATION - each Participating Hospital will provide MedComm with current contact information for its key emergency personnel including telephone, fax, email, radio and or any other useful and relevant information.

VI. MUTUAL AID RECEIVED BY OR PROVIDED TO A PARTICIPATING HOSPITAL

A. AUTHORITY AND COMMUNICATION

Only a senior hospital administrator or designee of a Participating Hospital which has a need for assistance including additional staff, equipment or supplies ("Recipient Hospital") has the authority to initiate a request for assistance pursuant to this MOU. This request may be made verbally through MedComm but must be followed by a written request as soon as practicable and if possible within forty eight (48) hours of the verbal request. MedComm will communicate the verbal request to the other Participating Hospitals and play an ongoing communication and
coordination role between Participating Hospitals. A Participating Hospital that sends assistance to another Participating Hospital is referred to as a “Transferring Hospital”.

B. IN GENERAL

The Recipient Hospital will assume direction and control of the personnel, equipment and supplies from Transferring Hospitals during the time the personnel, equipment and supplies are at the Recipient Hospital. The Recipient Hospital will reimburse each Transferring Hospital for all of the Transferring Hospital’s costs as determined by the Transferring Hospital’s established regular rates. Reimbursable costs includes salary, and benefits for personnel; all use, breakage, damage, replacement, and return costs of equipment and supplies; management and administration costs. Reimbursement will be made within ninety (90) days following receipt of the invoice.

C. TRANSFER OF PERSONNEL

1. Information Required: The Recipient Hospital will identify to the Transferring Hospital through MedComm the following:
   a. The type and number of requested personnel (“transferred personnel”).
   b. An estimate of how quickly the request is needed.
   c. The location where the transferred personnel are to report.
   d. An estimate of how long the transferred personnel will be needed.

2. Documentation: The arriving transferred personnel will be required to present their Transferring Hospital identification badge upon arrival at the site designated by the Recipient Hospital. The Recipient Hospital will be responsible for the following:
   a. Establishing and following procedures for the arriving transferred personnel that conform to the Joint Commission Standards pertaining to Disaster Privileges in effect at the time of the medical disaster.
   b. Confirming the transferred personnel’s ID badge with the list of transferred personnel provided by the Transferring Hospital.
   c. Providing appropriate additional identification, e.g., “visiting personnel” badge, to the arriving transferred personnel.

3. Supervision: The Recipient Hospital’s senior administrator or designee will identify where and to whom the transferred personnel are to report, and professional staff of the Recipient Hospital will supervise the transferred personnel. The Recipient Hospital’s supervisor or designee will meet the transferred personnel at the point of entry of the facility and brief the transferred personnel of the situation and their assignments. If appropriate, the “emergency staffing” rules of the Recipient Hospital will govern assigned shifts. The transferred personnel’s shift, however, should not be longer than required by the Recipient Hospital of its own personnel in such an emergency.

4. Legal and financial liability: Liability claims, malpractice claims, disability claims, attorneys’ fees, and other incurred costs related to the transferred personnel,
equipment and supplies are the responsibility of the Recipient Hospital. An extension of liability coverage to the transferred personnel will be provided by the Recipient Hospital, to the extent permitted by law. The Recipient Hospital will reimburse the Transferring Hospital for the actual costs of the transferred personnel which shall include salary, benefits and a fee for management and administration associated with the transfer that shall be an amount of ten percent (10%) of the salary and benefits. The reimbursement will be made within ninety (90) days following the Recipient Hospital’s receipt of an invoice from the Transferring Hospital.

The Medical Director of the Recipient Hospital will be responsible for providing a mechanism for granting emergency disaster privileges for physicians, nurses and other licensed health care providers to provide services at the Recipient Hospital that conform to the Joint Commission Standards pertaining to Disaster Privileges in effect at the time of the medical disaster.

5. Demobilization procedures: The Recipient Hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The Recipient Hospital is responsible for providing the transferred personnel any transportation necessary for their return to the Transferring Hospital.

D. TRANSFER OF PHARMACEUTICALS, SUPPLIES OR EQUIPMENT

The Recipient Hospital will utilize the Transferring Hospital’s standard order requisition forms as documentation of the receipt of the requested materials. The Recipient Hospital is responsible for tracking the borrowed inventory and returning any non-disposable equipment in good condition or paying the transffering Hospital for the cost of replacement. The Recipient Hospital will reimburse the Transferring Hospital for any consumable supplies or pharmaceuticals at actual cost including a fee for management and administration associated with the transfer that shall be an amount of ten percent (10%) of the base costs of the supplies or pharmaceuticals. The Recipient Hospital will pay for all reasonable transportation fees to and from the transfer site. The Recipient Hospital is responsible for appropriate tracking, use and necessary maintenance of all borrowed pharmaceuticals, supplies and equipment during the time such items are in the custody of the Recipient Hospital in accordance with law, and shall be responsible for risk of loss and may insure or self-insure risk of loss with the right of subrogation reserved.

E. REIMBURSEMENT IF ELIGIBLE UNDER THE STAFFORD ACT

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

2. Procedure: All Participating Hospitals agree that they will follow the FEMA procedures that are in effect at the time of a medical disaster that gives rise to reimbursement under
the Stafford Act or its successor. At the time of the execution of this MOU the Recipient Hospital that has paid the Transferring Hospital for the services of personnel or for the use of equipment, supplies and pharmaceuticals is the hospital that is entitled to apply for reimbursement. Procedures for reimbursement are managed by the emergency management agency of the state in which the Recipient Hospital is located.

F. REIMBURSEMENT IF ELIGIBLE UNDER OTHER MUTUAL AID AGREEMENTS OR LAWS

Participating Hospitals may enter into other mutual aid agreements with governmental or non-governmental agencies including other hospitals and health systems that provide for reimbursement during medical disasters and Participating Hospitals may be eligible for reimbursement under laws other than the Stafford Act that may be in effect at the time of a medical disaster during the effective life of this MOU. In either case, each Participating Hospital agrees to keep the records required to support its own request for reimbursement under any mutual aid agreement or law that provides for reimbursement and when appropriate, to substantiate and support the request for reimbursement of any other Participating Hospital. When a Participating Hospital is reimbursed for part or all of its expenses under another mutual aid agreement or law, it is not entitled to duplicate reimbursement from another Participating Hospital. If a Participating Recipient Hospital receives reimbursement under the Stafford Act and has not reimbursed a Transferring Hospital, the Recipient Hospital will reimburse the Transferring Hospital within sixty (60) days of receiving the Stafford Act funds. Reimbursement under this MOU will not include interest on the reimbursed amounts.

VII. Transfer/Evacuation of Patients

A. Communication and Documentation

In addition to using 911 and community resources, the request for transfer of patients may be made via MedComm. In making a request to transfer through MedComm, a Transferring Hospital must specify the number of patients needing to be transferred, the general nature of their illness or condition and any specialized services or placement required. The Participating Hospital requesting transfer of one or more of its patients is responsible for providing copies of the patient’s pertinent medical records, registration information and other information necessary for care to the Receiving Hospital to the extent that is practicable in the context of the medical disaster.

B. Transporting Patients

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

C. Patient Admission

Once the patient arrives at the patient-receiving Participating Hospital, that hospital will designate the patient’s admitting service, the admitting physician for each patient, and, if
requested, the patient's original attending physician will be eligible for disaster emergency privileges. The procedure for granting disaster emergency privileges to the patient’s original attending physician shall be the procedures established pursuant to Paragraph VI.C.2 of this MOU.

D. Financial and Legal Liability

Upon admission, the patient-receiving Participating Hospital is responsible for liability claims originating from the time the patient is admitted. Reimbursement for care should be negotiated with each hospital's insurer under the conditions for admissions without pre-certification requirements in the event of emergencies.

E. Notification

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

VIII. Auxiliary Hospital Locations

An “auxiliary hospital” which is defined as an emergency location designed to collect, triage or treat casualties during an epidemic or a critical incident involving mass casualties may need to be established on an urgent basis. Governmental or non-governmental agencies or one or more Participating Hospitals may assume command and control of such an auxiliary hospital pursuant to plans developed in conjunction with the STARRS Advisory Council or on an ad hoc basis. Other Participating Hospitals may be asked to transfer staff, equipment or supplies to the auxiliary hospital and if so, the processes set forth in Paragraphs VI, above, will be followed.

IX. Media Relations and Release of Information

Each Participating Hospital agrees to participate in a Joint Public Information Center that would be the primary source of information for the media related to a medical disaster affecting more than one Participating Hospital. MedComm will coordinate establishment of the Joint Public Information Center which will speak on behalf of the affected Participating Hospitals to assure consistent, timely flow of information to the public.

X. Mutual Aid Steering Committee

A Mutual Aid Steering Committee (MAST) is hereby established. The purpose of MAST is:

1. to consider and propose such amendments to this MOU as be necessary;
2. to consider and negotiate additional Mutual Aid Agreements that may be established with governmental or non-governmental agencies including other hospitals and health systems that are designed to enhance emergency medical care in a medical disaster;
3. to consider and advise Participating Hospitals on such other issues as are relevant to accomplishing the purposes of this MOU.

Each Participating Hospital may designate one representative to MAST. MAST may establish a structure including officers and an executive committee if it deems such a structure necessary to
facilitate its work. MAST will be staffed by STARRS and coordinate its efforts with the appropriate STARRS Advisory Council subcommittees.

No decisions or recommendations made by MAST will be binding on Participating Hospitals unless the Participating Hospitals agree in writing by amendment to this MOU or otherwise to accept the said decision or recommendation.

