Oregon Healthcare Preparedness Region 1
NW Oregon Health Preparedness Organization
Healthcare Coalition Preparedness Plan
2018

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I. Plan Introduction

a. *Purpose of the Plan*

This HCC Preparedness Plan (Plan) describes the organization and processes for the operation of the NW Oregon Health Preparedness Organization (HPO), which serves as the Health Care Coalition (HCC) for Oregon's Healthcare Preparedness Region 1 (HPR1). It also outlines how we prioritize and work collectively to develop and test operational capabilities that promote:

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

b. *Scope of the Plan*

This Plan covers the five-year Hospital Preparedness Program (HPP) life cycle of July 2018- June 2022. It does not supersede the authorities of participating entities. The Plan reflects semi-autonomous operations of Hospitals/Health Systems. Coastal Hospitals will likely execute other operations based on their different risks and resources. We will refer to other documents in these cases.

c. *Administrative Support for the Plan*

Approval of this Plan will occur in May 2018 by consensus of the HPO Steering Committee. HPO membership, with support from HPO staff, will review and revise the content through an annual review process in June of each year of the Cooperative Agreement. The Plan will be updated as necessary after exercises, as well as planned and real world events. This includes gap identification and working with HPO members and external partners to define strategies to address the gaps.

II. Coalition Overview

a. *Introduction/Role/Purpose of Coalition*

The HPO, as a HCC, serves a critical role in developing healthcare delivery system preparedness and response capabilities in the communities served. The HPO utilizes a collaborative approach to ensure an effective healthcare response to a wide range of emergencies. The HPO conducts healthcare preparedness strategic planning, operational planning and response, information sharing, resource coordination, management, and recovery. The HPO supports a multi-agency coordination system that supports and integrates with Emergency Support Function 8 (ESF-8) activities.

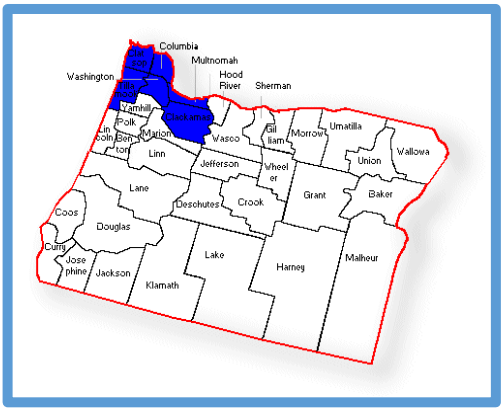
The HPO does not circumvent or usurp the authority of any private or governmental body.

The mission of the HPO is:

Members, both individually and collectively, are prepared for and will respond effectively and efficiently to serious, large-scale health emergencies that have impacts across institutional and jurisdictional lines.

d. Coalition Boundaries

The NW Oregon Health Preparedness Organization (HPO), formed in 2001, serves as the Regional Healthcare Coalition (HCC) for Oregon Healthcare Preparedness Region 1 (HPR1) (see detailed map, Appendix A). HPR1 is comprised of six Oregon counties:



Multnomah - (Portland Urban Area)
Washington - (Portland Urban Area)
Clackamas - (Portland Urban Area)
Columbia - (Portland Urban Area)
Clatsop - (Coastal Area)
Tillamook - (Coastal Area)

e. Coalition Members

The HPO is comprised of voluntary representatives of the healthcare delivery and public health systems from all counties in HPR1. Membership also includes Southwest Washington's *Region IV Healthcare Preparedness Alliance.*
Sectors/programs/organizations that are/may be represented in the membership are:

- Hospitals & Healthcare Systems
- Inpatient Specialty Care Centers (e.g. Oregon Burn Center, Pediatric Hospitals, Trauma Centers)
- County Emergency Management
- County Public Health Authorities
- Emergency Medical Services
- State of Oregon Public Health
- Oregon Association of Hospitals and Health Systems
- Regional Disaster Preparedness Organization (RDPO)
- National Disaster Medical System – Federal Coordinating Center (NDMS-FCC)
- Safety Net Clinics; community and Tribal Health Centers
- Healthcare Support Organizations (e.g. blood banks, pharmacies, laboratories)

- Dialysis Centers
- Skilled Nursing and/or Long Term Care Facilities
- Behavioral Health Services and Entities

f. HPO Organizational Structure

Multnomah County Health Department serves as the Regional Lead Agency for HPR1, and houses a Healthcare Preparedness Liaison and additional staff (as funding allows) that work on behalf of HPR1 and the HPO. The Liaison ensures effective, clear, and timely communication between the healthcare system and the Oregon Health Authority's Health Security, Preparedness and Response program (HSPR). The Liaison serves as a neutral convener, collaborator, and HCC representative in the broader preparedness community.

The Liaison develops, nurtures, and sustains HCC membership. It also has primary responsibility for monitoring and translating HPP federal guidance into succinct language easily understandable by HCC members. The Liaison develops and facilitates strategic planning, as well as ensures program alignment with items outlined in the Performance Measures guidance. The Liaison also facilitates HPO Steering Committee, Coastal Partners, Work Groups and all related coalition meetings. The position serves as the point of contact for all HCC Activities

The HPO Steering Committee is the "heartbeat" of the HCC. It identifies priority preparedness activities, develops regional budgets for use of HPP funds, and promotes effective and coordinated healthcare system preparedness within the region. The HPO utilizes the *2017-2022 Health Care Preparedness and Response Capabilities*, published by ASPR, as a guidance document for the program.

g. *Role of Executives*

HPO Steering Committee members keep their public or private executive leadership advised of HPO activities, identify issues for executive-level input or action, and facilitate planning relationships. Examples of potential executive-level engagement are: preparedness direction on complex issues; major policy questions; distribution of high amounts of resources; and strategic leadership and advocacy with key external high-level decision-makers. Executive leadership identifies and delegates authority to Agency Representatives who serve on the Health/Medical Multi-Agency Coordination Group. Additionally, these executives are signatories on the HPR1 Hospital Memorandum of Understanding (MOU).

h. Meetings

The HPO Steering Committee meets every other month, or a minimum of four times per year. In the spirit of facilitative leadership, members lead 'from their seats' at the table. The Steering Committee charters topic-specific work groups; members identify staff with related expertise from public and private sectors to meet for a limited time to create regional healthcare emergency operations approaches. Those approaches are shared for institutionalization, exercising, and improvement planning.

Coastal partner meetings occur at least four times a year. HPO members in Clatsop and Tillamook Counties provide input on Steering Committee topics, and bring attention to needs unique to coastal planning and response.

i. Decision-Making

The HPO makes strategic decisions by consensus, which brings people together to express their ideas, clarify areas of agreement and disagreement, and develop shared resolutions. It does not mean everyone agrees that a decision is optimal. Rather, it means reaching a decision that everyone can live with; in other words, the decision addresses stakeholders' most important issues.

Consensus exists when each member can say:

- "My personal views and ideas have been really listened to and considered."
- "I have openly listened to and considered the ideas and views of every other group member."
- "I can support this decision and work toward its implementation, even if it was not my choice."

A good faith effort to obtain consensus will occur first before moving to a voting procedure, except in the case of decisions involving the distribution of public funds. For funding decisions, the HPO Steering Committee will always conduct a vote.

j. Voting Procedures

The HPO Steering Committee strives to meet quorum in person/on the phone the day of the meeting. If quorum is not met, HPO staff reach back to missing voting members to complete a vote. A briefing document regarding the item being voted on is sent to all HPO Steering Committee members (voting and non-voting). Votes are cast within 24 hours of the request to vote, in order to be included.

Non-voting members may provide critical input to the discussion. HPO Steering Committee voting membership is described in the table below; this will be reviewed over time and with new membership.

Voting Membership	Vote	Quorum (50% of members +1)	Simple Majority (51% of votes cast)
Legacy	1	8	simple majority will be adjusted based on how many votes are cast
Providence	1		
OHSU	1		
Kaiser Permanente	1		
Adventist	1		
Tuality	1		
VA System	1		
Columbia Memorial	1		
Tillamook Regional MC	1		
Providence Seaside	1		
Vibra	1		
Shriner's	1		
Cedar Hills	1		
Total Votes	**13**		

k. *Relationship to Hospital Preparedness Program (HPP) at the Oregon Health Authority's Health Security, Preparedness, and Response Program (HSPR)*

The Liaison is an active member of the HSPR Program, participating in weekly HSPR meetings, semi-annual work retreats, conferences, and additional topic-specific meetings as requested. The Liaison shares resources and information with HSPR staff, and statewide HPP and Public Health Emergency Preparedness (PHEP) Liaisons. They also collaborate on projects as is appropriate and helpful. During real-time events, the HPR1 Liaison serves in the Oregon Health Authority's (OHA) Agency Operations Center in the Operations Section, Liaison Branch, providing local intelligence and information to OHA leadership on the current state of HPR1. If an event occurs just in HPR1, HPO staff gather and disseminate situation status reports to HSPR as well as regional partners.

l. *Relationship to Regional Disaster Preparedness Organization (RDPO)*

HPR1 counties in the Portland Urban Area affiliate with the RDPO; a regional planning body that supports the Urban Area Securities Initiative (UASI) Program of the U.S. Department of Homeland Security. The HPR1 Liaison represents the HPO on the RDPO Steering Committee. The HPO, in its capacity as the Healthcare System Work Group within the RDPO structure, submits project proposals for potential UASI grant funds that support regional healthcare system projects. An HPO Steering Committee member serves as the representative of the Healthcare System Work Group on the RDPO Program Committee (see RDPO Organizational Chart, Appendix B).

m. *Relationship to National Disaster Medical System's Federal Coordinating Center (NDMS-FCC)*

HPO hospital representatives serve as the strategic planning committee for the NDMS-FCC. The HPO encourages hospitals and health systems to participate in NDMS drills and exercises to ensure their integration as an effective partner in NDMS response. A representative from NDMS is an HPO Steering Committee member, and is kept apprised of HPO activities. The HPR1 Liaison shares NDMS exercise participation opportunities at HPO Steering Committee meetings to support the NDMS-FCC's mission.

n. *Alignment with County Emergency Management Offices & ESF-8*

The HPO has non-formal agreements with Multnomah County & Washington County Emergency Management (CEM) to support regional healthcare emergency operations. This includes resource ordering as well as the development and dissemination of situation status reports. CEM may also support a Regional Health/Medical Multi-Agency Coordination Group that would (depending on the event) prioritize incident activities, make scarce resource allocation decisions, propose altered standards of care, develop policy recommendations, and assure consistent and accurate public information concerning the health emergency. In Oregon, counties are delegated to provide public health functions; therefore, the ESF-8 lead agency role (instead of city governments). Each county maintains awareness of healthcare assets in their jurisdiction and provides support from the county Emergency Coordination Center through resource ordering. Some counties manage this through a dedicated ESF-8 desk in Operations, while others utilize a traditional NIMS/ICS model of integrating ESFs across the entire operation.

o. *Mutual Aid/Hospital MOU*

The HPO maintains a HPR1 Hospital MOU. It is a voluntary agreement among hospital/health system facilities for the purpose of: 1) coordinating emergency planning; 2) preparing for a coordinated health sector response to large-scale emergencies; 3) facilitating communications; and 4) providing mutual aid at the time of a medical disaster.

The MOU defines a medical disaster as an overwhelming incident that exceeds the effective response capability of the impacted hospital/health system facility or facilities. The disaster may be an "external" or "internal" event for hospital/health system facilities and assumes that each affected hospital/health system facility's emergency management plans have been fully implemented.

The Hospital MOU is not a legally binding contract; rather, it signifies the belief and commitment of the participating hospital/health system facilities that in the event of a disaster, the medical needs of the community will be best met if the hospital/health system facilities cooperate with each other and coordinate their response efforts. Each hospital/health system facility that signs it is evidencing its intent to abide by the terms of the MOU in the event of a medical disaster. MOU terms are to be incorporated into the hospital/health system facilities' emergency management plans.

The MOU does not replace individual hospital/health system facilities' disaster plans. Each hospital/health system facility has the responsibility for maintaining its own emergency management plan that includes, at minimum, provisions for the care of patients in an emergency or disaster situation. This also includes: the 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), and compliant with the National Incident Management System (NIMS).

III. Coalition Objectives

a. *Maintenance and Sustainability*

The HPO promotes the value of healthcare and medical readiness by representing the organization at community planning tables (RDPO Program & Steering Committees, Emergency Department/Emergency Medical Services Collaborative, Regional Emergency Managers Technical Group Meetings, Public Health Work Group, etc.). Additionally, we support our partners in reporting the community benefit funds provided in the form of the time spent by our non-federally funded partners on HPO-related meetings.

The HPO advocates for continuation of federal grant programs (UASI & HPP) that support healthcare preparedness by working with RDPO Policy Committee, to inform our Oregon Congressional delegation about legislation that informs our programs. The Committee is comprised of elected officials in the region. The Liaison provides information and status updates on key federal legislation to authorize these programs and the annual appropriations cycle for funding them.

Presenting at conferences, summits, and statewide coalitions, to highlight the HPO's best practices and lessons learned in specialty projects and initatives is key to sharing plans, approaches, and tools we have developed. It also raises the profile of the HPO as a high-functioning, well-established HCC. Past presentation topics included the Health/Medical MAC Group, Pediatric Surge Planning, Hospital Mutual Aid/MOU, Trauma Surge Planning, and Burn Surge Planning, our Ethical Framework, H1N1

Response, and Integrating Coalition Support with Government Response Agencies. In 2009-2010, the Health/Medical MAC System project received a "Model Practice" award by the National Association of City and County Health Officials (NACCHO). More recently, ASPR Tracie featured HPO planning tools and products in their Best Practice Resource Library for other HCCs.

b. *Engagement of Healthcare Executives*

As part of our routine HPO practice, members of the Steering Committee are committed to keeping executives apprised on HPO priorities and projects. Prior to the initiation of any major planning project, work group members develop a strategy to provide an executive engagement session to ensure the project have buy-in throughout the organization.

HPO Healthcare Executive engagement occurs through three distinct ways**:**

1) The Tri-County Public Health Officer conducts on-going, informal discussions on emerging issues/situations in hospital operations. Chief Medical Officers (CMO) and the Tri-County Health Officer are the primary parties involved. They are initiated either by the Health Officer to validate anecdotal information, or by Healthcare CMO(s) to request to compare situational information and challenges in hospital operations across the region.