XI. **MISCELLANEOUS PROVISIONS**

A. **Term, termination and Automatic Renewal of this Agreement** The term of this MOU is three (3) years commencing on January 1, 2007. Thereafter, for all Participating Hospitals who do not opt out by written notification to STARRS and all other Participating Hospitals, it will automatically renew for consecutive one (1) year terms commencing on January 1 of each year until amended. Any Participating Hospital may terminate its participation in this MOU at any time by providing written notice to STARRS and all other Participating Hospitals not less than thirty (30) days prior to the effective date of such termination. The obligation of any Participating Hospital to reimburse any other Participating Hospital that was incurred under Paragraphs VI or VII of this MOU, if not satisfied, shall survive the termination of this MOU.

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

C. **Insurance** Each Participating Hospital shall maintain self-insure, at its own expense, professional, worker’s compensation and general liability insurance coverage for itself and its respective employees and, where the Participating Hospital is a Recipient Hospital, agrees to extend its professional and general liability coverage to transferred personnel for claims arising out of services provided by such transferred personnel on behalf of the Recipient Hospital.

D. **Defense and Indemnification** The Recipient Hospital shall assume the defense and indemnification for liability claims arising from or asserting the negligent acts and omissions of transferred personnel who are employed or otherwise covered by the Transferring Hospital. In addition, the Recipient Hospital will be responsible for all expenses related to any injury of transferred personnel, including medical and other reasonable expenses. However, the Recipient Hospital shall not assume the defense and indemnification for liability claims that may arise from a pre-existing defect of transferred equipment, supplies or medications, or the failure to conduct preventive maintenance or to properly repair transferred equipment. Ownership of transferred equipment, supplies or medications shall remain with the Transferring Hospital which shall be responsible for the defense and indemnification of any liability claims that may arise from a pre-existing defect of transferred equipment, supplies or medications, or the failure to conduct preventive maintenance or to properly repair transferred equipment. The Transferring Hospital shall maintain the right to pursue claims against other parties including the manufacturer that may be responsible for any defect in the equipment, supplies or medications.
E. Hold Harmless The Recipient Hospital will hold harmless the Transferring Hospital for any general or professional liability claims, expenses, damages including reasonable attorneys’ fees or other costs resulting solely from the acts or omissions of transferred personnel covered by the Recipient Hospital while such transferred personnel are providing services for the Recipient Hospital pursuant to this MOU.

F. Payment of Fees All compensation for equipment or supplies provided to the Recipient Hospital pursuant to this MOU will be paid by the Recipient Hospital within ninety (90) days of its receipt of an invoice from the Transferring Hospital for such equipment or supplies.

G. Amendment This MOU may be amended in writing signed by all Participating Hospitals.

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

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

XII. EXECUTION

By the signatures below, the hospital named below hereby agrees that it will participate in the Saint Louis Metropolitan Region in this Hospital Mutual Aid Agreement with all other signatory hospitals effective as of January 1, 2007 under the terms and conditions set forth above.

Participating Hospital

Hospital Name

Signature of Authorized Representative

Printed Name of Authorized Representative:

Title
HOSPITAL MUTUAL AID AGREEMENT
MEMORANDUM OF UNDERSTANDING BETWEEN
HOSPITALS IN THE ST. LOUIS REGION
AND
HOSPITALS OPERATED BY THE MISSOURI DEPARTMENT OF MENTAL HEALTH IN THE ST. LOUIS REGION.

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

II. THIS MUTUAL AID AGREEMENT
The purpose of the Hospital Mutual Aid Agreement established by this Memorandum of Understanding (MOU) is to establish a coordinated system in which hospitals in the St. Louis Region including hospitals owned and/or operated by agencies of the State of Missouri will provide mutual aid to each other as necessary in order to provide emergency medical care needed in a medical disaster. The hospitals that are parties to this agreement are collectively referred to as “Participating Hospitals” or individually a “Participating Hospital” and are listed on Exhibit “A” attached hereto and incorporated herein.

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

This MOU:
1. addresses the relationships between and among hospitals and is intended to augment, not replace, each facility’s disaster plan;
2. describes the relationship between the Participating Hospitals and the St. Louis Area Regional Response System (“STARSS”) through its committee structure and area-wide Medical Communication Center (“MedComm”); and,
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Each Participating Hospital will maintain its own emergency management plan that includes, at a minimum, provisions for the care of patients in an emergency or disaster situation, maintenance of disaster equipment, appropriate training of staff and the implementation of an internal incident command system based on the principles of the Hospital Incident Command System (“HICS”).

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Each Participating Hospital will designate a representative to participate on STARRS Advisory Council subcommittees charged with planning and developing operational procedures for medical disasters and coordinating mutual aid initiatives.

V. COMMUNICATION

In the event of a medical disaster MedComm will serve as a center for collecting and disseminating current information about Participating Hospital resources and needs including equipment, bed capacity, personnel, supplies and other relevant matters. MedComm will serve as a point of contact between Participating Hospitals, state and local emergency management agencies, other governmental and non-governmental agencies as necessary. Each Participating Hospital will provide and update relevant information during drills or disasters to MedComm.

To accomplish this in the event of interruption of the telephone system, each Participating Hospital agrees to use, maintain, and upgrade when necessary the equipment necessary to participate in the following communication systems:

A. IHEAR/NERCI NETWORK – the Hospital Emergency Administrative Radio Network, operating on VHF radio frequencies 155.340 (hospital to hospital), 155.220 (ambulance to hospital), and 155.400 (incident command).

B. EMSystem – an internet-based hospital status system used by all St. Louis Metropolitan Hospitals to report open/closed/divert status in real-time. Messaging functions via EMSystem can reach all hospitals simultaneously.

C. ROUTINE COMMUNICATION- each Participating Hospital will provide MedComm with current contact information for its key emergency personnel including telephone, fax, email, radio and or any other useful and relevant information.
VI. MUTUAL AID RECEIVED BY OR PROVIDED TO A PARTICIPATING HOSPITAL

A. AUTHORITY AND COMMUNICATION

Only a senior hospital administrator or designee of a Participating Hospital which has a need for assistance including additional staff, equipment or supplies ("Recipient Hospital") has the authority to initiate a request for assistance pursuant to this MOU. This request may be made verbally through MedComm but must be followed by a written request as soon as practicable and if possible within forty eight (48) hours of the verbal request. MedComm will communicate the verbal request to the other Participating Hospitals and play an ongoing communication and coordination role between Participating Hospitals. A Participating Hospital that sends assistance to another Participating Hospital is referred to as a “Transferring Hospital”.

B. IN GENERAL

The Recipient Hospital will assume direction and control of the personnel, equipment and supplies from Transferring Hospitals during the time the personnel, equipment and supplies are at the Recipient Hospital. The Recipient Hospital will reimburse each Transferring Hospital for all of the Transferring Hospital’s costs as determined by the Transferring Hospital’s established regular rates. Reimbursable costs includes salary, and benefits for personnel; all use, breakage, damage, replacement, and return costs of equipment and supplies; management and administration costs. Reimbursement will be made within ninety (90) days following receipt of the invoice.

C. TRANSFER OF PERSONNEL

1. Information Required: The Recipient Hospital will identify to the Transferring Hospital through MedComm the following:

   a. The type and number of requested personnel ("transferred personnel").
   b. An estimate of how quickly the request is needed.
   c. The location where the transferred personnel are to report.
   d. An estimate of how long the transferred personnel will be needed.

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

   a. Establishing and following procedures for the arriving transferred personnel that conform to the Joint Commission Standards pertaining to Disaster Privileges in effect at the time of the medical disaster.
   b. Confirming the transferred personnel’s ID badge with the list of transferred personnel provided by the Transferring Hospital.
   c. Providing appropriate additional identification, e.g., "visiting personnel" badge, to the arriving transferred personnel.

3. Supervision: The Recipient Hospital’s senior administrator or designee will identify where and to whom the transferred personnel are to report, and professional staff of the Recipient Hospital will supervise the transferred personnel. The Recipient
Hospital’s supervisor or designee will meet the transferred personnel at the point of entry of the facility and brief the transferred personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the Recipient Hospital will govern assigned shifts. The transferred personnel’s shift, however, should not be longer than required by the Recipient Hospital of its own personnel in such an emergency.

4. Legal and financial liability: Liability claims, malpractice claims, disability claims, attorneys’ fees, and other incurred costs related to the transferred personnel, equipment and supplies are the responsibility of the Recipient Hospital to the extent permitted by law. An extension of liability coverage to the transferred personnel will be provided by the Recipient Hospital, to the extent permitted by law. The Recipient Hospital will reimburse the Transferring Hospital for the actual costs of the transferred personnel which shall include salary, benefits and a fee for management and administration associated with the transfer that shall be an amount of ten percent (10%) of the salary and benefits. The reimbursement will be made within ninety (90) days following the Recipient Hospital’s receipt of an invoice from the Transferring Hospital.

The Medical Director of the Recipient Hospital will be responsible for providing a mechanism for granting emergency disaster privileges for physicians, nurses and other licensed health care providers to provide services at the Recipient Hospital that conform to the Joint Commission Standards pertaining to Disaster Privileges in effect at the time of the medical disaster.

5. Demobilization procedures: The Recipient Hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The Recipient Hospital is responsible for providing the transferred personnel any transportation necessary for their return to the Transferring Hospital.