2) Healthcare Executives delegate authority for decision-making during events. To support this response role, the HPO through our Health/Medical MAC Group, requests that each system administrator completes a formal, signed Delegation of Authority to appoint the role of Agency Representative to the Health/Medical MAC Group. This appointment clearly articulates that the Agency Representative can authorize use of agency resources during regional events.

3) Each year, the HPO conducts a Coalition Surge Exercise, as required by ASPR. One of the requirements is to engage Healthcare Executives in the After Action process. The Tri-County Health Officer sends a letter of support, requesting Healthcare Executives support the exercise. HPO hospital partners agree to brief their Healthcare executive on the AAR outcomes within 30 days of exercise completion.

c. *Engagement of Clinicians*

Clinicians are critical to understanding health/medical emergency response and are invaluable at the HPO planning tables. For every project Work Group chartered, providers, nurses, and other technical experts' participation is incorporated.

The Health/Medical MAC Group relies on clinicians to serve as technical advisors to Public Health Officers in making recommendations on alternative standards of care that will have the least impact on patient care quality and provide the best care for the most good.

d. *Engaging Community Leaders: Elected Officials*

The RDPO Policy Committee fosters a unified regional vision and strategy for building and maintaining disaster preparedness capabilities. The Committee consists of elected leaders from around the region who work to ensure overall accountability for effective regional disaster preparedness coordination and the systems that support it. Meetings of the Policy Committee are open to the public. See the table below for a listing of roles and jurisdictions on the RDPO Policy Committee.

Role of Member	Jurisdictions Represented
Councilor	City of Hillsboro, OR
Councilor	City of Troutdale, OR
Councilor	City of Beaverton, OR
County Commissioner & Chair	Clackamas County, OR
Councilor	City of Gresham, OR
Councilor	City of Fairview, OR
Chief Operating Officer	Port of Portland
Councilor	Metro
Commissioner	Columbia County, OR
Mayor	City of Vancouver, WA
Commissioner	Multnomah County, OR
Safety and Security Executive	TriMet Transportation Agency
Commissioner	Washington County, OR
Councilor	Clark County, WA
Mayor	City of Portland, OR

e. *Engaging Community Leaders: Children, Pregnant Women, Seniors, Individuals with Access and Functional Needs*

HPO staff represent healthcare systems at the RDPO Public Health Work Group. In 2018, the group undertook a project highlighting infant feeding in emergencies and produced guidance, training tools, and field response resources to support responders in determining the best way to support nutritional needs in infants by either breastfeeding or formula feeding, based on resources available and health hazards present after a disaster. In addition, we are leading a Pediatric Surge Planning project with the goal of creating a pediatric surge system built on an understanding of all

hospitals' (pediatric and non-pediatric) and associated organizations' capacities, capabilities, and needs within Oregon's HPR1 counties.

To support those with access and functional disabilities as well as those on life-sustaining durable medical equipment, the HPO and Oregon Health Authority have utilized a combination of EmPower data from CMS and case management data from Human Service's Aging and Disability Program to provide insight into the planning of evacuation efforts that may be more complex. This was demonstrated in the course of response to the Eagle Creek Fire in 2017.

f. Work Plan: HPO Roles and Responsibilities Table

	Preparedness Functions			Response Functions		
Key Stakeholder Groups	Policy & Funding Advocacy	Project Management	Project Advising	Situation Status Reports	Community Care Standards/Scarce Resource Allocation	After Action Reports
HPO Staff		X		X		X
HPO Steering Committee			X	X		X
Executives	X				X	X
Clinicians			X		X	X
RDPO Policy Committee	X		X			
Health/Medical Multi-Agency Coordination Group	X				X	X

IV. Equity Considerations & Regional Demographics

Disasters that disrupt public health and healthcare operations are happening more frequently, necessitating preparedness policies and practices that account for health inequities and build resilience for the community and the healthcare institutions that serve them. The incorporation of health equity into preparedness policies would acknowledge that systemic policies result in disproportionate access to public health services and healthcare, as well as disparities in health outcomes.[1]

[1,2] Louissaint, N. "Building Community Resilience through Health Equity" a Disaster Preparedness.com Article – April 5, 2017 https://www.domesticpreparedness.com/healthcare/building-community-resilience-through-health-equity/

In terms of disaster health care access, gaps in community preparedness and resilience are revealed during a disaster, exacerbating poor health outcomes and health disparities that were already present in the community (e.g., centuries of racism and discrimination).[2]

We highlight the following vulnerable populations as key to effective and equitable whole community planning efforts. Data tables with these demographics are in Appendix C of this document.

- Pediatrics
- Gerontologic (i.e. Seniors)
- Pregnant Women
- Racial and Ethnic Groups
- Various Disability Types
- Non-English Speakers
- People experiencing homelessness
- People experiencing poverty

In light of the data presented, we recognize that people and places are not equally affected by emergencies or hazards. People with more economic, social or political capital are likely to better withstand disaster events and to bounce back more quickly. Structures outside hazard areas and constructed to higher building standards are more resilient[3] to natural hazards. "Looking at our communities through the lens of equity — how people and places are differently situated — increases our understanding of the disproportionate vulnerability[4] to hazards across the community." [5]

Nationally, 55% of the 32.3 million non-elderly uninsured are people of color. People of color face increased barriers to accessing health care compared to whites, and have a lower utilization of care.[6] This statistic, and many others like it, are the result of Oregon's lengthy history of racial discrimination and exclusion. This dates back to the 1840s during the establishment of the Oregon Territory, and continued with Oregon's decisions on slavery and statehood. Harassment and exclusion were also the norm for the Asian community (primarily Chinese & Japanese) settling in Oregon at the same

[3] Resilience is essentially the flip side of vulnerability. It is the ability to "survive, adapt, and grow in the face of stress and shocks, and even transform when conditions require it" (The Rockefeller Foundation, no date).
[4] Vulnerability is the degree to which people, property, resources, systems and cultural, economic, environmental and social activity is subject to harm, degradation or destruction. (PBEM, 2012)
[5] Excerpt from Multnomah County's Natural Hazard Mitigation Plan – Community Profile - Introduction
[6] Kaiser Family Foundation (KFF) – Key Facts on Health and Healthcare by Race & Ethnicity: 6/7/2016
https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/

time. In the 1960s, some Portland restaurants would not serve blacks; they also were not allowed in public accommodations.[7]

In Portland, homelessness is a significant planning challenge for our community. In 2017, Multnomah County had 4,177 people experiencing homelessness, representing 30% of the state's homeless population.[8] People experiencing homelessness have limited resources to evacuate, stockpile food, store medications, and shelter in place. They may also lack access to mainstream modes of emergency notification.[9] The circumstances of homelessness also contribute to high rates of mental illness, addiction, and poor physical health.[10] People without shelter have likely had past exposure to traumatic events. Considering that "About 4,000 people sleep on the streets, in cars, in shelters or in temporary housing each night because they cannot afford a permanent place to live in Multnomah County,[11]" they may be at higher risk of adverse psychological reactions following a disaster.[12]

Encouraging healthcare planners to consider those with Access and Functional Needs (AFN) in all operations is an ongoing element of Coalition work. Historically, AFN work has focused on the disability community, but it is much broader than just one disability type or category. Because health and medical services engage a significant portion of these community members routinely, it is imperative that they also work with those in the community or the people themselves to improve their disaster resiliency. We encourage our Coalition to consider individuals and families who would have difficulty, due to life stage, life place, health condition, or social structures, in accessing and utilizing disaster services in a general population model.

Today, Oregon citizens are working toward a more just and equitable Oregon. This occurs in part by engaging the institutions that serve vulnerable populations in conversations about institutional racism, and offering methods to increase their awareness of and reduce disparities. This includes hospitals and healthcare organizations. The HPO strives to highlight an "Equity and Empowerment Lens"[13] as part of its routine and disaster operations to support social justice and guide how we use information to inform decision-making. This includes engaging, as appropriate, in ethical and equitable processes that are transparent to all.

[7] Brown, DeNeen L. "When Portland banned blacks: Oregon's shameful history as an "all-white" state. Washington Post Articl, 7/7/2017 https://www.washingtonpost.com/news/retropolis/wp/2017/06/07/when-portland-banned-blacks-oregons-shameful-history-as-an-all-white-state/?noredirect=on&utm_term=.60d5a352392e
[8] 2017 Point-in-Time Estimates of Homelessness in Oregon http://www.oregon.gov/ohcs/ISD/RA/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf
[9, 10] Edgington, S. (2009). Disaster Planning for People Experiencing Homeless. National Health Care for the Homeless Council.
[11] Multnomah County and City of Portland's Joint Office on Homeless Services, 2016 Natural Hazards Mitigation Plan 2 Community Profile
[12] (Public Health Emergency, 2013).
[13] Multnomah County: https://multco.us/diversity-equity/equity-and-empowerment-lens

SPECIFIC EFFORTS TO DATE IN SUPPORT OF EQUITY IN HEALTHCARE PREPAREDNESS/RESPONSE
1) Implemented a Culturally Specific Populations Emergency Preparedness Project to improve community health through more effective emergency communications with selected culturally defined communities in Northwest Oregon. Goal: Methods for communicating with culturally specific populations in an emergency will be clearly defined and enhanced, in order to improve the timely distribution of information. As a result, culturally specific populations throughout the region will receive, understand, trust, and be able to act upon the information they receive.
2) Provision of HPP and Urban Area Security Initiative (UASI) funds from 2005-current to the Coalition of Community Health Clinics (CCHC); Health equity is a critical part of the CCHC's mission; the goal is to improve opportunities and services for historically underserved communities to access healthcare, promote health, improve health outcomes, and reduce disparities. Funds provided ensure that these goals can be achieved during an emergency by preparing clinics for natural/human-made disasters. This helps ensure that our region's most vulnerable seniors, people with disabilities, homeless, medically vulnerable and low-income residents receive the best quality care available during an emergency (95% of the CCHC's clinic patients have incomes below 200% of the federal poverty level).
3) Provision of HPP funds from 2005-2014 for Behavioral Health Preparedness Planning: Developed a community-level Behavioral Health Regional Surge Response Plan, and worked effectively with local behavioral health providers and affiliated staff to ensure their capacity to mobilize a behavioral health response to a large-scale emergency in HPR1. Also created a Disaster Behavioral Health Guide, and Family Assistance Center Guide. Provided Disaster Behavioral Health trainings across HPR1.
4) Developed and implemented a Health/Medical Multi-Agency Coordination Group (H/M MACG): Health/medical policy decisions are made by local public health officials at the jurisdictional level. In the event of a large-scale regional health emergency, the Health/Medical Multi-Agency Coordination (MAC) Group is convened when responding to health emergencies involving more than one county. The 2009 H1N1 Influenza event provided an opportunity for broad regional coordination of health/medical efforts between public health officials, area hospitals, community health clinics, emergency management and State officials, in order to ensure efficient and effective response to this pandemic. This multi-agency coordination was a key component in developing policy-level decisions, utilizing ethically based regional strategies related to the allocation/re-allocation of critical resources, and developing/implementing community mitigation approaches to limit transmission of disease in the community.

5) Developed and utilized an Ethical Framework for the Health/Medical Multi-Agency Coordination Group with community input: The framework's four principles provide a foundation for all decisions during the phases of incident response.
    a. Common good: Design the response to protect the health-related wellbeing of the whole population and the continuing functioning of society.
    b. Justice: Design the response to provide a fair distribution of health related benefits and burdens that result from public health activities.
    c. Prudence: Use relevant expert inputs while designing and implementing the public health response.
    d. Respect: Maintain communication and procedures to respect autonomy and dignity.

6) Are currently creating a region-wide Pediatric Surge System built on an understanding of all hospitals' (pediatric and non-pediatric) and associated organizations' capacities, capabilities, and needs. Goal: Establish a coordinated regional approach for the care of pediatric patients and their families during a large-scale health emergency that exhausts local emergency resources in HPR1. This approach will reflect an environment that supports family centered care and evidence-based practices within the limits of the disaster.

V. Risks, Threats, Hazards, & Planning Gaps in HPR1

a) *Defining Risks, Threats and Hazards*

The NW HPO adapted a template to conduct its Hazard Vulnerability Analysis based on an ASPR Tracie "best practice" from the Midlands HCC in South Carolina. This provided a granular scoring system for risks, impacts across multiple sectors, and mitigation and preparedness efforts by each risk. HPR1's top ten risks by Relative Threat Score (53% and above) are:

1) Medical/Pharmaceutical Supply Shortage – 89%
2) Wild Fire – 72%
3) Mass Casualty Incident – 67%
   Water Disruption/Interruption – 67%
   Staffing Shortage/Labor Action – 67%
6) Inclement Weather Event – 64%
7) Communications Disruption (data/internet) – 58%
8) Major HazMat Incident/Release - 56%
9) Communications Disruption (voice/fax) – 53%
   Cyber Terrorism – 53%

The HPO supports two Oregon coastal counties, Clatsop and Tillamook. The three critical access hospitals in these jurisdictions face unique challenges regarding the tsunami threats from a Cascadia Subduction Zone Earthquake.

Additionally, the RDPO conducts a THIRA process that identifies threats and hazards to the Portland Urban Area. To conduct analysis for each emergency capability, a planning scenario of a Cascadia Subduction Zone earthquake is used to project potential outcomes and impacts.

For a complete version of the HPR1 HVA, see Appendix A.
For the health/medical excerpt from the Portland Urban Area THIRA, see Appendix B.
For earthquake shake maps and injury estimates, see Appendix C.
For tsunami inundation maps for coastal hospitals, see Appendix D.

b. Planning Gaps in HPR1

The following HPR gaps have been identified through various sources of information including: Incident After Action Reports, HPO's Strategic Planning Process outcomes (Appendix E), the HCC Regional Hazard Vulnerability Analysis (Appendix A) , the RPDO's THIRA (Appendix B), regional resource inventories, and federal planning guidance.