D. TRANSFER OF PHARMACEUTICALS, SUPPLIES OR EQUIPMENT

The Recipient Hospital will utilize the Transferring Hospital’s standard order requisition forms as documentation of the receipt of the requested materials. The Recipient Hospital is responsible for tracking the borrowed inventory and returning any non-disposable equipment in good condition or paying the Transferring Hospital for the cost of replacement. The Recipient Hospital will reimburse the Transferring Hospital for any consumable supplies or pharmaceuticals at actual cost including a fee for management and administration associated with the transfer that shall be an amount of ten percent (10%) of the base costs of the supplies or pharmaceuticals. The Recipient Hospital will pay for all reasonable transportation fees to and from the transfer site. The Recipient Hospital is responsible for appropriate tracking, use and necessary maintenance of all borrowed pharmaceuticals, supplies and equipment during the time such items are in the custody of the Recipient Hospital in accordance with law, and shall be responsible for risk of loss and may insure or self-insure risk of loss with the right of subrogation reserved.
E. REIMBURSEMENT IF ELIGIBLE UNDER THE STAFFORD ACT

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

2. Procedure: All Participating Hospitals agree that they will follow the FEMA procedures that are in effect at the time of a medical disaster that gives rise to reimbursement under the Stafford Act or its successor. At the time of the execution of this MOU the Recipient Hospital has paid the Transferring Hospital for the services of personnel or for the use of equipment, supplies and pharmaceuticals is the hospital that is entitled to apply for reimbursement. Procedures for reimbursement are managed by the emergency management agency of the state in which the Recipient Hospital is located.

F. REIMBURSEMENT IF ELIGIBLE UNDER OTHER MUTUAL AID AGREEMENTS OR LAWS

Participating Hospitals may enter into other mutual aid agreements with governmental or non-governmental agencies including other hospitals and health systems that provide for reimbursement during medical disasters and Participating Hospitals may be eligible for reimbursement under laws other than the Stafford Act that may be in effect at the time of a medical disaster during the effective life of this MOU. In either case, each Participating Hospital agrees to keep the records required to support its own request for reimbursement under any mutual aid agreement or law that provides for reimbursement and when appropriate, to substantiate and support the request for reimbursement of any other Participating Hospital. When a Participating Hospital is reimbursed for part or all of its expenses under another mutual aid agreement or law, it is not entitled to duplicate reimbursement from another Participating Hospital. If a Participating Recipient Hospital receives reimbursement under the Stafford Act and has not reimbursed a Transferring Hospital, the Recipient Hospital will reimburse the Transferring Hospital within sixty (60) days of receiving the Stafford Act funds. Reimbursement under this MOU will not include interest on the reimbursed amounts.

VII. TRANSFER/EVACUATION OF PATIENTS

A. Communication and Documentation

In addition to using 911 and community resources, the request for transfer of patients may be made via MedComm. In making a request to transfer through MedComm, a Transferring Hospital must specify the number of patients needing to be transferred, the general nature of their illness or condition and any specialized services or placement required. The Participating Hospital requesting transfer of one or more of its patients is responsible for providing copies of the patient’s pertinent medical records, registration information and other information necessary for care to the Receiving Hospital to the extent that is practicable in the context of the medical disaster.
B. Transporting Patients
The Participating Hospital requesting transfer of its patients is responsible for triage of patients to be transported and any transfer and transportation costs not otherwise reimbursable by the patient or the patient’s third-party payer incurred for the transportation of its patients. MedComm will coordinate the transportation of patients. The patient-transferring Participating Hospital is responsible for transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if it has them when and if requested to do so by the patient-receiving Participating Hospital.

C. Patient Admission
Once the patient arrives at the patient-receiving Participating Hospital, that hospital will designate the patient’s admitting service, the admitting physician for each patient, and, if requested, the patient’s original attending physician will be eligible for disaster emergency privileges. The procedure for granting disaster emergency privileges to the patient’s original attending physician shall be the procedures established pursuant to Paragraph VI.C.2 of this MOU.

D. Financial and Legal Liability
Upon admission, the patient-receiving Participating Hospital is responsible for liability claims originating from the time the patient is admitted. Reimbursement for care should be negotiated with each hospital’s insurer under the conditions for admissions without pre-certification requirements in the event of emergencies.

E. Notification
The Participating Hospital requesting transfer of a patient is responsible for notifying and, if applicable, obtaining transfer authorization from the patient or the patient’s legal representative, as appropriate, and for notifying the patient’s attending physician of the transfer and re-location of patient as soon as reasonably practical.

VIII. Auxiliary Hospital Locations
An “auxiliary hospital” which is defined as an emergency location designed to collect, triage or treat casualties during an epidemic or a critical incident involving mass casualties may need to be established on an urgent basis. Governmental or non-governmental agencies or one or more Participating Hospitals may assume command and control of such an auxiliary hospital pursuant to plans developed in conjunction with the STARRS Advisory Council or on an ad hoc basis. Other Participating Hospitals may be asked to transfer staff, equipment or supplies to the auxiliary hospital and if so, the processes set forth in Paragraphs VI, above, will be followed.

IX. Media Relations and Release of Information
Each Participating Hospital agrees to participate in a Joint Public Information Center that would be the primary source of information for the media related to a medical disaster affecting more than one Participating Hospital. MedComm will coordinate establishment of the Joint Public
Information Center which will speak on behalf of the affected Participating Hospitals to assure consistent, timely flow of information to the public.

X. **MUTUAL AID STEERING COMMITTEE**

A Mutual Aid Steering Committee (MAST) is hereby established. The purpose of MAST is:

1. to consider and propose such amendments to this MOU as be necessary;
2. to consider and negotiate additional Mutual Aid Agreements that may be established with governmental or non-governmental agencies including other hospitals and health systems that are designed to enhance emergency medical care in a medical disaster;
3. to consider and advise Participating Hospitals on such other issues as are relevant to accomplishing the purposes of this MOU.

Each Participating Hospital may designate one representative to MAST. MAST may establish a structure including officers and an executive committee if it deems such a structure necessary to facilitate its work. MAST will be staffed by STARRS and coordinate its efforts with the appropriate STARRS Advisory Council subcommittees.

No decisions or recommendations made by MAST will be binding on Participating Hospitals unless the Participating Hospitals agree in writing by amendment to this MOU or otherwise to accept the said decision or recommendation.

XL. ** MISCELLANEOUS PROVISIONS**

A. **Term, termination and Automatic Renewal of this Agreement** The term of this MOU is one (1) year commencing on January 1, 2008. Thereafter, for all Participating Hospitals who do not opt out by written notification to STARRS and all other Participating Hospitals, it will automatically renew for consecutive one (1) year terms commencing on January 1 of each year until amended. Any Participating Hospital may terminate its participation in this MOU at any time by providing written notice to STARRS and all other Participating Hospitals not less than thirty (30) days prior to the effective date of such termination. The obligation of any Participating Hospital to reimburse any other Participating Hospital that was incurred under Paragraphs VI or VII of this MOU, if not satisfied, shall survive the termination of this MOU.

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

C. **Insurance** Each Participating Hospital shall maintain or self-insure, at its own expense, professional, worker’s compensation and general liability insurance coverage for itself and its respective employees and, where the Participating Hospital is a Recipient Hospital, agrees to extend its professional and general liability coverage to transferred personnel for claims arising out of services provided by such transferred personnel on behalf of the Recipient Hospital to the extent permitted by law.
D. **Defense and Indemnification** Except as provided in this section for agencies of the State of Missouri, the Recipient Hospital shall assume the defense and indemnification for liability claims arising from or asserting the negligent acts and omissions of transferred personnel who are employed or otherwise covered by the Transferring Hospital. In addition, the Recipient Hospital will be responsible for all expenses related to any injury of transferred personnel, including medical and other reasonable expenses. However, the Recipient Hospital shall not assume the defense and indemnification for liability claims that may arise from a pre-existing defect of transferred equipment, supplies or medications, or the failure to conduct preventive maintenance or to properly repair transferred equipment. Ownership of transferred equipment, supplies or medications shall remain with the Transferring Hospital which shall be responsible for the defense and indemnification of any liability claims that may arise from a pre-existing defect of transferred equipment, supplies or medications, or the failure to conduct preventive maintenance or to properly repair transferred equipment. The Transferring Hospital shall maintain the right to pursue claims against other parties including the manufacturer that may be responsible for any defect in the equipment, supplies or medications. As required by state law, no agency of the State of Missouri including the Missouri Department of Mental Health and any of its facilities agree to save, indemnify, hold harmless, or defend the Transferring Hospital or any third party under this Agreement. Any such provision purporting to impose such responsibilities on any agency of the State of Missouri or any of its facilities is null, void, and of no force or effect. No agency of the State of Missouri including the Missouri Department of Mental Health will be liable for any indirect, special, punitive, incidental or consequential damages arising out of this Agreement.

E. **Hold Harmless** Except as provided in this section for agencies of the State of Missouri, the Recipient Hospital will hold harmless the Transferring Hospital for any general or professional liability claims, expenses, damages including reasonable attorneys’ fees or other costs resulting solely from the acts or omissions of transferred personnel covered by the Recipient Hospital while such transferred personnel are providing services for the Recipient Hospital pursuant to this MOU. As required by state law, no agency of the State of Missouri including the Missouri Department of Mental Health and any of its facilities agree to save, indemnify, hold harmless, or defend the Transferring Hospital or any third party under this Agreement. Any such provision purporting to impose such responsibilities on any agency of the State of Missouri or any of its facilities is null, void, and of no force or effect. No agency of the State of Missouri including the Missouri Department of Mental Health will be liable for any indirect, special, punitive, incidental or consequential damages arising out of this Agreement.