- **Regional threat-specific plan annexes for the HPO Response Plan.**
  - Using the 10 hazards receiving the highest scores on the HVA, develop specific overviews of each threat and describe potential response for the HCC.
- **Determination of Alternate Care Sites for existing permanent hospital facilities.**
  - Conduct this work in 2020-2021 as part of the HPO 5-year Strategic Plan.
- **Post-earthquake structural assessments of clinics.**
  - Work with health systems and safety net clinics to improve seismic preparedness, including developing Essential Elements of Information for earthquake recovery. Assessments will be a combination of public and private engineers. Focus is on ensuring access and understanding of processes and expectations between building engineers and hospital operations.
- **Pediatric Health/Medical Surge Planning**
  - Continue to advocate for children in disasters; complete the Regional Pediatric Surge System by 2020.
- **Patient Tracking**
  - Delayed due to its complexity, and the need to bring a large number of stakeholders to the table.

VI. Compliance Requirements/Legal Authorities

a. *Emergency Medical Treatment and Labor Act (EMTALA)*
A federal law that requires Medicare-participating hospitals with emergency departments (EDs) to screen and treat emergency medical conditions of patients in a non-discriminatory manner to anyone regardless of their ability to pay, insurance status, national origin, race, creed or color. All Medicare-participating hospitals with dedicated EDs to provide an appropriate medical screening exam (MSE) to determine if the patient has an emergency medical condition (EMC) as defined.

Within its capabilities, the hospital must treat and stabilize an EMC or transfer the individual to a hospital capable of doing so. The risk of a significant surge in demand, because of pandemic, has raised concerns about the ability of hospitals to comply with EMTALA under such extraordinary circumstances. Based on a 2009 CMS memorandum, hospitals may set up alternative screening sites on campus. The MSE must still be conducted by qualified personnel, which may include RNs properly trained and acting within the scope of the State's Nurse Practice Act. Hospitals may also set up screening at off-campus, hospital-controlled sites and encourage the public to utilize them, but they may not tell those who have come to the ED to go off-site for an MSE.

The hospital may hold such an off-campus site as a specialized "influenza-like illness" screening center but not as a place, that provides care for EMCs in general or on an urgent, unscheduled basis. Communities, of course, may set up screening clinics at sites not under hospital control; EMTALA would not apply to such sites. Again, the hospital may encourage the public to utilize such sites, but may not tell those who have already come to its ED to go there.

Hospitals may also seek EMTALA waivers. An EMTALA waiver may permit directing individuals coming to the ED to an alternative off-campus site for the MSE in accordance with a state emergency or pandemic preparedness Plan. Hospitals may also effect transfers normally prohibited under EMTALA, so long as the transfer is necessitated by the circumstances of the declared emergency.

The EMTALA MSE and stabilization requirements can be waived only if:

a) the President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act;
b) the Secretary of HHS has declared a Public Health Emergency;
c) the Secretary invokes waiver authority, and notifies Congress at least 48 hours in advance; and

d) the waiver includes a waiver of EMTALA requirements and the hospital is covered by the waiver. All four are required.[14]

b. *Centers for Medicare & Medicaid Services (CMS)*
At the request of the Governor of an affected State, the President may, under the authority of the *Robert T. Stafford Disaster Relief and Emergency Act*, declare a major disaster or emergency if an event is beyond the combined response capabilities of the State and affected local governments. If a Presidential declaration occurs, the HHS Secretary may, under section 319 of the Public Health Service Act, declare that a Public Health Emergency (PHE) exists in the affected State. Once a PHE is declared, section 1135 of the Social Security Act authorizes the Secretary, among other things, to temporarily modify or waive certain Medicare, Medicaid, CHIP, and HIPAA requirements as determined necessary by CMS.

CMS helps states and U.S. territories to maintain access to care for those with Medicare and Medicaid by supporting the ability of participating hospitals and other healthcare facilities to provide timely care to as many people impacted by an emergency or disaster as possible. CMS will exercise allowable flexibilities and issue waivers as needed to accommodate the needs of those impacted by an emergency or disaster. Specific waivers granted because of the emergency or disaster may be retroactive to the beginning of the emergency or disaster if warranted. CMS also has the authority to exercise certain flexibilities, which are agency policies or procedures that can be adjusted under current authority – and can be adjusted without reprogramming CMS's systems.

Under Section 1135 or 1812(f) of the Social Security Act, CMS can issue several blanket waivers because of a disaster or emergency. These waivers will prevent gaps in access to care for beneficiaries impacted by the emergency. Providers do not need to apply for an individual waiver if a blanket waiver is issued.[15]

Additionally, CMS provides guidance to 17 types of provider types regarding the standards required in emergency preparedness Planning, exercises, and drills to ensure staff and patient safety in disasters and emergencies. The purpose of this is to establish national emergency preparedness requirements

[14] Segments extracted from:
American College of Emergency Physicians Website:
https://www.acep.org/news-media-top-banner/emtala/#sm.00004pmrxilaeqk11p2292g45qtmf
McGuire & Woods Legal Practice:
https://www.mcguirewoods.com/Client-Resources/Alerts/2009/9/EMTALA-in-Disasters.aspx
[15] Segments extracted from
CMS Website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/

to ensure adequate Planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems.[16]

The *Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers* regulation outlines four core elements, which are applicable to all seventeen-provider types, with a degree of variation based on inpatient versus outpatient, long-term care versus non long-term care.

Four Core Elements of Emergency Preparedness[17]

Risk Assessment and Emergency Planning

(Includes but not limited to):

Hazards likely in geographic area
physicians, other necessary persons
Care-related emergencies
Equipment and Power failures
Interruption in Communications, including cyber-attacks
Loss of all/portion of facility
Loss of all/portion of supplies
Plan is to be reviewed and updated at least annually

Communication Plan

Complies with Federal and State Laws
System to contact staff, including patients'
Well-coordinated within the facility, across health care providers, and with state and local public health departments and emergency management agencies.

Policies and Procedures

Complies with federal and state laws

Training and Testing

Complies with federal and state laws
Maintain and at a minimum update annually

c. *The Joint Commission (TJC)*

An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Their mission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. [18]

[16] Segments extracted from CMS Website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/ SurveyCertEmergPrep/Emergency-Prep-Rule.html

[17] Segments extracted from CMS Website:

[18] Extract from: https://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

TJC provides a structure for Healthcare Emergency Management programs in the following settings:

- Ambulatory Surgical Centers
- Home Health Agencies
- Hospices
- Hospitals
- Critical Access Hospitals
- Federally Qualified Health Centers and Rural Health Clinics

If an institution on this list is accredited by TJC, they are by definition compliant with the CMS Emergency Preparedness Rule. However, if an organization is compliant with CMS standards they are not necessarily accredited by The Joint Commission.[19]

d. *National Fire Protection Association (NFPA)*
Establishes criteria for levels of healthcare services or systems based on risk to the patients, staff, or visitors in health care facilities to minimize the hazards of fire, explosion, and electricity.[20]

CMS agencies must be in compliance with the NFPA's 101 Life Safety Code (LSC) and NFPA 99 Health Care Facilities Code (HCFC) requirements. The LSC is a set of Fire Protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The HCFC is a set of requirements intended to provide minimum requirements for the installation, testing, maintenance, performance, and safe practices for facilities, material, equipment and appliances. State Agencies who may subcontract with the State Fire Authority to:

- Survey non-accredited hospitals, hospices, Ambulatory Surgery Centers, Skilled Nursing Facilities, Nursing Facilities, Critical Access Hospitals, Programs for All-Inclusive Care for the Elderly , End Stage Renal Dialysis, and Intermediate Care Facilities for Individuals with Intellectual Disabilities in accordance with schedules the State Authority furnishes;
- Survey accredited hospitals selected for validation surveys or surveyed as a result of a substantial allegation of an unsafe conditions;
- Complete the appropriate Fire Safety Survey Report;

[19] Extract from: http://healthcare.intermedix.com/blog/the-joint-commission-vs.-cms-requirements-whats-the-difference
[20] Extract from: https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=99

- Prepare statements of deficiencies and review Plans of Correction;
- Make recommendations to the SA regarding facilities' compliance with program fire safety requirements; and
- Use only qualified fire safety inspectors who have received CMS training in the performance of these surveys.[21]

e. *Health Insurance Portability and Accountability Act (HIPPA)*

The HIPAA Privacy Rule protects the privacy of patients' health information (protected health information) but is balanced to ensure that appropriate uses and disclosures of the information still may be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes. Health care providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public – consistent with applicable law (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct.

The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, the Secretary of HHS may waive certain provisions of the Privacy Rule under the Project Bioshield Act of 2004 (PL 108-276) and section 1135(b)(7) of the Social Security Act. If the President declares an emergency or disaster and the Secretary declares a public health emergency, the Secretary may waive sanctions and penalties against a covered hospital that does not comply with the following provisions of the HIPAA Privacy Rule:

- The requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care.
- The requirement to honor a request to opt out of the facility directory
- The requirement to distribute a notice of privacy practices.
- The patient's right to request privacy restrictions.
- The patient's right to request confidential communications.

If the Secretary issues such a waiver, it only applies: (1) in the emergency area and for the emergency period identified in the public health emergency declaration; (2) to hospitals that have instituted a disaster protocol; and (3) for up to 72 hours from the time the hospital implements its disaster protocol. When the Presidential or Secretarial declaration terminates, a hospital must then comply with all the requirements of the Privacy Rule for any patient still

[21] Extract from: https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandComplianc/LSC.html

under its care, even if 72 hours has not elapsed since implementation of its disaster protocol.[22]

f. Public Health & Emergency Response Law in Oregon

Public health law examines the authority of the government at various jurisdictional levels to improve the health of the general population within societal limits and norms. Local and state health agencies are the first line of preparedness for infectious disease pandemics and other threats to the health of the public. Their success hinges on many factors, including, their "legal preparedness," that is, their understanding of and capacity to use, laws and legal authorities that support effective response. Those legal authorities are complex and involve laws at the federal, state, local, and Tribal levels. Further, they are found in multiple sectors, including not only the public health sector but also such sectors as emergency management, health care, law enforcement, education, and transportation.[23]

Oregon Administrative Rules – Chapter 333, Division 3: Public Health Preparedness discusses various actions and authorities regarding an "Impending Public Health Crisis".[24]

Oregon Revised Statutes- Title 36: Public Health & Safety; Chapter 431: State and Local Administration and Enforcement of Public Health Laws

Discusses actions, definitions, responsibilities, authorities of the Local Health Officer (431.418).

Oregon Revised Statutes- Title 36: Public Health & Safety, Chapter 433: Disease and Condition Control, Indoor Air

Discusses actions, definitions, responsibilities, and authorities of the local public health authority to use isolation/quarantine measures to protect the public from an individual(s) that are infectious and contagious with a communicable disease. Section 433.441 details "Public Health Emergency" Declaration authorities.[25]

[22] Exerpt from: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/ hipaa-privacy -emergency-situations.pdf.
[23] Excerpt from: http://www.oregon.gov/oha/PH/Preparedness/Partners/Pages/ PublicHealthLawinEmergencies .aspx
[24] For Reference: https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=89
[25] For Reference: https://www.oregonlegislature.gov/bills_laws/ors/ors433.html

Oregon Revised Statutes – Title 32: Military Affairs & Emergency Services; Chapter 401: Emergency Management & Services discusses definitions, responsibilities, actions, and authorities for the State's Emergency Management Structure; including the powers of the Governor during a state of emergency, suspension of agency rules, and additional powers granted during an emergency. Credentialing standards and registration of healthcare providers during an emergency and Provision of healthcare services after a declaration of an emergency. The Governor, if needed in an emergency, can also manage the supply chain for health and medical supplies.[26]

***Oregon's Crisis Standards of Care*:** This framework outlines efficient ways to provide health care in a crisis, when services are overwhelmed. The strategies outlined address two types of public health crises: 1) severe outbreaks of infectious disease, such as pandemic influenza, and 2) mass trauma events, such as a major earthquake. This guidance applies to allocation decisions made at different levels of government, as well as in the non-profit and private sectors. It outlines strategies that help standardize an ethical response but also allowing sufficient flexibility to be adapted to meet the needs of different facilities, communities, or disasters.[27]

VII. Appendices

a. Signed HPO Charter (Commitment to Participate)
b. HPR1 Hazard Vulnerability Analysis
c. Portland Urban Area THIRA
d. Earthquake shake maps and injury projections for Portland Urban Area
e. Tsunami inundation maps for coastal hospitals
f. HPO Strategic Planning Document and Budget
g. Regional & County Estimates for vulnerable and AFN populations in 2017
h. Communications Overview
i. Hospital Capabilities Chart
j. CMS EP Organizations Aggregate count by county by type

[26] For Reference: https://www.oregonlegislature.gov/bills_laws/ors/ors401.html
[27] Excerpt from:
http://www.theoma.org/system/files/Oregon%20Crisis%20Care%20Guidance%20January%202017%20update.pdf

Appendix A
HPO Signed Charter – A Commitment to Participate

Note: *The HPO Charter is a guiding document that we revise routinely to support our coalition's work. It is signed by the regional liaison, representing community consensus on this document.*

NW Oregon Health Preparedness Organization

Public Health
426 SW Stark Street
8th Floor
Portland, OR 97204
503-988-3674
503-988-3676 (fax)

Healthcare Preparedness Region 1 Coalition Charter

Name

The Northwest Oregon Health Preparedness Organization (HPO), formed in 2001, serves as the Regional Healthcare Coalition (HCC) for Oregon Healthcare Preparedness Region 1 (HPR1).

Mission

The HPO members, both individually and collectively, are prepared for and will respond effectively and efficiently to serious, large-scale health emergencies that have impacts across institutional and jurisdictional lines.

Jurisdictional Composition of HPR1

HPR1 is compromised of the following six Oregon counties:

- Multnomah - (Portland Urban Area)
- Washington - (Portland Urban Area)
- Clackamas - (Portland Urban Area)
- Columbia - (Portland Urban Area)
- Clatsop - (Coastal Area)
- Tillamook - (Coastal Area)

Responsibilities

The HPO, as a HCC, serves a critical role in developing healthcare delivery system preparedness and response capabilities in the communities served. The HPO utilizes a collaborative approach to ensure an effective healthcare response to a wide range of emergencies.* The HCC guides healthcare preparedness strategic planning, operational planning and response, information sharing, and resource coordination and management. The HCC supports a multi-agency coordination system that supports and integrates with Emergency Support Function 8 (ESF-8) activities. The HPO is committed to supporting our communities across a spectrum of

planning, response/coordination, and recovery. The HPO does not circumvent or usurp the authority of any private or governmental body.

Membership

The HPO is comprised of voluntary representatives of the healthcare delivery and public health systems from all counties in HPR1. Membership also includes Southwest Washington's *Region IV Healthcare Preparedness Alliance.* Sectors/programs/organizations that are/may be represented in the membership are:

- Hospitals & Healthcare Systems
  - Specialty Referral Centers (e.g. Oregon Burn Center, Pediatric Hospitals, Trauma Centers)
- Emergency Management
- Public Health Authorities
- Emergency Medical Services
- State of Oregon Public Health
- Oregon Association of Hospitals and Health Systems
- Regional Disaster Preparedness Organization (RDPO)
- National Disaster Medical System – Federal Coordinating Center (NDMS-FCC)
- Safety Net Clinics; community and Tribal Health Centers
- Healthcare Support Organizations (e.g. blood banks, pharmacies, laboratories)
- Dialysis Centers
- Skilled Nursing and/or Long Term Care Facilities
- Behavioral Health Services and Entities

Governance

Multnomah County Health Department serves as the Regional Lead Agency for healthcare preparedness in Region 1 and houses a liaison and other staff to the HPO. The HPR1 liaison ensures effective, clear, and timely communication between the healthcare system and the Oregon Health Authority's Health Security, Preparedness and Response program (HSPR). The HPR1 liaison facilitates the HPO Steering Committee meetings, Coastal Partner meetings, and ensures program alignment with items contained in the performance measures for the HPP program, as needed, in cooperation with the HSPR office. The HPO Steering Committee is the "heartbeat" of the HCC; it develops the overall strategic direction for the region's activities, and determines the distribution of funding.

HPO Steering Committee members keep their public or private executive leadership advised of HPO activities, identify issues for CEO input or action, and facilitate planning relationships. Examples of potential engagement are: preparedness direction on complex issues; major policy questions; distribution of high amounts of resources; and strategic leadership and advocacy with key external high-level decision-makers. Executive leadership identifies and delegates authority to Agency Representatives who serve on the Health/Medical Multi-Agency Coordination Group.

Meetings

The HPO Steering Committee meets a minimum of four times per year. In the spirit of facilitative leadership, members lead 'from their seats' at the table.

The Steering Committee charters topic-specific work groups and identifies staff with related expertise from the public and private sectors to meet for a limited time to create regional healthcare emergency operations approaches. These groups determine their meeting schedules depending on the work required.

Coastal partner meetings occur at least four times a year. HPO members in Clatsop and Tillamook Counties provide input on Steering Committee topics, and bring attention to needs unique to coastal planning and response.

Decision Making

The HPO utilizes an ethical decision making framework to ensure its decisions support the common good and justice, reflect prudence, and model respect. The HPO makes decisions using consensus building, which brings people together to express their ideas, clarify areas of agreement and disagreement, and develop shared resolutions. It does not mean everyone agrees that a decision is optimal. Rather, it means reaching a decision that everyone can live with; in other words, the decision addresses stakeholders' most important issues.

Consensus exists when each member can say:

- "My personal views and ideas have been really listened to and considered."
- "I have openly listened to and considered the ideas and views of every other group member."
- "I can support this decision and work toward its implementation, even if it was not my choice."

A good faith effort to obtain consensus will occur first before moving to a voting procedure, except in the case of decisions involving the distribution of public funds. For funding decisions, the HPO Steering Committee will always conduct a vote.

Voting procedures:

- We strive to meet quorum in person/on the phone the day of the meeting.
- If quorum requirement is met, voting members will vote during the meeting.
- If voting requirement is not met during the meeting, HPO staff will reach back to missing voting members to complete a vote. A briefing document regarding the item(s) for vote will be sent to all HPO Steering Committee members (voting and non-voting). Voting members will cast their vote(s) within 24 hours of the request to vote in order to be included.
- All voting will be electronic.
- Non-voting members may provide critical input to the discussion.
- Voting on the annual HPP Regional Distribution Funds will be on the entire proposed package (vs. line-item).
- If there are ‹$5,000 in HPP Regional Distribution Funds available for reallocation, HPO staff are authorized to reallocate the funds without a vote.
- If there are ›$5,000 in HPP Regional Distribution Funds available for reallocation, a briefing document regarding the item(s) for vote will be sent to all HPO Steering Committee members (voting and non-voting). Voting members will cast their vote(s) within 24 hours of the request to vote in order to be included.
- HPO Steering Committee voting membership is described in the table below; this will be reviewed over time and with new membership.

Voting Membership	Vote
Legacy	1
Providence	1
OHSU	1
Kaiser	1
Adventist	1
Tuality	1
VA Hospital	1
Columbia Memorial	1
Tillamook Regional MC	1
Providence Seaside	1
Vibra	1
Shriner's	1
Cedar Hills	1
Total	13

Quorum: 50% of voting members +1 are present. (Currently 7)

Simple Majority: 50% of votes cast

Relationship to Hospital Preparedness Program (HPP)

The HPO Steering Committee identifies priority preparedness activities, develops regional budgets for use of HPP funds and promotes effective and coordinated healthcare system preparedness within the region. The *2017-2022 Health Care Preparedness and Response Capabilities*, published by ASPR** is used as a guidance document for the program.

Relationship to Regional Disaster Preparedness Organization (RDPO)

HPR1 counties in the Portland Urban Area are affiliated with the RDPO; a regional planning body that supports the Urban Area Securities Initiative (UASI) program of the U.S. Department of Homeland Security. The HPR1 liaison represents the HPO on the RDPO Steering Committee. The HPO Steering Committee is a work group within the RDPO structure. The HPO, in its capacity as the Healthcare System Work Group, submits project proposals for potential UASI grant funds.

Relationship to National Disaster Medical System's Federal Coordinating Center (NDMS-FCC)

HPO hospital representatives serve as the strategic planning committee for the NDMS-FCC. The HPO encourages hospitals and health systems to participate in NDMS drills and exercises to ensure their integration as an effective partner in NDMS response. A representative from NDMS is kept apprised of HPO activities; the HPR1 Liaison shares NDMS opportunities at HPO Steering Committee meetings as needed.

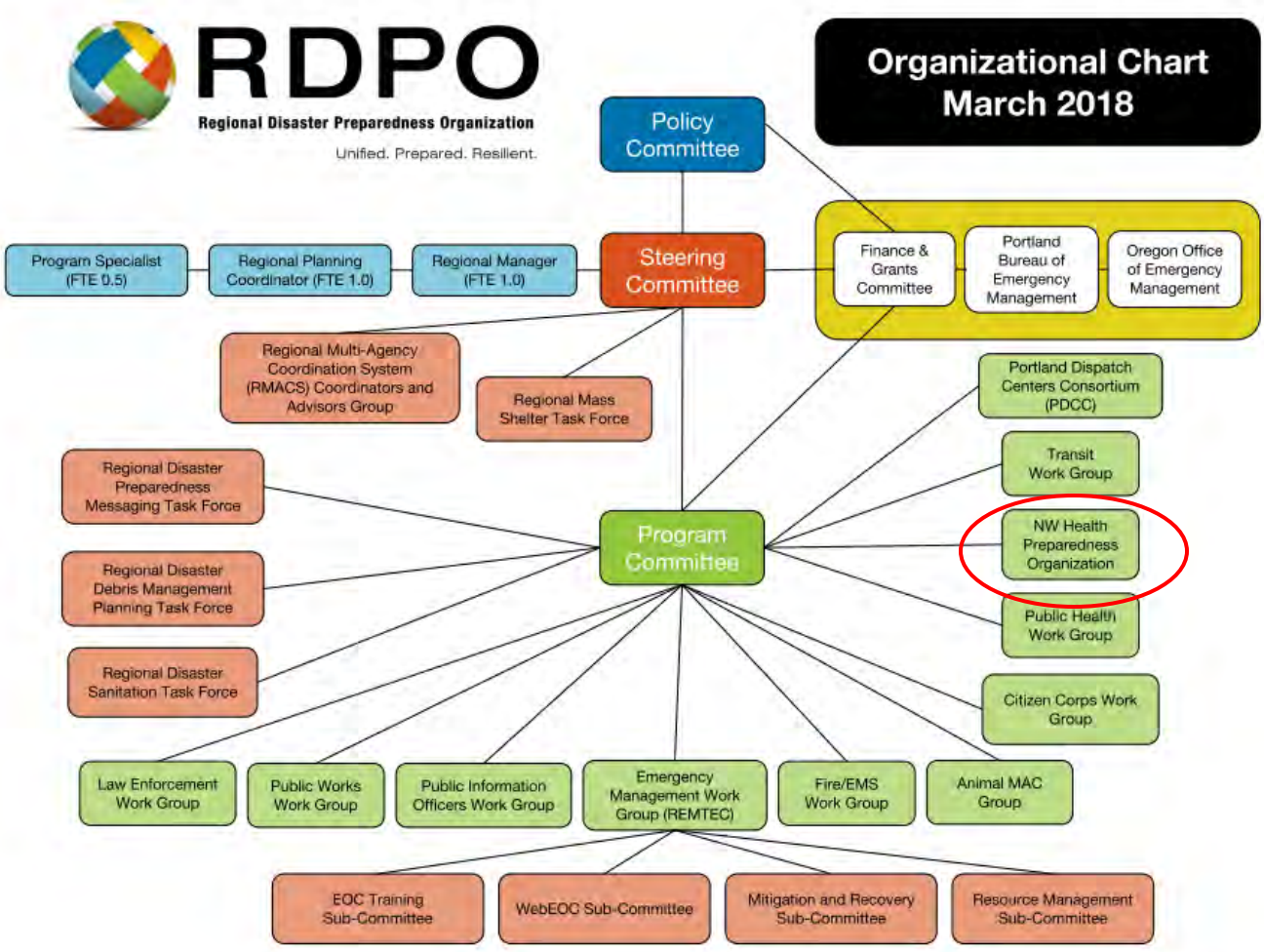
Adoption

I affirm that the HPR1 Healthcare Coalition adopted this Charter on September 25, 2017.

Kathryn Richer

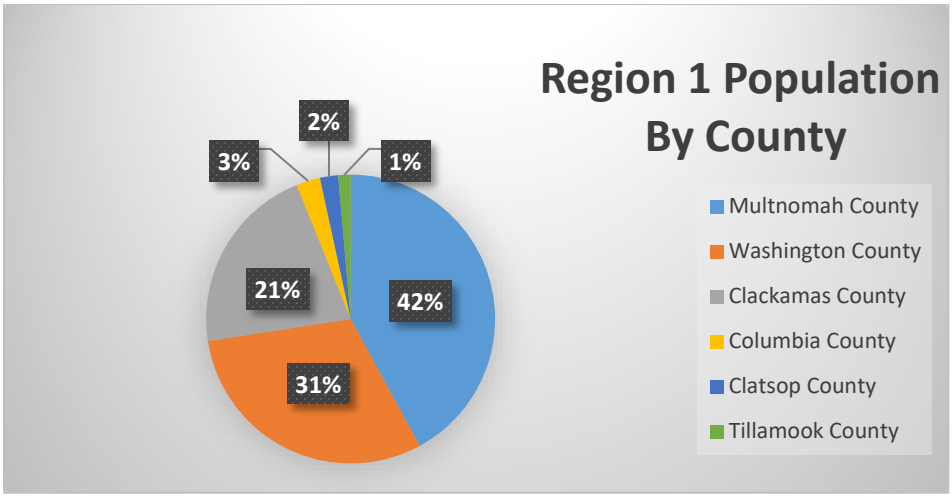
Kathryn Richer, Healthcare Preparedness Region 1 Liaison

Appendix B: RDPO Organization Chart



Appendix C: Vulnerable/Access and Functional Needs Population Estimates

Demographic profile of HPR1 vulnerable populations and those with access and functional needs. Taken from the 5 year population estimates (2012-2016) of the American Community Survey.



Population Totals

Area	Total Population	Percent of state Population	Percent of Regional Population
Oregon	3,982,267	-	-
Region 1	**1,849,835**	**46%**	**-**
Multnomah County	778,193	20%	42%
Washington County	564,088	14%	30%
Clackamas County	394,697	10%	21%
Columbia County	49,645	1.2%	3%
Clatsop County	37,660	1%	2%
Tillamook County	25,552	.6%	1%

Pediatric & Gerontologic Populations by State, Region 1, and Counties			
Area	**Total Population Under 5**	**Total Population 5-14**	**Total Population 62 and Over**
Oregon	230,971 (5.8% of state)	481,854 (12.1% of state)	792,471 (19.9% of state)
Region 1	**110,659 (47% of state under 5)**	**222,271 (46% of state 5-14)**	**312,243 (40% of state 62 and over)**
Multnomah	45,913	84,044	120,620
Washington	37,229	77,280	84,049
Clackamas	21,723	47,791	80,178
Columbia	2,482	6,355	10,972
Clatsop	2,034	4,067	8,963
Tillamook	1,278	2,734	7,461

- Source: American Community Survey 2012-2016 5 year estimates

Racial & Ethnic Populations by State, Region 1, and Counties*							
Area	**Black/ African American**	**Asian**	**Native American/ Alaskan Native**	**Native Hawaiian Pacific Islander**	**White**	**2 or More Races**	**Hispanic /Latino Ethnicity**
Oregon	74,012 (1.9% of state)	160,155 (4% of state)	45,233 (1.1% of state)	14,936 (.4% of state)	3,387,825 (85.1% of state)	175,541 (4.4% of state)	494,806 (12.4% of state)
Region 1							
Multnomah	42,317	53,626	6,142	4,883	608,567	40,617	86,579
Washington	10,288	53,569	3,550	2,329	437,467	27,522	91,495
Clackamas	3,604	16,002	2,895	1,066	351,391	13,271	32,503
Columbia	**	**	**	**	**	**	**
Clatsop	290	422	265	75	34,102	1,723	3,074
Tillamook	87	190	207	105	23,352	756	2,573

- Source: American Community Survey 2012-2016 5- year estimates

* Racial and Ethnicity estimates likely lower than actual as minority populations are under-counted (historically and currently have not had equal voice in institutions, processes, and policy-making and have not been equitably served by programs and services)