F. **Payment of Fees** All compensation for equipment or supplies provided to the Recipient Hospital pursuant to this MOU will be paid by the Recipient Hospital within ninety (90) days of its receipt of an invoice from the Transferring Hospital for such equipment or supplies.

G. **Amendment** This MOU may be amended in writing signed by all Participating Hospitals.
II. Severability If any of the provisions of this MOU shall be determined to be illegal or unenforceable by a court of competent jurisdiction, those provisions shall be severed from this MOU and the remaining terms of this MOU shall remain in full force and effect.

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

XII. EXECUTION

By the signatures below, the hospital named below hereby agrees that it will participate in the Saint Louis Metropolitan Region in this Hospital Mutual Aid Agreement with all other signatory hospitals effective as of January 1, 2007 under the terms and conditions set forth above.

Participating Hospital

_________ __________________________
Hospital Name                          Signature of Authorized Representative
_________ __________________________
_________ __________________________
_________ __________________________
_________ __________________________
Printed Name of Authorized Representative:
_________ __________________________
Title

Hospital Address/ Contact Information

-9-
The following list of resource maps show the location of regional assets that may be needed to support emergency medical response activities. Please see the supporting geographical information system (GIS) files to print out operational maps.

List of Resource Maps:
- Summary of Regional Resources: Regional Assets
- Decontamination Trailers
- Dispatch Offices
- Emergency Operations Centers (EOCs)
- Fire Rescue Assets
- HazMat Assets
- Mass Casualty Basic Life Support Assets
- Medical Surge Trailers
- Medical Surge Assets
- Mobile Command
- Pediatric Small Surge
- Pediatric Surge Trailers
- Personal Protective Equipment (PPE)
- Special Population Needs
- Regional Mass Casualty – Basic Life Support
Figure F-1
Regional Assets
Figure F-2
Decontamination Trailers
Figure F-4
Emergency Operation Centers

[Map showing emergency operation centers]
Figure F-5
Fire Rescue Assets
Figure F-7
Mass Casualty Basic Life Support Supply Trailers
Figure F-8
Medical Surge Trailers
Figure F-9
Medical Surge Assets
Figure F-12
Pediatric Surge Trailer

- St. John's Mercy Medical Center
- St. Louis
- Barnes-Jewish Hospital
- City of St. Louis
- St. Andrew's Medical Center
- Franklin
- Jefferson
- Monroe
- Washington
- Washington County Memorial Hospital
- St. Francis

Pediatric Surge Trailer
Figure F-13
PPE Trailers
Figure F-14
Special Population Needs Caches of Supplies
Figure F-15
Regional Mass Casualty Basic Life Support Supply Trailers
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMA</td>
<td>Emergency Management Agency</td>
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<tr>
<td>EMAC</td>
<td>Emergency Mutual Aid Compact</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Operations Center</td>
</tr>
<tr>
<td>EOP</td>
<td>Emergency Operations Plan</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>FYI</td>
<td>For Your Information</td>
</tr>
<tr>
<td>HazMat</td>
<td>Hazardous Materials</td>
</tr>
<tr>
<td>HCC</td>
<td>Hospital Command Center</td>
</tr>
<tr>
<td>HICS</td>
<td>Hospital Incident Command System</td>
</tr>
<tr>
<td>HOV</td>
<td>High-Occupancy Vehicle</td>
</tr>
<tr>
<td>ICS</td>
<td>Incident Command System</td>
</tr>
<tr>
<td>ILI</td>
<td>Influenza Like Illness</td>
</tr>
<tr>
<td>LEPC</td>
<td>Local Emergency Planning Committee</td>
</tr>
<tr>
<td>MAA</td>
<td>Mutual Aid Agreement</td>
</tr>
<tr>
<td>MCI</td>
<td>Mass Casualty Incident</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MSDS</td>
<td>Material Safety Data Sheets</td>
</tr>
<tr>
<td>NDMS</td>
<td>National Disaster Medical System</td>
</tr>
<tr>
<td>NIMS</td>
<td>National Incident Management System</td>
</tr>
<tr>
<td>OEM</td>
<td>Office of Emergency Management</td>
</tr>
<tr>
<td>RHCC</td>
<td>Regional Hospital Control Center</td>
</tr>
<tr>
<td>RHCP</td>
<td>Regional Hospital Coordination Plan</td>
</tr>
<tr>
<td>SME</td>
<td>Subject Matter Expert</td>
</tr>
<tr>
<td>SMOC</td>
<td>St. Louis Medical Operations Center</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>SNS</td>
<td>Strategic National Stockpile</td>
</tr>
<tr>
<td>STARRS</td>
<td>St. Louis Area Regional Response System</td>
</tr>
<tr>
<td>UASI</td>
<td>Urban Area Security Initiative</td>
</tr>
</tbody>
</table>
Additional common emergency management terms that are not included in this plan are listed below for educational purposes.

This reference document contains definitions of key terms as they are applied within the National Response Framework as described by the Federal Emergency Management Agency (FEMA).

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accessible:</strong></td>
<td>Having the legally required features and/or qualities that ensure entrance, participation, and usability of places, programs, services, and activities by individuals with a wide variety of disabilities.</td>
</tr>
<tr>
<td><strong>Advanced Readiness Contracting:</strong></td>
<td>A type of contracting that ensures contracts are in place before an incident for commonly needed commodities and services such as ice, water, plastic sheeting, temporary power, and debris removal.</td>
</tr>
<tr>
<td><strong>Agency:</strong></td>
<td>A division of government with a specific function offering a particular kind of assistance. In the Incident Command System, agencies are defined either as jurisdictional (having statutory responsibility for incident management) or as assisting or cooperating (providing resources or other assistance). Governmental organizations are most often in charge of an incident, though in certain circumstances private-sector organizations may be included. Additionally, nongovernmental organizations may be included to provide support.</td>
</tr>
<tr>
<td><strong>Agency Representative:</strong></td>
<td>A person assigned by a primary, assisting, or cooperating Federal, State, tribal, or local government agency or private organization that has been delegated authority to make decisions affecting that agency's or organization's participation in incident management activities following appropriate consultation with the leadership of that agency.</td>
</tr>
<tr>
<td><strong>All-Hazards:</strong></td>
<td>Describing an incident, natural or manmade, that warrants action to protect life, property, environment, and public health or safety, and to minimize disruptions of government, social, or economic activities.</td>
</tr>
<tr>
<td><strong>Annexes:</strong></td>
<td>See Emergency Support Function Annexes, Incident Annexes, and Support Annexes.</td>
</tr>
</tbody>
</table>
### Appendix H

| **Area Command:** | An organization established to oversee the management of multiple incidents that are each being handled by a separate Incident Command System organization or to oversee the management of a very large or evolving incident that has multiple incident management teams engaged. An agency administrator/executive or other public official with jurisdictional responsibility for the incident usually makes the decision to establish an Area Command. An Area Command is activated only if necessary, depending on the complexity of the incident and incident management span-of-control considerations. |
| **Assessment:** | The evaluation and interpretation of measurements and other information to provide a basis for decision-making. |
| **Assignment:** | A task given to a resource to perform within a given operational period that is based on operational objectives defined in the Incident Action Plan. |
| **Attorney General:** | The chief law enforcement officer of the United States. Generally acting through the Federal Bureau of Investigation, the Attorney General has the lead responsibility for criminal investigations of terrorist acts or terrorist threats by individuals or groups inside the United States or directed at U.S. citizens or institutions abroad, as well as for coordinating activities of the other members of the law enforcement community to detect, prevent, and disrupt terrorist attacks against the United States. |
| **Branch:** | The organizational level having functional or geographical responsibility for major aspects of incident operations. A Branch is organizationally situated between the Section Chief and the Division or Group in the Operations Section, and between the Section and Units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area. |
| **Cache:** | A predetermined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use. |
| **Catastrophic Incident:** | Any natural or manmade incident, including terrorism, that results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions. |
| **Chain of Command:** | A series of command, control, executive, or management positions in hierarchical order of authority. |
| **Chief:** | The Incident Command System title for individuals responsible for management of functional Sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence/Investigations (if established as a separate Section). |
| **Chief Elected Official:** | A mayor, city manager, or county manager. |
| **Citizen Corps:** | A community-level program, administered by the Department of Homeland Security, that brings government and private-sector groups together and coordinates the emergency preparedness and response activities of community members. Through its network of community, State, and tribal councils, Citizen Corps increases community preparedness and response capabilities through public education, outreach, training, and volunteer service. |
| **Command:** | The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority. |
| **Command Staff:** | An incident command component that consists of a Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. |
| **Common Operating Picture:** | A continuously updated overview of an incident compiled throughout an incident's life cycle from data shared between integrated systems for communication, information management, and intelligence and information sharing. The common operating picture allows incident managers at all levels to make effective, consistent, and timely decisions. The common operating picture also helps ensure consistency at all levels of incident management across jurisdictions, as well as between various governmental jurisdictions and private-sector and nongovernmental entities that are engaged. |
| **Comprehensive Preparedness Guide (CPG) 101:** | Producing Emergency Plans: |
| **Concept Plan (CONPLAN):** | A plan that describes the concept of operations for integrating and synchronizing Federal capabilities to accomplish critical tasks, and describes how Federal capabilities will be integrated into and support regional, State, and local plans to meet the objectives described in the Strategic Plan. |
**Coordinate:**  To advance systematically an analysis and exchange of information among principals who have or may have a need to know certain information to carry out specific incident management responsibilities.

**Corrective Actions:**  Implementing procedures that are based on lessons learned from actual incidents or from training and exercises.