** Data unavailable

Access and Functional Needs/Disability by Disability Type by Region 1 and Counties						
Area	**Hearing Difficulty**	**Vision Difficulty**	**Cognitive Difficulty**	**Ambulatory Difficulty**	**Self-Care Difficulty**	**Independent Living Difficulty**
Oregon	185,021	98,874	233,003	281,654	107,531	194,351
Region 1	**66,645 (36% of State with Hearing Difficulty)**	**38,350 (39% of State with Vision Difficulty)**	**94,416 (40% of State with Cognitive Difficulty)**	**106,914 (38% of State with Ambulatory Difficulty)**	**42,864 (39% of State with Self-care Difficulty)**	**79,726 (41% of State with Independent Living Difficulty)**
Multnomah County	27,843	19,026	44,592	47,693	20,047	37,269
Washington County	16,295	10,044	24,034	26,406	10,662	20,147
Clackamas County	16,000	6,469	17,935	22,611	8,641	15,497
Columbia County	2,460	1,025	3,373	4,286	1,484	2,907
Clatsop County	2,381	1,125	2,797	3,492	1,135	2,292
Tillamook County	1,666	661	1,685	2,426	895	1,614

Definitions:

- ***Hearing Difficulty****: Deaf or having serious difficulty hearing*
- ***Vision Difficulty****: Blind or having serious difficulty seeing, even when wearing glasses*
- ***Cognitive Difficulty:*** *Because of a physical, mental or emotional problem, having difficulty remembering, concentrating or making decisions*
- ***Ambulatory Difficulty:*** *Having serious difficulty walking or climbing stairs*
- ***Self-care Difficulty:*** *Having difficulty bathing or dressing*
- ***Independent Living Difficulty:*** *Because of a physical, mental or emotional problem, having difficulty doing errands alone such as visiting a doctor's office or shopping*

Source:

- Source: American Community Survey 2012-2016 5 year estimates

Limited English Speaking Households				
Area	**Spanish- Speaking Households**	**Other Indo-European Languages**	**Asian and Pacific Island Languages**	**Other Languages**
Oregon	23,296	5,320	11,227	1,660
Region 1	10,783 (46% of State)	4,111 (77% of State)	8,745 (77% of State)	1,413 (85% of State)
Multnomah County	4,504	2,205	4,909	960
Washington County	4,495	1,206	2,985	298
Clackamas County	1,556	693	775	124
Columbia County	38	4	20	0
Clatsop County	175	0	56	31
Tillamook County	15	3	0	0

- Source: American Community Survey, 2012-2016 5-Year Estimates
- Definition of Limited English Speaking Household: no member 14 years or older:
  - Speaks a non- English language and speaks English "very well"
  - In other words, all members 14 years old and over have at least some difficulty with English. Previously named "linguistically isolated."

Pregnancy Estimates	
Area	**Estimated Number of Pregnant Women**
Region 1	**16,956**
Multnomah County	7,284
Washington County	5,546
Clackamas County	3,221
Columbia County	411
Clatsop County	303
Tillamook County	191

- Source: https://www.cdc.gov/reproductivehealth/emergency/pdfs/pregnacyestimatobrochure508.pdf

2017 Point-in-Time Homeless Count Figures	
Area	**Estimated Number of People Experiencing Homeless**
Oregon	13,953
Region 1	**6,287 (45% of the state's homeless population)**
Multnomah	4,177 (30% of the state's homeless population)
Washington	544
Clackamas	497
Columbia	158
Clatsop	680
Tillamook	231
➢ Source: http://www.oregon.gov/ohcs/ISD/RA/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf	

Poverty Estimates: Income Levels in Last 12 Months		
Area	# of Persons Below FPL	% of population Below FPL
Oregon	536,146	13.3% of state population
Region 1+ Lincoln	**259,461**	**48% of state poverty level**
Multnomah	113,489	14% of county population
Clackamas	35,647	8.8% of county population
Washington	52,590	9.1% of county population
Columbia, Lincoln, Clatsop, Tillamook Counties	22,246	13.8% of combined counties
➢ Source: American Community Survey 2016, 1- year estimates. Note: Lincoln County is included in this table as the data was unable to be separated out by individual counties.		

Appendix D: HPR1 Hazard Vulnerability Analysis

NW Oregon HPO HVA 2018

	Event	Probability	Severity = Magnitude + Mitigation						Severity	Risk (severity x probability)/54
			Magnitude (negative consequences of event)			Mitigation				
			Human Impact	Property Impact	Business Impact	Regional Preparedness	Internal Resources	Regional Resources		
		Likelihood this will occur	Produces # of patient surge	Response Costs and Damages	Disrupts Normal Ops for # Days	Pre-Planning	Level of Facility-Level Resources to Respond	Level of Regional-Level Resources	Relative Impact if this event occurs	Relative Threat
	Score	0= None .5= Minimal 1= Low 2= Moderate 3=High	0= None .5= <20 1= Btw. 20-50 2= Btw. 50-100 3= >100	0 = $0 1= $1K-$100K 2= $100K-$500K 3= >$500K	0 = not likely 1= up to 24 hours 2= 2-3 days 3= >3 days	0 = n/a 1= High 2= Moderate 3= Low	0 = n/a 1= Sufficient 2= Moderate 3= Minimal	0 = n/a 1= Sufficient 2= Moderate 3= Minimal	6 to 18	1-100
Natural Events	Earthquake - 5.0 and over	1	3	3	3	3	3	3	18	33%
	Tsunami	0.5	3	1	1	3	3	1	12	11%
	Flood with potential disruption/harm	0.5	2	1	1	3	3	2	12	11%
	Infectious Disease Pandemic	1	3	1	3	3	3	3	16	30%
	Wild Fire	3	1	3	3	3	2	1	13	72%
	Inclement Weather Event (e.g., heat wave, severe thunderstorm, tornado, high wind event, ice storm, snow)	3	0.5	1	3	3	2	2	11.5	64%
	Volcanic Eruption	0.5	3	3	3	3	3	1	16	15%
	Air Quality/Pollution	3	1	1	0	3	2	1	8	44%
MCI & Human-Made Events	Active Shooter incident	3	1	1	1	3	2	1	9	50%
	Attack Biological Weapons	0.5	3	1	3	3	3	2	15	14%
	Attack with Chemical Weapons	0.5	3	1	3	3	3	2	15	14%
	Mass Casualty Incident	3	3	1	1	3	3	1	12	67%
	Major HazMat Incident/Release	2	3	1	3	3	3	2	15	56%
	MCI from explosives involving radiation materials	0.5	3	3	3	3	3	3	18	17%
	Mental Health Type Incident: Increase in mental health patients in hospital Eds	3	1	0	0	3	3	2	9	50%
	Nuclear Event	0.5	3	3	3	3	3	3	18	17%
	Regional Civil Disturbance	2	1	0	1	3	2	1	8	30%
	Planned Mass Gathering	3	0.5	0	1	3	2	1	7.5	42%
	VBIED or IED	0.5	2	2	1	3	3	2	13	12%
Facility & Technical Events	Cyber Terrorism	3	0.5	1	1	3	2	2	9.5	53%
	Fuel Shortage	0.5	2	2	3	3	2	2	14	13%
	Massive Transportation Disruption/Failure	0.5	0.5	0	3	3	2	2	10.5	10%
	Communications Disruption -Data/Internet	3	0.5	1	1	3	2	3	10.5	58%
	Communications Disruption- Voice/Fax	3	0.5	1	1	3	2	2	9.5	53%
	Electrical Failure/Blackout	0.5	3	3	3	3	3	2	17	16%
	Natural Gas Disruption	0.5	2	2	3	3	2	2	14	13%
	Sewer/Water Treatment Failure	0.5	2	2	2	3	2	2	13	12%
	Water Disruption/Interruption	3	2	2	1	3	2	2	12	67%
	Medical/Pharmaceutical Supply Shortage	3	3	2	3	3	2	3	16	89%
	Staffing Shortage/Labor Action	3	1	2	2	3	2	2	12	67%

HVA Key

Probability for Naturally Occuring or Facility/Technological
0= Event has never occurred in region
.5= Event has occurred at some point in the region
1= Event has occurred in the region in the last 10 years
2= Event has occurred in the region within the last 5 years
3= Event has occurred in the region within the last 12 months

Probability for Mandmade or MCI
.5= Event has occurred somewhere on globe
1= Event has occurred in the region or a similar region within 5-10 years
2= Event has occurred in the region or a similar region within the last 5 years
3= Event has occurred in the region or similar region within 12 months

Magnitude

Human Impact
0= Event is likely to produce no patient surge
.5= Event is likely to produce patient surge less than 20
1= Event is likely to produce patient surge between 20-50
2= Event is likely to produce patient surge between 50-100
3= Event is likely to produce patient surge over 100

Property Impact
0= Event is likely to produce no negligable response costs
1= Event is likely to produce damages or additional response costs between $1- $100K
2= Event is likely to produce damages or additional response costs between $100K - $500K
3= Event is likely to produce damages or additional response costs in excess of $500K

Business Impact
0= Event is not likely to create any disruption of normal operations at facilities within region
1= Event is likely to disrupt normal operations at facilities within region for up to 24 hrs.
2= Event is likely to disrupt normal operations at facilities within region for 2-3 days.
3= Event is likely to disrupt normal operations at facilities within region for more than 3 days.

Mitigation

Regional Preparedness
0= Not Applicable
3= Event is covered by regional all-hazards plan but has no functional annex and has not been exercised.
2= Event is covered by regional all-hazards plan and has been exercised at least once.
1= Event has a functional annex or has been exercised in the last 12 months.

Internal Resources
0= Not Applicable
3= Minimal resources exist at the facility level to respond to this event
2= Moderate resources exist at the facility level to respond to this event
1= Sufficient resources exist at the facility level to respond to this event

Regional Resources
0= Not Applicable
3= Minimal reosurces exist at the regional level to respond to this event
2= Moderate resources exist at the regional level to respond to this event
1= Sufficient resources exist at the regional level to respond to this event

Appendix E: Portland Urban Area THIRA Hazards/Threats and Public Health/Medical Outcomes

Hazard Type	Hazard	Probability	Vulnerability
Natural	Animal Disease	Medium	Medium
	Drought	Medium	Medium
	Flood	High	Medium
	Invasive Species	Medium	Medium
	Pandemic - Human*	Medium	Medium
	Severe Storm / High Winds	High	Medium
	Sinkhole / Landslide / Expansive Soils	Medium	Medium
	Tornado	Low	Medium
	Tsunami	Low	Medium
	Volcanic Eruption	Low	Low
	Wildfire	High	Low
	Winter Storm / Ice Storm	High	Medium
Technological	Dam Failure	Low	Medium
	Levee Failure	Medium	Medium
	Fuel Shortage	Medium	High
	Hazmat Release – Chemical	Medium	Medium
	Hazmat Release - Radiological	Low	Medium
	Transportation Accident (major regional impact, e.g. airport or highway damaged)	Medium	High
	Urban Conflagration	Low	Low
	Utility Interruption	Medium	High
	Water Contamination	Medium	Medium
Human Caused	Active Shooter	Medium	Medium
	Biological Attack	Low	Medium
	Civil Disturbance	Medium	Medium
	Food/Water Contamination*	Medium	High

Note: * Hazard was included in the PUA 2012 THIRA but removed in 2014 pending further refinement

Note: This rank order was compiled based on a City, County, and State Hazard Mitigation Plans, the FEMA Region 10 2014 THIRA, and with input from regional mitigation planners.

Note: Probability estimates are based on the frequency of previous events of a regional scale, and vulnerability estimates are based on potential regional impacts of the hazard or threat. Probability scores address the likelihood of future impact within a specific period of time as follows: High = One incident likely within a 10-35 year period; Medium = One incident likely within a 35-75 year period; Low = One incident likely within a 75-100 year period. Vulnerability scores address the percentage of population or regional assets likely to be as follows: High = More than 10% affected; Medium = 1-10% affected; Low = Less than 1% affected. This methodology mirrors the Risk Assessment methodology applied in the 2015 State of Oregon Natural Hazard Mitigation Plan.

Public Health and Medical Services Core Capability

Desired Outcomes and Impacts

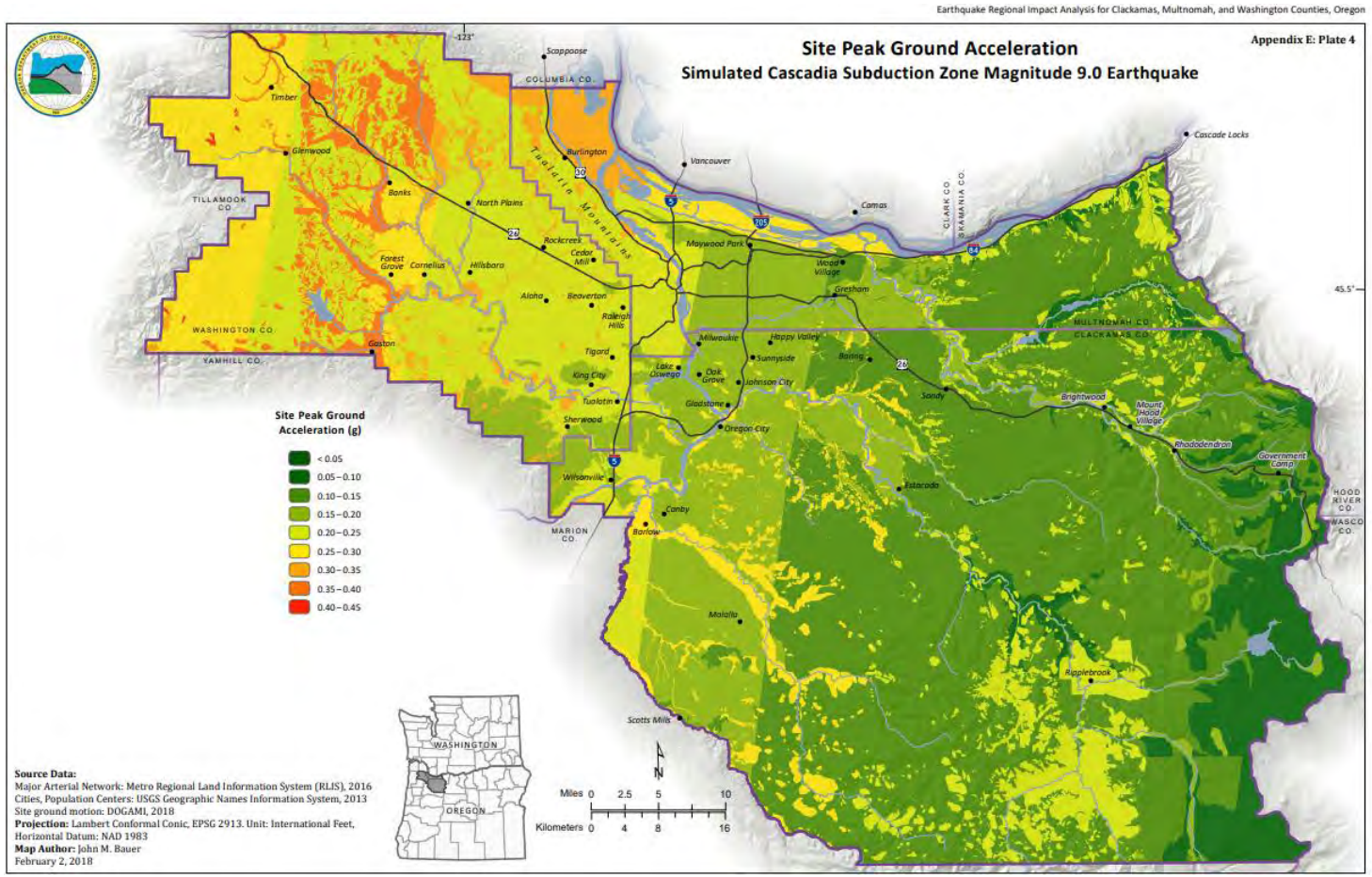
Threat/Hazard	Desired Outcomes	Impacts
Earthquake	Public health and medical assistance support to include patient collection and reception areas, field hospitals, acute and non-acute care, and medical evacuations are efficiently organized and employed to save lives and reduce the suffering of disaster survivors requiring professional medical care, psychiatric support, elder support services, and other services.	Medical/health care services for 4,300 existing hospital patients[xliv]; estimated 5,000 long-term care patients and 23,600 injured disaster survivors (3,000 of whom need to be hospitalized-including 1,000 children[xlv]; an additional 600 need critical care- including 200 children). Hospital facilities experience up to 50% damage, drastically reducing capacity; 25% reduction in health/medical personnel further reduces capacity. In total, more than 5,790[xlvi] people need inpatient beds where none are available due to hospital damages and staff losses from the emergency; in addition, more than 1,000[xlvii] people need critical care where no ICU beds capacity exists post- earthquake. 8,000 medical patients from hospitals and nursing homes need to be evacuated outside the region (and / or supplies, equipment, and services need to be imported), including those needing critical care and those requiring ongoing life-sustaining / maintaining medical care (e.g., dialysis patients, oxygen dependent, pharmaceutical dependent, etc).