**Counterterrorism Security Group (CSG):**  An interagency body convened on a regular basis to develop terrorism prevention policy and to coordinate threat response and law enforcement investigations associated with terrorism. This group evaluates various policy issues of interagency importance regarding counterterrorism and makes recommendations to senior levels of the policymaking structure for decision.

**Critical Infrastructure:**  Systems, assets, and networks, whether physical or virtual, so vital to the United States that the incapacity or destruction of such systems and assets would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters.

**Defense Coordinating Officer (DCO):**  Individual who serves as the Department of Defense (DOD)'s single point of contact at the Joint Field Office (JFO) for requesting assistance from DOD. With few exceptions, requests for Defense Support of Civil Authorities originating at the JFO are coordinated with and processed through the DCO. The DCO may have a Defense Coordinating Element consisting of a staff and military liaison officers to facilitate coordination and support to activated Emergency Support Functions.

**Defense Support of Civil Authorities (DSCA):**  Support provided by U.S. military forces (Regular, Reserve, and National Guard), Department of Defense (DOD) civilians, DOD contract personnel, and DOD agency and component assets, in response to requests for assistance from civilian Federal, State, local, and tribal authorities for domestic emergencies, designated law enforcement support, and other domestic activities.

**Demobilization:**  The orderly, safe, and efficient return of a resource to its original location and status.

**DHS:**  Department of Homeland Security

**Director of National Intelligence:**  Official who leads the Intelligence Community, serves as the President's principal intelligence advisor, and oversees and directs the implementation of the National Intelligence Program.
**Disaster Recovery Center (DRC):** A facility established in a centralized location within or near the disaster area at which disaster victims (individuals, families, or businesses) apply for disaster aid.

**Division:** The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A Division is located within the Incident Command System organization between the Branch and resources in the Operations Section.

**DOD:** Department of Defense

**Domestic Readiness Group (DRG):** An interagency body convened on a regular basis to develop and coordinate preparedness, response, and incident management policy. This group evaluates various policy issues of interagency importance regarding domestic preparedness and incident management and makes recommendations to senior levels of the policymaking structure for decision. During an incident, the DRG may be convened by the Department of Homeland Security to evaluate relevant interagency policy issues regarding response and develop recommendations as may be required.

**Emergency:** Any incident, whether natural or manmade, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States.

**Emergency Management:** As subset of incident management, the coordination and integration of all activities necessary to build, sustain, and improve the capability to prepare for, protect against, respond to, recover from, or mitigate against threatened or actual natural disasters, acts of terrorism, or other manmade disasters.

**Emergency Management Assistance Compact (EMAC):** A congressionally ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-affected State can request and receive assistance from other member States quickly and efficiently, resolving two key issues up front: liability and reimbursement.
Emergency Manager: The person who has the day-to-day responsibility for emergency management programs and activities. The role is one of coordinating all aspects of a jurisdiction's mitigation, preparedness, response, and recovery capabilities.

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or some combination thereof.

Emergency Plan: The ongoing plan maintained by various jurisdictional levels for responding to a wide variety of potential hazards.

Emergency Public Information: Information that is disseminated primarily in anticipation of an emergency or during an emergency. In addition to providing situational information to the public, it also frequently provides directive actions required to be taken by the general public.

Emergency Support Function (ESF) Annexes: Present the missions, policies, structures, and responsibilities of Federal agencies for coordinating resource and programmatic support to States, tribes, and other Federal agencies or other jurisdictions and entities when activated to provide coordinated Federal support during an incident.

Emergency Support Function (ESF) Coordinator: The entity with management oversight for that particular ESF. The coordinator has ongoing responsibilities throughout the preparedness, response, and recovery phases of incident management.

Emergency Support Function (ESF) Primary Agency: A Federal agency with significant authorities, roles, resources, or capabilities for a particular function within an ESF. A Federal agency designated as an ESF primary agency serves as a Federal executive agent under the Federal Coordinating Officer (or Federal Resource Coordinator for non-Stafford Act incidents) to accomplish the ESF mission.

Emergency Support Function (ESF) Support Agency: An entity with specific capabilities or resources that support the primary agencies in executing the mission of the ESF.
Emergency Support Functions (ESFs): Used by the Federal Government and many State governments as the primary mechanism at the operational level to organize and provide assistance. ESFs align categories of resources and provide strategic objectives for their use. ESFs utilize standardized resource management concepts such as typing, inventorying, and tracking to facilitate the dispatch, deployment, and recovery of resources before, during, and after an incident.

External Affairs: Organizational element that provides accurate, coordinated, and timely information to affected audiences, including governments, media, the private sector, and the local populace.

Evacuation: Organized, phased, and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas.

Event: See Planned Event.

FBI: Federal Bureau of Investigation

Federal: Of or pertaining to the Federal Government of the United States of America.

Federal Coordinating Officer (FCO): The official appointed by the President to execute Stafford Act authorities, including the commitment of Federal Emergency Management Agency (FEMA) resources and mission assignment of other Federal departments or agencies. In all cases, the FCO represents the FEMA Administrator in the field to discharge all FEMA responsibilities for the response and recovery efforts underway. For Stafford Act events, the FCO is the primary Federal representative with whom the State Coordinating Officer and other State, tribal, and local response officials interface to determine the most urgent needs and set objectives for an effective response in collaboration with the Unified Coordination Group.

Federal-to-Federal Support: Support that may occur when a Federal department or agency responding to an incident under its own jurisdictional authorities requests Department of Homeland Security coordination to obtain additional Federal assistance. As part of Federal-to-Federal support, Federal departments and agencies execute interagency or intra-agency reimbursable agreements, in accordance with the Economy Act or other applicable authorities.
<table>
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<tr>
<th><strong>Federal Resource Coordinator (FRC):</strong></th>
<th>Official who may be designated by the Department of Homeland Security in non-Stafford Act situations when a Federal department or agency acting under its own authority has requested the assistance of the Secretary of Homeland Security to obtain support from other Federal departments and agencies. In these situations, the FRC coordinates support through interagency agreements and memorandums of understanding. The FRC is responsible for coordinating timely delivery of resources to the requesting agency.</th>
</tr>
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<tbody>
<tr>
<td><strong>FEMA:</strong></td>
<td>Federal Emergency Management Agency</td>
</tr>
<tr>
<td><strong>FEMA Regional Offices:</strong></td>
<td>FEMA has 10 regional offices, each headed by a Regional Administrator. The regional field structures are FEMA's permanent presence for communities and States across America.</td>
</tr>
<tr>
<td><strong>Finance/Administration Section:</strong></td>
<td>(1) Incident Command: Section responsible for all administrative and financial considerations surrounding an incident. (2) Joint Field Office (JFO): Section responsible for the financial management, monitoring, and tracking of all Federal costs relating to the incident and the functioning of the JFO while adhering to all Federal laws and regulations.</td>
</tr>
<tr>
<td><strong>Function:</strong></td>
<td>One of the five major activities in the Incident Command System: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved (e.g., the planning function). A sixth function, Intelligence/Investigations, may be established, if required, to meet incident management needs.</td>
</tr>
<tr>
<td><strong>Fusion Center:</strong></td>
<td>Facility that brings together into one central location law enforcement, intelligence, emergency management, public health, and other agencies, as well as private-sector and nongovernmental organizations when appropriate, and that has the capabilities to evaluate and act appropriately on all available information.</td>
</tr>
<tr>
<td><strong>General Staff:</strong></td>
<td>A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief. An Intelligence/Investigations Chief may be established, if required, to meet incident management needs.</td>
</tr>
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</table>
**Governor's Authorized Representative:**
An individual empowered by a Governor to: (1) execute all necessary documents for disaster assistance on behalf of the State, including certification of applications for public assistance; (2) represent the Governor of the impacted State in the Unified Coordination Group, when required; (3) coordinate and supervise the State disaster assistance program to include serving as its grant administrator; and (4) identify, in coordination with the State Coordinating Officer, the State's critical information needs for incorporation into a list of Essential Elements of Information.

**Group:**
Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between Branches and resources in the Operations Section. See Division.

**Hazard:**
Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

**Hazard Identification and Risk Assessment (HIRA):**
A process to identify hazards and associated risk to persons, property, and structures and to improve protection from natural and human-caused hazards. HIRA serves as a foundation for planning, resource management, capability development, public education, and training and exercises.

**Homeland Security Council (HSC):**
Entity that advises the President on national strategic and policy during large-scale incidents. Together with the National Security Council, ensures coordination for all homeland and national security-related activities among executive departments and agencies and promotes effective development and implementation of related policy.

**Homeland Security Exercise and Evaluation Program (HSEEP):**
A capabilities and performance-based exercise program that provides a standardized methodology and terminology for exercise design, development, conduct, evaluation, and improvement planning.

**Homeland Security Information Network (HSIN):**
The primary reporting method (common national network) for the Department of Homeland Security to reach departments, agencies, and operations centers at the Federal, State, local, and private-sector levels. HSIN is a collection of systems and communities of interest designed to facilitate information sharing, collaboration, and warnings.

**HSPD-5:**
| **HSPD-7:** | Homeland Security Presidential Directive 7, "Critical Infrastructure, Identification, Prioritization, and Protection" |
| **HSPD-8:** | Homeland Security Presidential Directive 8, "National Preparedness" |
| **Hurricane Liaison Team (HLT):** | A small team designed to enhance hurricane disaster response by facilitating information exchange between the National Hurricane Center in Miami and other National Oceanic and Atmospheric Administration components, as well as Federal, State, tribal, and local government officials. |
| **Incident:** | An occurrence or event, natural or manmade, that requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response. |
| **Incident Action Plan (IAP):** | An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods. |
| **Incident Annexes:** | Describe the concept of operations to address specific contingency or hazard situations or an element of an incident requiring specialized application of the National Response Framework. |
| **Incident Command:** | Entity responsible for overall management of the incident. Consists of the Incident Commander, either single or unified command, and any assigned supporting staff. |
| **Incident Command Post (ICP):** | The field location where the primary functions are performed. The ICP may be co-located with the incident base or other incident facilities. |
**Incident Command System (ICS):**

A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is a management system designed to enable effective incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

**Incident Commander:**

The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The Incident Commander has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

**Incident Management:**

Refers to how incidents are managed across all homeland security activities, including prevention, protection, and response and recovery.

**Incident Management Assistance Team (IMAT):**

An interagency national- or regional-based team composed of subject-matter experts and incident management professionals from multiple Federal departments and agencies.

**Incident Management Team (IMT):**

An incident command organization made up of the Command and General Staff members and appropriate functional units of an Incident Command System organization. The level of training and experience of the IMT members, coupled with the identified formal response requirements and responsibilities of the IMT, are factors in determining the "type," or level, of IMT. IMTs are generally grouped in five types. Types I and II are national teams, Type III are State or regional, Type IV are discipline- or large jurisdiction-specific, and Type V are ad hoc incident command organizations typically used by smaller jurisdictions.
Appendix H

Incident Objectives: Statements of guidance and direction needed to select appropriate strategy(s) and the tactical direction of resources. Incident objectives are based on realistic expectations of what can be accomplished when all allocated resources have been effectively deployed. Incident objectives must be achievable and measurable, yet flexible enough to allow strategic and tactical alternatives.

Indian Tribes: The United States recognizes Indian tribes as domestic dependent nations under its protection and recognizes the right of Indian tribes to self-government. As such, tribes are responsible for coordinating tribal resources to address actual or potential incidents. When their resources are exhausted, tribal leaders seek assistance from States or even the Federal Government.

Infrastructure Liaison: Individual assigned by the Department of Homeland Security Office of Infrastructure Protection who advises the Unified Coordination Group on regionally or nationally significant infrastructure and key resources issues.

Intelligence/Investigations: Different from operational and situational intelligence gathered and reported by the Planning Section. Intelligence/investigations gathered within the Intelligence/Investigations function is information that either leads to the detection, prevention, apprehension, and prosecution of criminal activities (or the individual(s) involved), including terrorist incidents, or information that leads to determination of the cause of a given incident (regardless of the source) such as public health events or fires with unknown origins.

Interoperability: The ability of emergency management/response personnel to interact and work well together. In the context of technology, interoperability also refers to having an emergency communications system that is the same or is linked to the same system that a jurisdiction uses for non-emergency procedures, and that effectively interfaces with national standards as they are developed. The system should allow the sharing of data with other jurisdictions and levels of government during planning and deployment.

Job Aid: A checklist or other visual aid intended to ensure that specific steps for completing a task or assignment are accomplished.
| **Joint Field Office (JFO):** | The primary Federal incident management field structure. The JFO is a temporary Federal facility that provides a central location for the coordination of Federal, State, tribal, and local governments and private-sector and nongovernmental organizations with primary responsibility for response and recovery. The JFO structure is organized, staffed, and managed in a manner consistent with National Incident Management System principles and is led by the Unified Coordination Group. Although the JFO uses an Incident Command System structure, the JFO does not manage on-scene operations. Instead, the JFO focuses on providing support to on-scene efforts and conducting broader support operations that may extend beyond the incident site. |
| **Joint Information Center (JIC):** | An interagency entity established to coordinate and disseminate information for the public and media concerning an incident. JICs may be established locally, regionally, or nationally depending on the size and magnitude of the incident. |
| **Joint Information System (JIS):** | Mechanism that integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, accurate, accessible, timely, and complete information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; developing, recommending, and executing public information plans and strategies on behalf of the Incident Commander; advising the Incident Commander concerning public affairs issues that could affect a response effort; and controlling rumors and inaccurate information that could undermine public confidence in the emergency response effort. |
| **Joint Operations Center (JOC):** | An interagency command post established by the Federal Bureau of Investigation to manage terrorist threats or incidents and investigative and intelligence activities. The JOC coordinates the necessary local, State, and Federal assets required to support the investigation, and to prepare for, respond to, and resolve the threat or incident. |
Joint Task Force (JTF): Based on the complexity and type of incident, and the anticipated level of Department of Defense (DOD) resource involvement, DOD may elect to designate a JTF to command Federal (Title 10) military activities in support of the incident objectives. If a JTF is established, consistent with operational requirements, its command and control element will be co-located with the senior on-scene leadership at the Joint Field Office (JFO) to ensure coordination and unity of effort. The co-location of the JTF command and control element does not replace the requirement for a Defense Coordinating Officer (DCO)/Defense Coordinating Element as part of the JFO Unified Coordination Staff. The DCO remains the DOD single point of contact in the JFO for requesting assistance from DOD.

Joint Task Force (JTF) Commander: Individual who exercises operational control of Federal military personnel and most defense resources in a Federal response. Some Department of Defense (DOD) entities, such as the U.S. Army Corps of Engineers, may respond under separate established authorities and do not provide support under the operational control of a JTF Commander. Unless federalized, National Guard forces remain under the control of a State Governor. Close coordination between Federal military, other DOD entities, and National Guard forces in a response is critical.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, and local boundary lines) or functional (e.g., law enforcement, public health).

Jurisdictional Agency: The agency having jurisdiction and responsibility for a specific geographical area, or a mandated function.

Key Resources: Any publicly or privately controlled resources essential to the minimal operations of the economy and government.

Liaison Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies or organizations.
**Local Government:** A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under State law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal entity, or in Alaska a Native Village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. See Section 2 (10), Homeland Security Act of 2002, P.L. 107?296, 116 Stat. 2135 (2002).

**Logistics Section:** (1) Incident Command: Section responsible for providing facilities, services, and material support for the incident. (2) Joint Field Office (JFO): Section that coordinates logistics support to include control of and accountability for Federal supplies and equipment; resource ordering; delivery of equipment, supplies, and services to the JFO and other field locations; facility location, setup, space management, building services, and general facility operations; transportation coordination and fleet management services; information and technology systems services; administrative services such as mail management and reproduction; and customer assistance.

**Long-Term Recovery:** A process of recovery that may continue for a number of months or years, depending on the severity and extent of the damage sustained. For example, long-term recovery may include the complete redevelopment of damaged areas.

**Major Disaster:** Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought) or, regardless of cause, any fire, flood, or explosion in any part of the United States that, in the determination of the President, causes damage of sufficient severity and magnitude to warrant major disaster assistance under the Stafford Act to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby.
### Mission Assignment:
The mechanism used to support Federal operations in a Stafford Act major disaster or emergency declaration. It orders immediate, short-term emergency response assistance when an applicable State or local government is overwhelmed by the event and lacks the capability to perform, or contract for, the necessary work. See also Pre-Scripted Mission Assignment.

### Mitigation:
Activities providing a critical foundation in the effort to reduce the loss of life and property from natural and/or manmade disasters by avoiding or lessening the impact of a disaster and providing value to the public by creating safer communities. Mitigation seeks to fix the cycle of disaster damage, reconstruction, and repeated damage. These activities or actions, in most cases, will have a long-term sustained effect.

### Mobile Emergency Response Support (MERS):
Response capability whose primary function is to provide mobile telecommunications capabilities and life, logistics, operational and power generation support required for the on-site management of disaster response activities. MERS support falls into three broad categories: (1) operational support elements; (2) communications equipment and operators; and (3) logistics support.

### Mobilization:
The process and procedures used by all organizations-Federal, State, tribal, and local-for activating, assembling, and transporting all resources that have been requested to respond to or support an incident.