Capability Targets

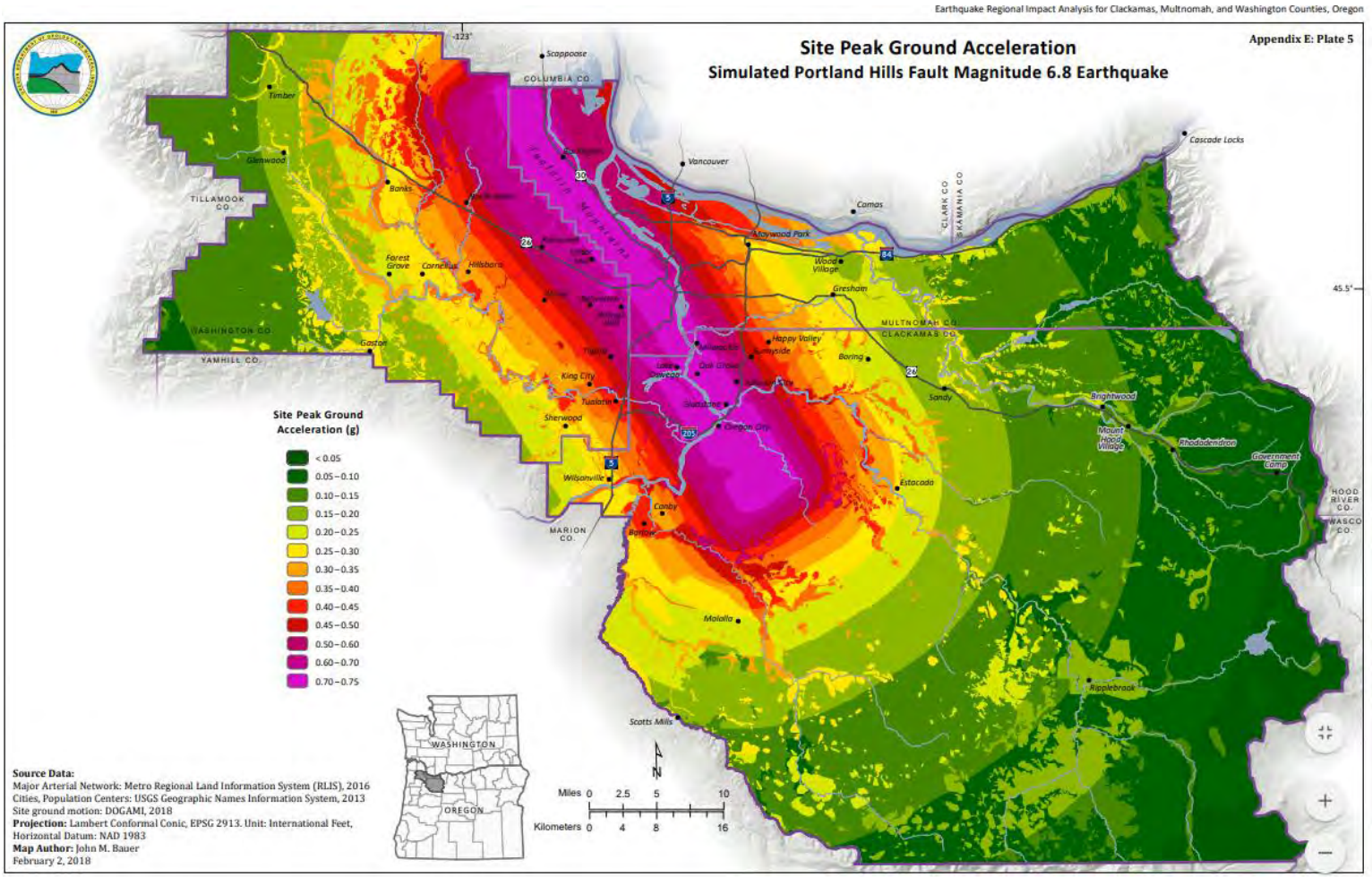
- Within the first 96 hours, onsite staff and personnel establish status of medical facilities as "under evacuation", or implement revised standards of care.
- Within the first 96 hours and continuing, in coordination with ESF 8 partners, provide medical assistance, including appropriate patient tracking, for all patient collection and reception areas, field hospitals, acute and non-acute care, and medical evacuations to save lives and reduce the suffering of approximately 4,300 existing hospital patients, estimated 5,000 long-term care patients and 23,600 injured disaster survivors. Among these, 3,000 need hospitalization; an additional 600 need critical care; and 17,300 people in assisted living and adult care homes.
- Within 14 days of the incident, evacuate 8,000 medical patients from hospitals and nursing homes to areas outside the impacted area. Among them are those needing critical care and those requiring ongoing lifesaving medical care (e.g., dialysis patients, oxygen dependent, et al). Ensure 6,000 patients remaining in the region receive acute medical services. Provide public health services to include food inspection, elder care, and water testing for several hundred communities across the metropolitan region.

Appendix F: DOGAMI Earthquake Shaking Maps

Peak Ground Acceleration Cascadia Subduction Zone Magnitude 9.0 Earthquake Map (Shaking Strength) for Tri-County Area

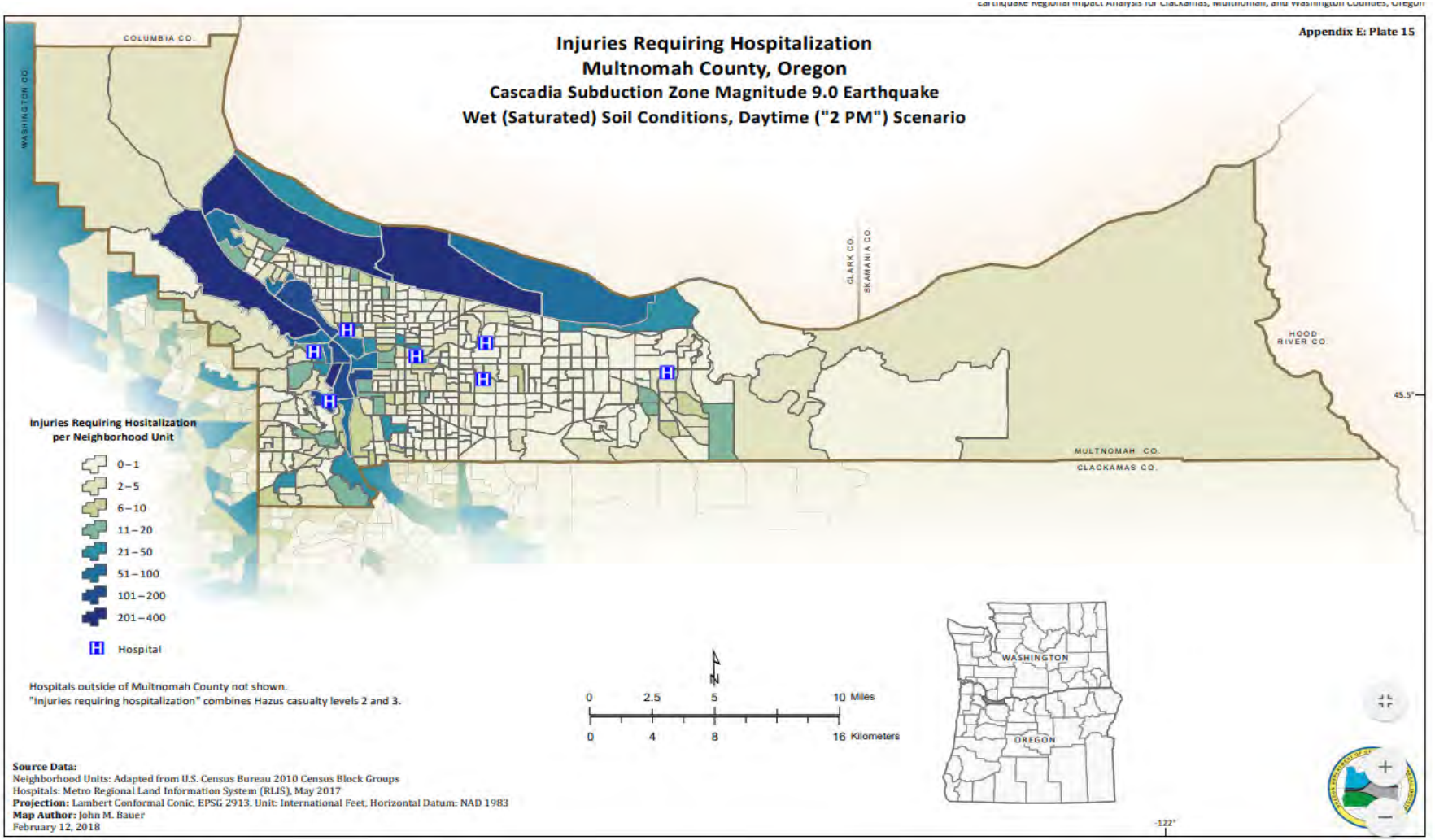


DOGAMI Peak Ground Acceleration Portland Hills Fault Magnitude 6.8 Earthquake Map (Shaking Strength) for Tri-County Area