### Multiagency Coordination (MAC) Group:
Typically, administrators/executives, or their appointed representatives, who are authorized to commit agency resources and funds, are brought together and form MAC Groups. MAC Groups may also be known as multiagency committees, emergency management committees, or as otherwise defined by the system. A MAC Group can provide coordinated decision-making and resource allocation among cooperating agencies, and may establish the priorities among incidents, harmonize agency policies, and provide strategic guidance and direction to support incident management activities.
<p>| <strong>Multiagency Coordination System(s) (MACS):</strong> | Multiagency coordination systems provide the architecture to support coordination for incident prioritization, critical resource allocation, communications systems integration, and information coordination. The elements of multiagency coordination systems include facilities, equipment, personnel, procedures, and communications. Two of the most commonly used elements are emergency operations centers and MAC Groups. These systems assist agencies and organizations responding to an incident. |
| <strong>Multijurisdictional Incident:</strong> | An incident requiring action from multiple agencies that each have jurisdiction to manage certain aspects of the incident. In the Incident Command System, these incidents will be managed under Unified Command. |
| <strong>Mutual Aid and Assistance Agreement:</strong> | Written or oral agreement between and among agencies/organizations and/or jurisdictions that provides a mechanism to quickly obtain emergency assistance in the form of personnel, equipment, materials, and other associated services. The primary objective is to facilitate rapid, short-term deployment of emergency support prior to, during, and/or after an incident. |
| <strong>National:</strong> | Of a nationwide character, including the Federal, State, tribal, and local aspects of governance and policy. |
| <strong>National Counterterrorism Center (NCTC):</strong> | The primary Federal organization for integrating and analyzing all intelligence pertaining to terrorism and counterterrorism and for conducting strategic operational planning by integrating all instruments of national power. |
| <strong>National Disaster Medical System (NDMS):</strong> | A federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters. NDMS, under Emergency Support Function #8 - Public Health and Medical Services, supports Federal agencies in the management and coordination of the Federal medical response to major emergencies and federally declared disasters. |
| <strong>National Exercise Program:</strong> | A Department of Homeland Security-coordinated exercise program based upon the National Planning Scenarios contained which are the National Preparedness Guidelines. This program coordinates and, where appropriate, integrates a 5-year homeland security exercise schedule across Federal agencies and incorporates exercises at the State and local levels. |</p>
<table>
<thead>
<tr>
<th><strong>National Incident Management System (NIMS):</strong></th>
<th>System that provides a proactive approach guiding government agencies at all levels, the private sector, and nongovernmental organizations to work seamlessly to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life or property and harm to the environment.</th>
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<tr>
<td><strong>National Infrastructure Coordinating Center (NICC):</strong></td>
<td>As part of the National Operations Center, monitors the Nation's critical infrastructure and key resources on an ongoing basis. During an incident, the NICC provides a coordinating forum to share information across infrastructure and key resources sectors through appropriate information-sharing entities.</td>
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<tr>
<td><strong>National Infrastructure Protection Plan (NIPP):</strong></td>
<td>Plan that provides a coordinated approach to critical infrastructure and key resources protection roles and responsibilities for Federal, State, tribal, local, and private-sector security partners. The NIPP sets national priorities, goals, and requirements for effective distribution of funding and resources that will help ensure that our government, economy, and public services continue in the event of a terrorist attack or other disaster.</td>
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<tr>
<td><strong>National Joint Terrorism Task Force (NJTF):</strong></td>
<td>Entity responsible for enhancing communications, coordination, and cooperation among Federal, State, tribal, and local agencies representing the intelligence, law enforcement, defense, diplomatic, public safety, and homeland security communities by providing a point of fusion for terrorism intelligence and by supporting Joint Terrorism Task Forces throughout the United States.</td>
</tr>
<tr>
<td><strong>National Military Command Center (NMCC):</strong></td>
<td>Facility that serves as the Nation's focal point for continuous monitoring and coordination of worldwide military operations. It directly supports combatant commanders, the Chairman of the Joint Chiefs of Staff, the Secretary of Defense, and the President in the command of U.S. Armed Forces in peacetime contingencies and war. Structured to support the President and Secretary of Defense effectively and efficiently, the NMCC participates in a wide variety of activities, ranging from missile warning and attack assessment to management of peacetime contingencies such as Defense Support of Civil Authorities activities. In conjunction with monitoring the current worldwide situation, the Center alerts the Joint Staff and other national agencies to developing crises and will initially coordinate any military response required.</td>
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### National Operations Center (NOC):
Serves as the primary national hub for situational awareness and operations coordination across the Federal Government for incident management. The NOC provides the Secretary of Homeland Security and other principals with information necessary to make critical national-level incident management decisions.

### National Planning Scenarios:
Planning tools that represent a minimum number of credible scenarios depicting the range of potential terrorist attacks and natural disasters and related impacts facing our Nation. They form a basis for coordinated Federal planning, training, and exercises.

### National Preparedness Guidelines:
Guidance that establishes a vision for national preparedness and provides a systematic approach for prioritizing preparedness efforts across the Nation. These Guidelines focus policy, planning, and investments at all levels of government and the private sector. The Guidelines replace the Interim National Preparedness Goal and integrate recent lessons learned.

### National Preparedness Vision:
Provides a concise statement of the core preparedness goal for the Nation.

### National Response Coordination Center (NRCC):
As a component of the National Operations Center, serves as the Department of Homeland Security/Federal Emergency Management Agency primary operations center responsible for national incident response and recovery as well as national resource coordination. As a 24/7 operations center, the NRCC monitors potential or developing incidents and supports the efforts of regional and field components.

### National Response Framework (NRF):
Guides how the Nation conducts all-hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. And it describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It allows first responders, decision makers, and supporting entities to provide a unified national response.
National Security Council (NSC): Advises the President on national strategic and policy during large-scale incidents. Together with the Homeland Security Council, ensures coordination for all homeland and national security-related activities among executive departments and agencies and promotes effective development and implementation of related policy.

National Urban Search and Rescue (SAR) Response System: Specialized teams that locate, rescue (extricate), and provide initial medical stabilization of victims trapped in confined spaces.

National Voluntary Organizations Active in Disaster (National VOAD): A consortium of more than 30 recognized national organizations active in disaster relief. Their organizations provide capabilities to incident management and response efforts at all levels. During major incidents, National VOAD typically sends representatives to the National Response Coordination Center to represent the voluntary organizations and assist in response coordination.

Nongovernmental Organization (NGO): An entity with an association that is based on interests of its members, individuals, or institutions. It is not created by a government, but it may work cooperatively with government. Such organizations serve a public purpose, not a private benefit. Examples of NGOs include faith-based charity organizations and the American Red Cross. NGOs, including voluntary and faith-based groups, provide relief services to sustain life, reduce physical and emotional distress, and promote the recovery of disaster victims. Often these groups provide specialized services that help individuals with disabilities. NGOs and voluntary organizations play a major role in assisting emergency managers before, during, and after an emergency.

Officer: The ICS title for the personnel responsible for the Command Staff positions of Safety, Liaison, and Public Information.

Operations Section: (1) Incident Command: Responsible for all tactical incident operations and implementation of the Incident Action Plan. In the Incident Command System, it normally includes subordinate Branches, Divisions, and/or Groups. (2) Joint Field Office: Coordinates operational support with on-scene incident management efforts. Branches, divisions, and groups may be added or deleted as required, depending on the nature of the incident. The Operations Section is also responsible for coordinating with other Federal facilities that may be established to support incident management activities.
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<tr>
<th><strong>Operations Plan (OPLAN):</strong></th>
<th>A plan developed by and for each Federal department or agency describing detailed resource, personnel, and asset allocations necessary to support the concept of operations detailed in the Concept Plan.</th>
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<tr>
<td><strong>Other Senior Officials:</strong></td>
<td>Representatives of other Federal departments and agencies; State, tribal, or local governments; and the private sector or nongovernmental organizations who may participate in a Unified Coordination Group.</td>
</tr>
<tr>
<td><strong>Planned Event:</strong></td>
<td>A planned, non-emergency activity (e.g., sporting event, concert, parade, etc.).</td>
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<tr>
<td><strong>Planning Section:</strong></td>
<td>1) Incident Command: Section responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the Incident Action Plan. This Section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident. 2) Joint Field Office: Section that collects, evaluates, disseminates, and uses information regarding the threat or incident and the status of Federal resources. The Planning Section prepares and documents Federal support actions and develops unified action, contingency, long-term, and other plans.</td>
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<tr>
<td><strong>Preparedness:</strong></td>
<td>Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents, and developing jurisdiction-specific plans for delivering capabilities when needed for an incident.</td>
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<td><strong>Pre-Positioned Resources:</strong></td>
<td>Resources moved to an area near the expected incident site in response to anticipated resource needs.</td>
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<td><strong>Pre-Scripted Mission Assignment:</strong></td>
<td>A mechanism used by the Federal Government to facilitate rapid Federal resource response. Pre-scripted mission assignments identify resources or capabilities that Federal departments and agencies, through various Emergency Support Functions (ESFs), are commonly called upon to provide during incident response. Pre-scripted mission assignments allow primary and supporting ESF agencies to organize resources that will be deployed during incident response.</td>
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</table>
Prevention: Actions to avoid an incident or to intervene to stop an incident from occurring. Prevention involves actions to protect lives and property. It involves applying intelligence and other information to a range of activities that may include such countermeasures as deterrence operations; heightened inspections; improved surveillance and security operations; investigations to determine the full nature and source of the threat; public health and agricultural surveillance and testing processes; immunizations, isolation, or quarantine; and, as appropriate, specific law enforcement operations aimed at deterring, preempting, interdicting, or disrupting illegal activity and apprehending potential perpetrators and bringing them to justice.

Primary Agency: See Emergency Support Function (ESF) Primary Agency.

Principal Federal Official (PFO): May be appointed to serve as the Secretary of Homeland Security's primary representative to ensure consistency of Federal support as well as the overall effectiveness of the Federal incident management for catastrophic or unusually complex incidents that require extraordinary coordination.

Private Sector: Organizations and entities that are not part of any governmental structure. The private sector includes for-profit and not-for-profit organizations, formal and informal structures, commerce, and industry.

Protocol: A set of established guidelines for actions (which may be designated by individuals, teams, functions, or capabilities) under various specified conditions.

Public Information: Processes, procedures, and systems for communicating timely, accurate, accessible information on an incident's cause, size, and current situation; resources committed; and other matters of general interest to the public, responders, and additional stakeholders (both directly affected and indirectly affected).

Public Information Officer (PIO): A member of the Command Staff responsible for interfacing with the public and media and/or with other agencies with incident-related information requirements.
| **Recovery:** | The development, coordination, and execution of service- and site-restoration plans; the reconstitution of government operations and services; individual, private-sector, nongovernmental, and public-assistance programs to provide housing and to promote restoration; long-term care and treatment of affected persons; additional measures for social, political, environmental, and economic restoration; evaluation of the incident to identify lessons learned; post incident reporting; and development of initiatives to mitigate the effects of future incidents. |
| **Regional Response Coordination Centers (RRCCs):** | Located in each Federal Emergency Management Agency (FEMA) region, these multiagency agency coordination centers are staffed by Emergency Support Functions in anticipation of a serious incident in the region or immediately following an incident. Operating under the direction of the FEMA Regional Administrator, the RRCCs coordinate Federal regional response efforts and maintain connectivity with State emergency operations centers, State fusion centers, Federal Executive Boards, and other Federal and State operations and coordination centers that have potential to contribute to development of situational awareness. |
| **Resource Management:** | A system for identifying available resources at all jurisdictional levels to enable timely and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management includes mutual aid and assistance agreements; the use of special Federal, State, tribal, and local teams; and resource mobilization protocols. |
| **Resources:** | Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Under the National Incident Management System, resources are described by kind and type and may be used in operational support or supervisory capacities at an incident or at an emergency operations center. |
| **Response:** | Immediate actions to save lives, protect property and the environment, and meet basic human needs. Response also includes the execution of emergency plans and actions to support short-term recovery. |
Appendix H

Secretary of Defense: Responsible for homeland defense and may also authorize Defense Support of Civil Authorities for domestic incidents as directed by the President or when consistent with military readiness operations and appropriate under the circumstances and the law. When Department of Defense military forces are authorized to support the needs of civil authorities, command of those forces remains with the Secretary of Defense.

Secretary of Homeland Security: Serves as the principal Federal official for domestic incident management, which includes coordinating both Federal operations within the United States and Federal resources used in response to or recovery from terrorist attacks, major disasters, or other emergencies. The Secretary of Homeland Security is by Presidential directive and statutory authority also responsible for coordination of Federal resources utilized in the prevention of, preparation for, response to, or recovery from terrorist attacks, major disasters, or other emergencies, excluding law enforcement responsibilities otherwise reserved to the Attorney General.

Secretary of State: Responsible for managing international preparedness, response, and recovery activities relating to domestic incidents and the protection of U.S. citizens and U.S. interests overseas.

Section: The organizational level having responsibility for a major functional area of incident management (e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence/Investigations (if established)).

Senior Federal Law Enforcement Official (SFLEO): An official appointed by the Attorney General during an incident requiring a coordinated Federal response to coordinate all law enforcement, public safety, and security operations with intelligence or investigative law enforcement operations directly related to the incident. The SFLEO is a member of the Unified Coordination Group and, as such, is responsible to ensure that allocation of law enforcement requirements and resource allocations are coordinated as appropriate with all other members of the Group. In the event of a terrorist incident, the SFLEO will normally be a senior Federal Bureau of Investigation official who has coordinating authority over all law enforcement activities related to the incident, both those falling within the Attorney General's explicit authority as recognized in Homeland Security Presidential Directive 5 and those otherwise directly related to the incident itself.
Short-Term Recovery: A process of recovery that is immediate and overlaps with response. It includes such actions as providing essential public health and safety services, restoring interrupted utility and other essential services, reestablishing transportation routes, and providing food and shelter for those displaced by a disaster. Although called "short term," some of these activities may last for weeks.

Situation Report: Document that contains confirmed or verified information and explicit details (who, what, where, and how) relating to an incident.

Situational Awareness: The ability to identify, process, and comprehend the critical elements of information about an incident.

Span of Control: The number of resources for which a supervisor is responsible, usually expressed as the ratio of supervisors to individuals. (Under the National Incident Management System, an appropriate span of control is between 1:3 and 1:7, with optimal being 1:5.)

Special Needs Populations: Populations whose members may have additional needs before, during, and after an incident in functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, and medical care. Individuals in need of additional response assistance may include those who have disabilities; who live in institutionalized settings; who are elderly; who are children; who are from diverse cultures; who have limited English proficiency or are non-English speaking; or who are transportation disadvantaged.

Stafford Act: The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended. This Act describes the programs and processes by which the Federal Government provides disaster and emergency assistance to State and local governments, tribal nations, eligible private nonprofit organizations, and individuals affected by a declared major disaster or emergency. The Stafford Act covers all hazards, including natural disasters and terrorist events.

Staging Area: Any location in which personnel, supplies, and equipment can be temporarily housed or parked while awaiting operational assignment.
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**Standard Operating Procedure (SOP):** Complete reference document or an operations manual that provides the purpose, authorities, duration, and details for the preferred method of performing a single function or a number of interrelated functions in a uniform manner.

**State:** When capitalized, refers to any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and any possession of the United States. See Section 2 (14), Homeland Security Act of 2002, P.L. 107-296, 116 Stat. 2135 (2002).

**State Coordinating Officer (SCO):** The individual appointed by the Governor to coordinate State disaster assistance efforts with those of the Federal Government. The SCO plays a critical role in managing the State response and recovery operations following Stafford Act declarations. The Governor of the affected State appoints the SCO, and lines of authority flow from the Governor to the SCO, following the State's policies and laws.

**State Emergency Management Agency Director:** The official responsible for ensuring that the State is prepared to deal with large-scale emergencies and for coordinating the State response in any incident. This includes supporting local governments as needed or requested and coordinating assistance with other States and/or the Federal Government.

**State Homeland Security Advisor:** Person who serves as counsel to the Governor on homeland security issues and may serve as a liaison between the Governor's office, the State homeland security structure, the Department of Homeland Security, and other organizations both inside and outside of the State.

**Status Report:** Relays information specifically related to the status of resources (e.g., the availability or assignment of resources).

**Strategic Guidance Statement and Strategic Plan:** Documents that together define the broad national strategic objectives; delineate authorities, roles, and responsibilities; determine required capabilities; and develop performance and effectiveness measures essential to prevent, protect against, respond to, and recover from domestic incidents.
Strategic Information and Operations Center (SIOC):
The focal point and operational control center for all Federal intelligence, law enforcement, and investigative law enforcement activities related to domestic terrorist incidents or credible threats, including leading attribution investigations. The SIOC serves as an information clearinghouse to help collect, process, vet, and disseminate information relevant to law enforcement and criminal investigation efforts in a timely manner.

Strategy:
The general plan or direction selected to accomplish incident objectives.

Support Agency:
See Emergency Support Function (ESF) Support Agency.

Support Annexes:
Describe how Federal departments and agencies, the private sector, volunteer organizations, and nongovernmental organizations coordinate and execute the common support processes and administrative tasks required during an incident. The actions described in the Support Annexes are not limited to particular types of events, but are overarching in nature and applicable to nearly every type of incident.

Tactics:
Deploying and directing resources on an incident to accomplish the objectives designated by the strategy.

Target Capabilities List:
Defines specific capabilities that all levels of government should possess in order to respond effectively to incidents.

Task Force:
Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.

Territories:
Under the Stafford Act, U.S. territories are may receive federally coordinated response within the U.S. possessions, including the insular areas, and within the Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI). Stafford Act assistance is available to Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, which are included in the definition of "State" in the Stafford Act. At present, Stafford Act assistance also is available to the FSM and the RMI under the compact of free association.
| **Terrorism:** | As defined under the Homeland Security Act of 2002, any activity that involves an act dangerous to human life or potentially destructive of critical infrastructure or key resources; is a violation of the criminal laws of the United States or of any State or other subdivision of the United States in which it occurs; and is intended to intimidate or coerce the civilian population or influence or affect the conduct of a government by mass destruction, assassination, or kidnapping. See Section 2 (15), Homeland Security Act of 2002, P.L. 107?296, 116 Stat. 2135 (2002). |
| **Threat:** | An indication of possible violence, harm, or danger. |
| **Tribal:** | Referring to any Indian tribe, band, nation, or other organized group or community, including any Alaskan Native Village as defined in or established pursuant to the Alaskan Native Claims Settlement Act (85 Stat. 688) [43 U.S.C.A. and 1601 et seq.], that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. |
| **Tribal Leader:** | Individual responsible for the public safety and welfare of the people of that tribe. |
| **Unified Area Command:** | Command system established when incidents under an Area Command are multijurisdictional. See Area Command. |
| **Unified Command (UC):** | An Incident Command System application used when more than one agency has incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single Incident Action Plan. |
| **Unified Coordination Group:** | Provides leadership within the Joint Field Office. The Unified Coordination Group is comprised of specified senior leaders representing State and Federal interests, and in certain circumstances tribal governments, local jurisdictions, the private sector, or nongovernmental organizations. The Unified Coordination Group typically consists of the Principal Federal Official (if designated), Federal Coordinating Officer, State Coordinating Officer, and senior officials from other entities with primary statutory or jurisdictional responsibility and significant operational responsibility for an aspect of an incident (e.g., the Senior Health Official, Department of Defense representative, or Senior Federal Law Enforcement Official if assigned). Within the Unified Coordination Group, the Federal Coordinating Officer is the primary Federal official responsible for coordinating, integrating, and synchronizing Federal response activities. |
| **Unity of Command:** | Principle of management stating that each individual involved in incident operations will be assigned to only one supervisor. |
| **Universal Task List:** | A menu of unique tasks that link strategies to prevention, protection, response, and recovery tasks for the major events represented by the National Planning Scenarios. It provides a common vocabulary of critical tasks that support development of essential capabilities among organizations at all levels. The List was used to assist in creating the Target Capabilities List. |
| **Urban Search and Rescue (US&R) Task Forces:** | A framework for structuring local emergency services personnel into integrated disaster response task forces. The 28 National US&R Task Forces, complete with the necessary tools, equipment, skills, and techniques, can be deployed by the Federal Emergency Management Agency to assist State and local governments in rescuing victims of structural collapse incidents or to assist in other search and rescue missions. |
| **Volunteer:** | Any individual accepted to perform services by the lead agency (which has authority to accept volunteer services) when the individual performs services without promise, expectation, or receipt of compensation for services performed. See 16 U.S.C. 742f(c) and 29 CFR 553.101. |