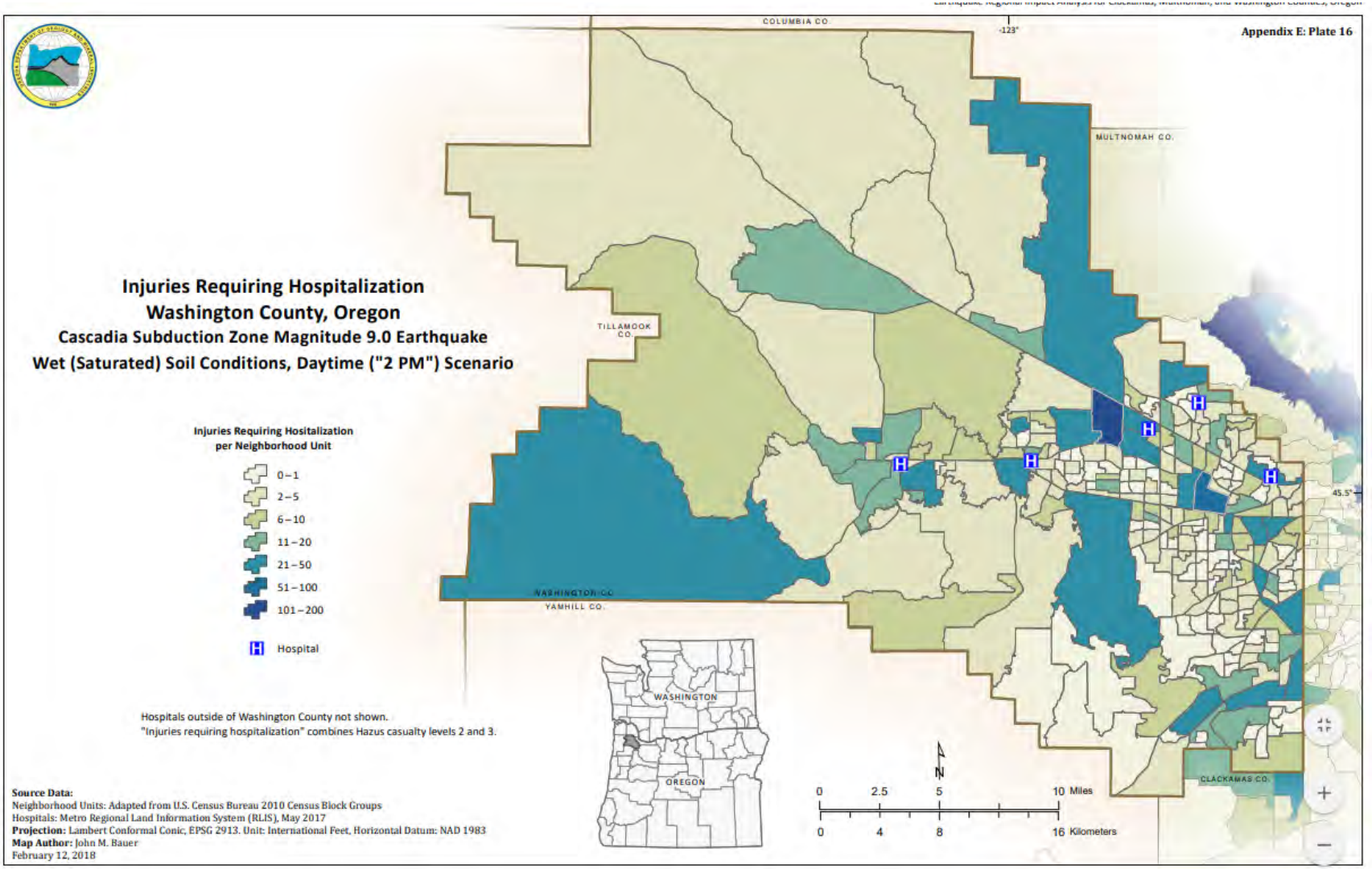


DOGAMI Earthquake Map- Injuries requiring hospitalization Tri-County Maps

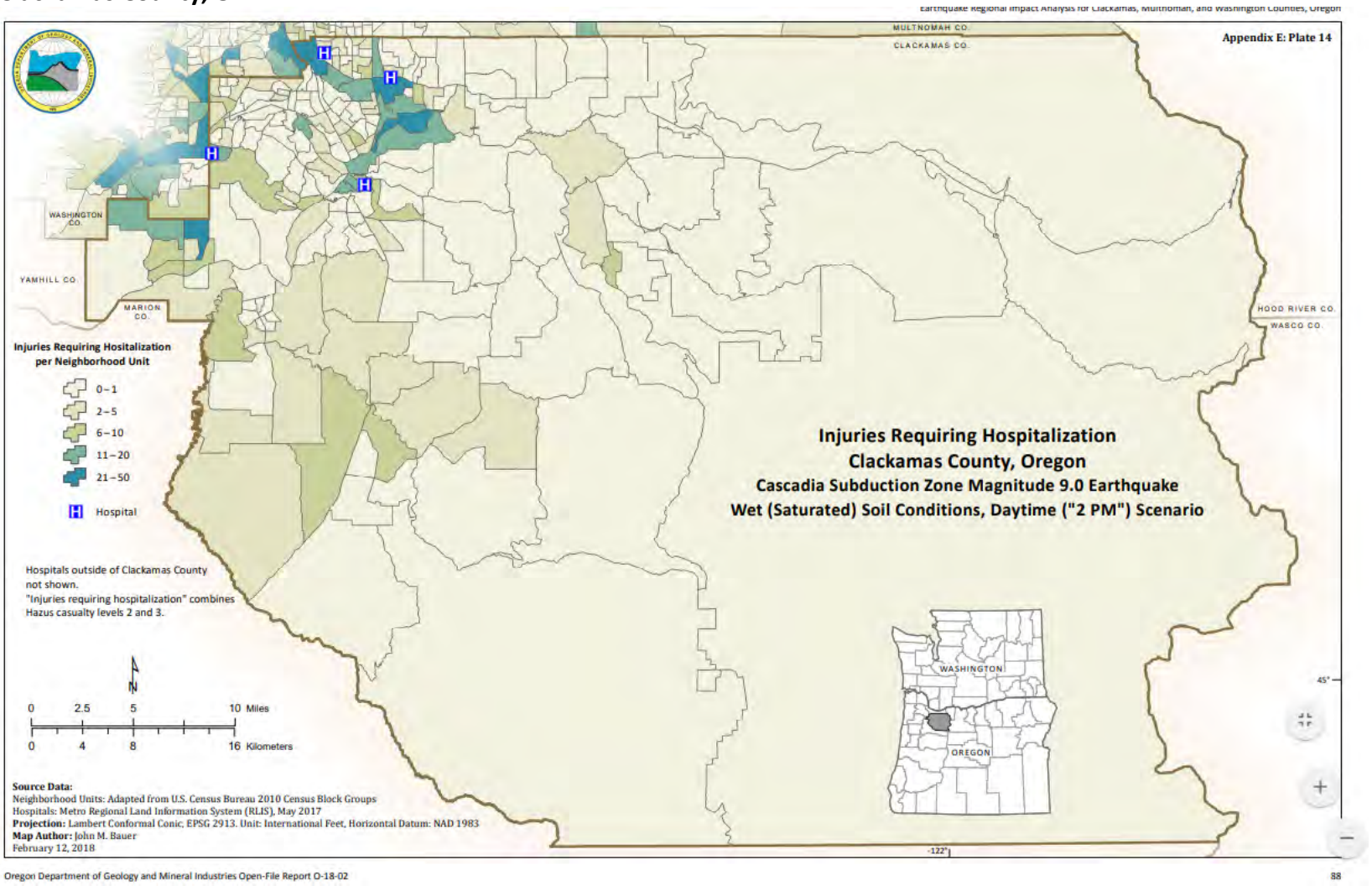
Multnomah County, OR



DOGAMI Earthquake Map- Injuries requiring hospitalization Tri-County Maps
Washington County, OR

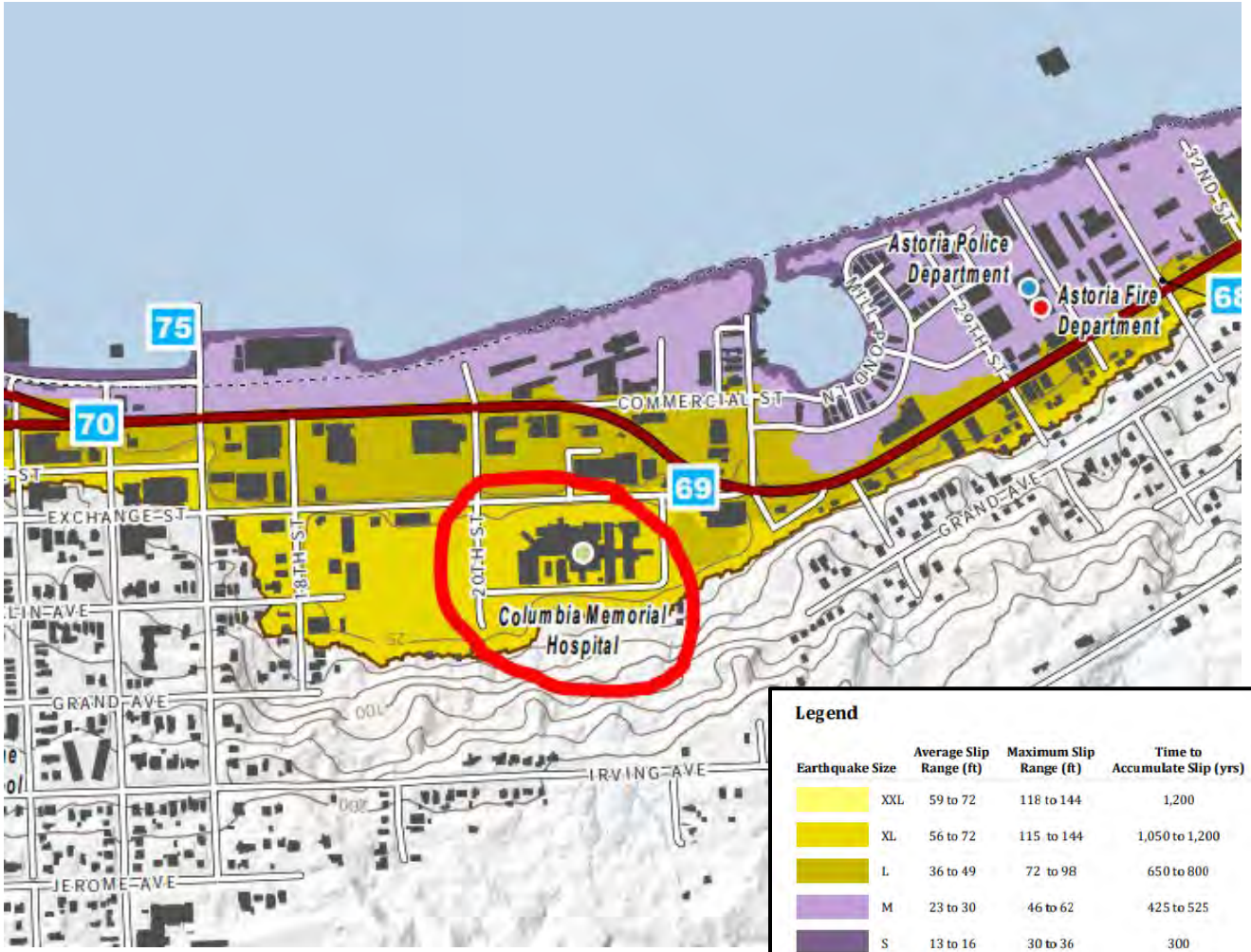


DOGAMI Earthquake Map- Injuries requiring hospitalization Tri-County Maps
Clackamas County, OR



Appendix G: Tsunami Inundation Zone Maps- Coastal Hospitals

Astoria, OR- Columbia Memorial Hospital



Legend

Earthquake Size	Average Slip Range (ft)	Maximum Slip Range (ft)	Time to Accumulate Slip (yrs)	Earthquake Magnitude
XXL	59 to 72	118 to 144	1,200	~9.1
XL	56 to 72	115 to 144	1,050 to 1,200	~9.1
L	36 to 49	72 to 98	650 to 800	~9.0
M	23 to 30	46 to 62	425 to 525	~8.9
S	13 to 16	30 to 36	300	~8.7
XXL Wet/Dry Zone				

ABOUT THE MAP

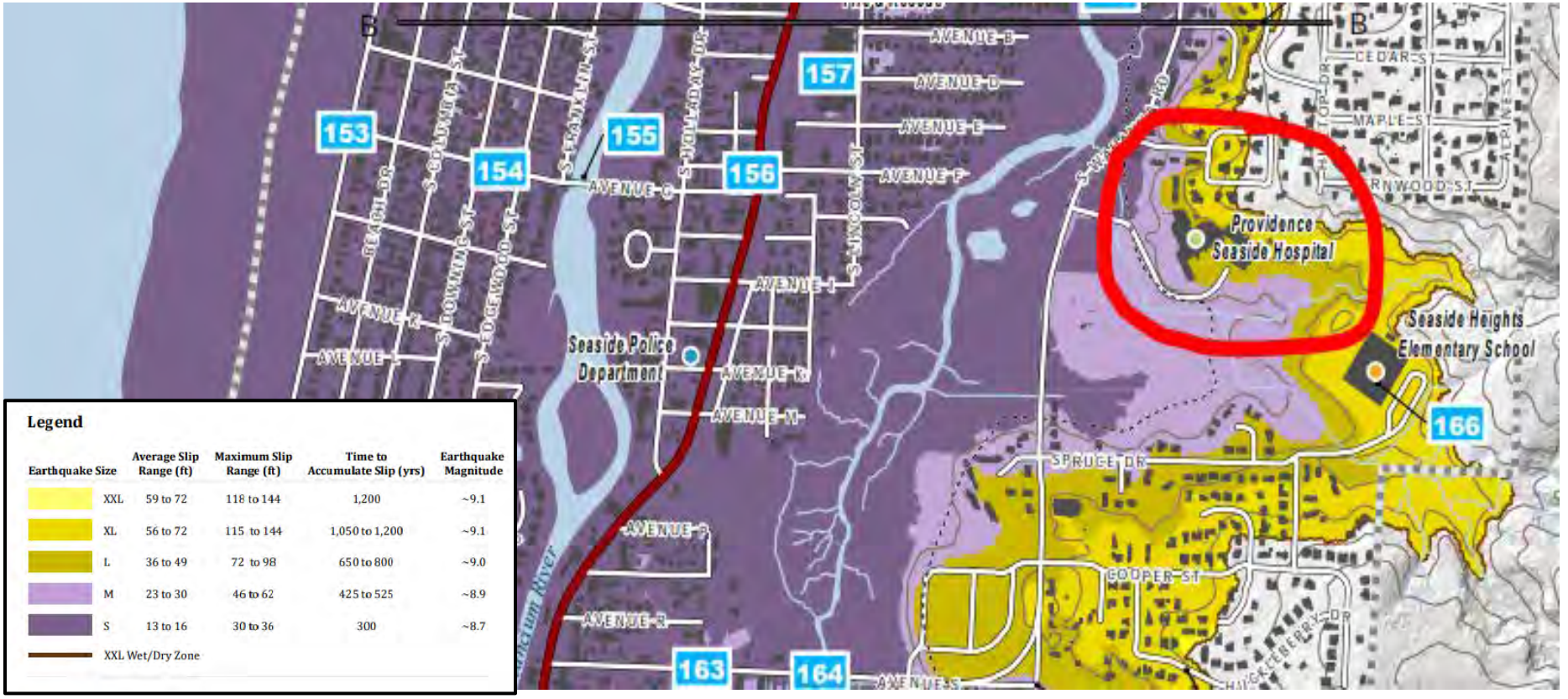
The three Tsunami Inundation Zone maps in this Appendix show the levels of "slip" between the two plates making up the "Cascadia Subduction Zone".

As the average slip and potential maximum slip range increase, the duration of time between events also increases, along with the magnitude.

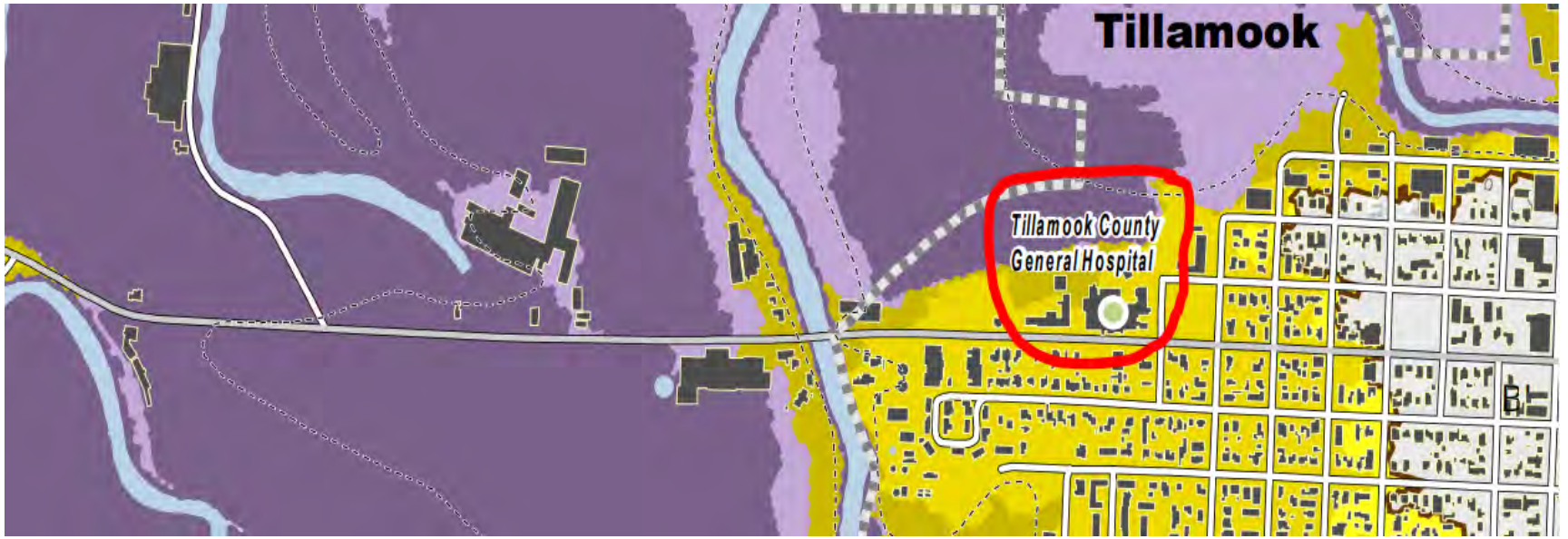
Tsunami Inundation is the final and most destructive phase of tsunami evolution. Likely hospitals will only see debris and flooding inundation affect their structure if the Large or Extra Large event happens (according to the map).

However, they may have utility and supply challenges to operations in the aftermath of a smaller event.

Seaside, OR- Providence Seaside Hospital



Tillamook, OR- Tillamook Medical Center



Legend

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XXL	59 to 72	118 to 144	1,200	~9.1
XL	56 to 72	115 to 144	1,050 to 1,200	~9.1
L	36 to 49	72 to 98	650 to 800	~9.0
M	23 to 30	46 to 62	425 to 525	~8.9
S	13 to 16	30 to 36	300	~8.7
XXL Wet/Dry Zone				

Appendix H: 5 & 1 year Program Plan and HCC Budget

Region 1 HPP FY17 Budget

Total Regional Distribution = $354,272

Regional Projects w/ a Budget Tool for HSPR Grant Agreement		Capability	Capability Title	Specific Activity
Clackamas Electrical Systems - Communications	$ 195,160	C2.O3	Coordinate Response Strategy, Resources, and Communications	**Activity 3: Utilize Communications Systems and Platforms**: Hardware purchases to support inter-hospital communications in Region 1; 11 hospitals will be served by this project; Licensing fees, training tools, contractor labor.
All Clear - Pediatric Surge Plan Writer	$ 16,000	C4.O2	Respond to a Medical Surge	**Activity 4: Provide Pediatric Care during a Medical Surge Response:** Pediatric Surge Plan Writer services
Legacy DMEP Courses - Trauma Surge Training	$ 24,000	C1.O4	Train and Prepare the Health Care and Medical Workforce	**Activity 4**: Educate and Train on Identified Preparedness and Response Gaps; 4 Disaster Management and Emergency Preparedness Courses for
Regional Projects Supported by HSPR Grant Agreement				
DOGAMI - Coastal Hospital Consultations	$ 33,000	C3.O7	Coordinate HealthCare Delivery System Recovery	**Activity 1:** Plan for Health Care system Recovery & **Activity 2:** Assess Health Care Delivery System Recovery after an Emergency
HPP Liaison and Office Staff FTE Support via Regional Distribution Funds	$ 86,112			
TOTAL (HPP Staff + All Projects)	**$ 354,272**			

Appendix I: HPO Communications Overview

Method	Routine Use	Emergency Use	Description of Planned Use
Email	x	x	Employed to achieve routine & emergency operations of the NW OR HPO.
VOIP/Land Line/Cellular	x	x	
HOSCAP	x	x	Web-based system hospitals use to report bed status every 24 hours. Integrates HAvBed for NDMS purposes; used by regional transfer centers for regional ambulance coordination. EDs use this to report closures and surge operations. Regional Hospital at OHSU relies on to manage Mass Casualty Incidents. HCC leaders use it to understand health system functioning on a regional and statewide basis. Managed by the Oregon Health Authority's Health Security, Preparedness and Response (HSPR) Program.
Health Alert Network	x	x	Used to alert regional partners to an emerging public health threat. Exercised regularly by HCC and State Public Health.
Geographic Info Systems	x	x	Used to communicate information about emergency operation locations and understand the geo-spatial relationship between emergency assets, infrastructure, healthcare facilities, and the population. Can be used as a preparedness tool.
Oregon Emergency Response System (OERS)		x	Used as a statewide notification of natural, technical, or civil unrest events involving multi-jurisdictional cooperation between all levels of government and the private sector. Primary point of contact by which any public agency provides the state notification of an emergency or disaster (all hazards) or requests access to state or federal resources. http://www.oregon.gov/oem/emops/Pages/OERS.aspx
Web EOC		x	Secure internet-based crisis information management systems that provides a common operating picture to facilitate "instant" situational awareness for incidents/events and resource requests. Many city/county/healthcare partners in Oregon utilize this tool.

Ops Center/RAPTOR		x	Official resource requesting system utilized by the Oregon State Office of Emergency Management. Counties must put in resource requests into OpsCenter, per NIMS guidance. Houses mapping program RAPTOR.
VHF Radios (UASI Template)		x	Originally intended to be used by fire agencies, the Urban Area Securities Initiative (UASI) Radio Template and corresponding VHF radios provide a common radio template throughout the state to communicate for events, exercises, and response. There are channels for Public Health, EMS agencies, Disaster Medical Teams, and Emergency Management programs.
UHF Hospital Administrative Radio System (HARS)		x	The HARS Net will provide the hospitals in the Portland Metro area with a common radio communication path in the event of the failure or interruption of the normal communication paths. The purpose of HARS is to provide hospitals the ability to communicate vital information between hospitals in real time in order to ensure that the public is being served at the highest level possible.
Amateur Radio		x	Amateur radio capabilities vary greatly from hospital to hospital in HPR1. It is considered a last resort if all other communication modes fail. Volunteers are required to operate these systems, as paid staff cannot use the amateur channels.

Appendix J: Hospital Treatment Capabilities Matrix & Hospital Emergency Assets

Hospital	Hospital Treatment Capabilities															
	Burn Unit	Hyper-baric	Adult Trauma Center	Adult Critical Care	Cardiac Surgery	STEMI Center	Stroke Center	Cardiac CATH	INR	Pediatric Trauma Center	Peds Acute	NICU	PICU	OB	Psych ED	Psych Inpt
Adventist (OHSU Affiliate)		x			x	x	x	x						x		
Cedar Hills Hospital																x
Kaiser Sunnyside				x	x	x	x	x	x			X (lev 3)		x	x	x
Kaiser Westside				x										x	x	
Legacy Emanuel/ Randall Children's Hospital	x	x	Level I	x	x	x	x	x		Level I	x	x	x	x	x	
Legacy Good Samaritan					x	x	x	x						x	x	
Legacy Meridian Park					x	x	x	x						x	x	
Legacy Mt. Hood					x	x	x	x						x	x	

	Burn Unit	Hyper-baric	Adult Trauma Center	Adult Critical Care	Cardiac Surgery	STEMI Center	Stroke Center	Cardiac CATH	INR	Pediatric Trauma Center	Peds Acute	NICU	PICU	OB	Psych ED	Psych Inpt
OHSU/ Doernbecher			x	x	x	x	x	x	x	x	x	x	x	x	x	
Providence Milwaukie				x												x
Providence Portland		x		x	x		x	x	x		x	x	x	x		x
Providence St. Vincent				x	x		x	x	x		x	x	x			x
Providence Willamette Falls				x												x
Tuality (OHSU Affiliate)						x	x	x						x		
Unity Center for Behav Health (Legacy)															x	x
Veteran's Admin Hospital				x	x			x							x	x

Coastal Hospitals																
	Burn Unit	Hyper-baric	Adult Trauma Center	Adult Critical Care	Cardiac Surgery	STEMI Center	Stroke Center	Cardiac CATH	INR	Pediatric Trauma Center	Peds Acute	NICU	PICU	OB	Psych ED	Psych Inpt
Columbia Memorial (OHSU affiliate)																
Tillamook Regional (Adventist Health)			**Level IV**											**x**		
Providence Seaside				**x**							**x**			**x**	**x**	
Inpatient Specialty Care																
Shriner's Hospital (Pediatric Ortho)	Chest Wall Deformity Treatments Cleft Lip and Palate Pediatric Orthopedics https://www.shrinershospitalsforchildren.org/portland/orthopaedics															
Vibra Healthcare (Long Term Acute Care)	Long Term Acute Care Medical Rehabilitation Skilled Nursing Facility https://www.vibrahealthcare.com/our-services/															

Definitions:

- **Burn Unit**
  - Team of surgeons and nurses, physical therapists, and support staff provides comprehensive care for serious burn injuries. The only Burn Center in Oregon is at Legacy Emanuel.
- **Hyperbaric**
  - Oxygen therapy in a pressurized room or tube for decompression sickness, serious infections, bubbles of air in blood vessels and wounds that will not heal as a result of diabetes or radiation injury.
- **Adult Trauma Center**
  - **Level I:** A comprehensive regional resource that is a tertiary care facility central to the trauma system. These facilities are able to provide total care for every aspect of injury from prevention through rehabilitation.
  - **Level IV:** Facility with a demonstrated ability to provide advanced trauma life support (ATLS) prior to transfer of patients to a higher-level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.
- **Adult Critical Care**
  - Specialized care of patients whose conditions are life threatening and who require comprehensive care and constant monitoring, usually in intensive care units.
- **Cardiac Surgery**
  - Surgery on the heart or great vessels performed by cardiac surgeons. Often used to treat complications of ischemic heart disease (for example, with coronary artery bypass grafting), correct congenital heart disease, or to treat valvular heart disease from various causes, including endocarditis, rheumatic heart diseases, atherosclerosis. It also includes heart transplantation.
- **STEMI Center**
  - Medical Centers that specialize in receiving ST-elevation myocardial infarction (STEMI) (most deadly form of a heart attack). STEMIs express fully blocked coronary arteries.
- **Stroke Center**
  - **Comprehensive Stroke Center:** Hospitals that are Joint Commission credentialed to care for all elements of stroke care and have a Neuro ICU.
  - **Intervention Capable Center:** Hospitals that provide drugs, catheterize the brain, but lack the infrastructure for specialization.
  - **Telestroke Center:** Give thrombolytic drugs but no other interventional capabilities. These facilities will transfer patients to other more capable facilities.
- **Cardiac CATH**
  - Catheterization lab-exam room in a hospital with diagnostic imaging equipment used to visualize the arteries and chambers of the heart, and treat any stenosis or abnormality found.
- **INR - Interventional Neuroradiology**
  - Medical subspecialty specializing in minimally invasive image-based technologies and procedures used in diagnosis and treatment of diseases of the head, neck, and spine.

Hospital Emergency Assets Matrix

Hospital Name	**Emergency Assets**				
	CHEMPACK	DECON	Tents	HELIPAD	Designated Helicopter Landing Zone
Adventist Medical Center	x	x		x	x
Legacy Emanuel/Randall Children's		x	x	x	
Kaiser Sunnyside		x	x		x
Kaiser Westside		x	limited		x
Legacy Good Samaritan		x	x		
Legacy Mt. Hood Medical Center		x	x	x	x
Legacy Meridian Park		x	x	x	x
OHSU/Doernbecher Children's	x	x	x	x	x
Tillamook Regional Medical Center		x		x	
Tuality Healthcare		x	x	x	
Providence Milwaukie		x	x		x
Providence Portland		x	x	x	
Providence St. Vincent	x	x	x	x	
Providence Willamette Falls		x	x	x	
Providence Seaside		x	x	x	
VA		x	x		

Definitions:

- **CHEMPACK**
  - Nerve agent antidotes (medical countermeasures) that are pre-positioned and deployable in the community for a quick response to a potential attack.
- **DECON**
  - Emergency tents/showering structures for cleansing individuals after exposure to a hazardous material or radiation. Usually collapsible, connected to water with hoses, inflatable, and located next to an emergency department to quickly move patients to triage and treatment.

- **TENTS**
  - External portable/collapsible structures that provide shelter and an expansion of clinical space in an emergency. Typically, these are used for mass casualty triage, influenza triage/evaluation, or other emergency operations due to medical surge.
- **HELIPAD**
  - Landing area or platform for helicopters and powered lift aircraft. Clearly marked, paved, hard surface away from obstacles to ensure safe landing and take off. Some are heated to avoid snow/ice build-up.

- **DESIGNATED HELICOPTER LANDING ZONE**
  - Pre-identified location where aircraft, especially helicopters, land to exchange cargo/patients/staff in a disaster. May contain multiple landing sites.

Appendix K: CMS EP Rule-Impacted Organizations Aggregate Count by County by Type (excluding categories not present in Region 1)

	Hospitals	Critical Access Hospital	Skilled Nursing Facilities	Ambulatory Surgical Centers	Dialysis Centers	Hospice	Home Health Agencies	FQHC/ Rural Health Clinics	Community Mental Health Centers	Psychiatric Residential Treatment Facilities	All-Inclusive Care for the Elderly (PACE)	Totals
Multnomah	11	0	27	14	15	9	32	40	0	2	8	158
Clackamas	3	0	10	9	9	4	25	13	1	0	1	75
Washington	5	0	9	15	10	4	40	5	0	0	1	89
Columbia	0	0	1	0	1	0	0	4	0	0	0	6
Clatsop	0	2	1	0	2	1	2	4	0	0	1	13
Tillamook	0	1	1	0	1	0	1	8	0	0	0	12
Totals	**19**	**3**	**49**	**38**	**38**	**18**	**100**	**74**	**1**	**2**	**11**	**353**

This table does not reflect in what counties the provider operates; rather, it is a reflection of the address on the facility's license.

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