**Continuity of Operations** **Plan Template**



 **(Insert CMHC Name)**

 Behavioral Health Services

 **(Enter Date)**

Contents

[Executive Summary 4](#_Toc389049664)

[Introduction 5](#_Toc389049665)

[Purpose Statement 5](#_Toc389049666)

[Plan Activation 6](#_Toc389049667)

[Administrative Management Team (AMT) 6](#_Toc389049668)

[Plan Maintenance 7](#_Toc389049669)

[Authority to Implement Plan 8](#_Toc389049670)

[Concept of Operations 8](#_Toc389049671)

[Objectives 9](#_Toc389049672)

[Assumptions 9](#_Toc389049673)

[Essential Functions 10](#_Toc389049674)

[Essential Tasks 12](#_Toc389049675)

[Order of Succession 12](#_Toc389049676)

[Emergency Delegations of Authority 12](#_Toc389049677)

[Warnings or External Notification 17](#_Toc389049678)

[Internal Notifications 17](#_Toc389049679)

[Phases of Implementation 17](#_Toc389049680)

[Phase I - Activation 18](#_Toc389049681)

[Decision Process 18](#_Toc389049682)

[Notification 19](#_Toc389049683)

[Emergency Callback 20](#_Toc389049684)

[Phase II - Relocation 20](#_Toc389049685)

[Alternate Facility Locations 21](#_Toc389049686)

[Relocation and Advance Team 22](#_Toc389049687)

[Augmentation Staff 23](#_Toc389049688)

[Go-Kits 24](#_Toc389049689)

[Personal Preparedness 24](#_Toc389049690)

[Deployment and Departure Procedures / Administrative Procedures 24](#_Toc389049691)

[Phase III - Alternate Facility Operations 25](#_Toc389049692)

[Personnel Coordination 25](#_Toc389049693)

[County Notification 25](#_Toc389049694)

[Logistics 26](#_Toc389049695)

[Phase IV - Reconstitution Phase 27](#_Toc389049696)

[Financial Considerations 28](#_Toc389049697)

[Employee Leave and Compensation During a Disaster 28](#_Toc389049698)

[Records Management 29](#_Toc389049699)

[Testing, Training and Exercise Program 30](#_Toc389049700)

[Pandemic Annex 32](#_Toc389049701)

[Introduction 32](#_Toc389049702)

[Background 33](#_Toc389049703)

[Fundamental Elements to Prevent Influenza Transmission 33](#_Toc389049704)

[Take Steps to Minimize Potential Exposures 34](#_Toc389049705)

[Planning Assumptions and Considerations 34](#_Toc389049706)

[Personal Protective Gear 35](#_Toc389049707)

[Policy Requiring The Wear Of Personal Protective Equipment By Staff 36](#_Toc389049708)

[Facility Exposure Control 36](#_Toc389049709)

[Before Arrival of clients or VISITORS to a Facility 36](#_Toc389049710)

[Upon Entry and During Visit to a Facility 37](#_Toc389049711)

[Information Management 37](#_Toc389049712)

[Internal Information and Communication 37](#_Toc389049713)

[External Public Information and Warnings 38](#_Toc389049714)

[Attachment 1 – CMHC Organizational Chart 40](#_Toc389049715)

[Attachment 2 – CMHC Employee Contact Information 41](#_Toc389049716)

[Attachment 3 – Client Risk Analysis 43](#_Toc389049717)

[Attachment 4 - Homebound Client Evacuation 44](#_Toc389049718)

[Attachment 4 – Tornado Sheltering Procedures 46](#_Toc389049719)

[Attachment 5 – Fire Procedures 47](#_Toc389049720)

[Attachment 6 – Active Shooter Procedures 48](#_Toc389049721)

[Attachment 7 – Bomb Threat 49](#_Toc389049722)

[Attachment 8 – Building Evacuation (Non Fire) 50](#_Toc389049723)

# Executive Summary

The State of Kansas is vulnerable to a variety of hazards that threaten its citizens, communities, businesses, economy, and environment. This Continuity of Operations (COOP) Planning Template is a guide designed to help Community Mental Health Centers (CMHCs) develop plans to assure their ability to continue critical mental health support during an emergency or disaster where the staff or the facilities are compromised.

The Kansas Department of Aging and Disability Services (KDADS) is the Kansas Mental Health Authority, and oversee necessary mental health supports and services to Kansans. It is imperative that mental health services be protected from interruption in all types of emergency situations.

Clinical services include psychiatric assessment and medication treatment, psychological testing, out-patient therapy, crisis management services, and child advocacy services. Additional community based and rehabilitation services are provided to Seriously Emotionally Disturbed (SED) and Severe and Persistent Mental Illness (SPMI) targeted populations.

This document incorporates federal recommendations for improved planning of staffing, resources and guidance, found in the Federal Emergency Management Agency’s (FEMA’s) COOP Self-Assessment Tool.

NOTE: Guidance statements can be found throughout the document and are indicated in shaded text boxes. Those statements must be deleted before printing a final plan.

# Introduction

This section is a sample introduction to your CMHC COOP Plan. You may tailor as you see fit.

State law charges **CMHCs** with providing a community-based public mental health “safety net”. In addition to providing the full range of outpatient clinical services, the CMHCs provide comprehensive mental health rehabilitation services such as psychosocial rehabilitation, community psychiatric supportive treatment, and peer support, case management and attendant care. Rehabilitation services, case management, and attendant care have been proven to be a key factor in supporting people with SPMI in their recovery.

Kansas law designates CMHCs as the gatekeeper for admission to state mental health hospitals. Under contract, CMHCs must carry out similar functions for nursing facilities for mental health, psychiatric residential treatment facilities, some correctional facilities and Medicaid-funded community hospital psychiatric services.

This COOP Template was developed to ensure services continue to be provided to clients in the event of an internal disaster or in conjunction with the CMHCs Emergency Operations Plan for large-scale events. It outlines actions to be taken by management and staff to secure its own facilities and personnel. If necessary, relocate to an alternate facility and reconstitute as quickly as possible to meet the needs of the community requiring mental health supports and services.

# Purpose Statement

This Sample Purpose Statement can be modified to address situations and organizational structures that are unique or specific to a particular CMHC.

CMHCs have a responsibility to maintain critical operations and provide disaster services in times of crisis. The purpose of the COOP is to provide policies and protocols to be followed in times of internal and external disaster. This CMHC has identified Essential Functions that must be performed to keep the center viable. Essential Functions are those tasks that must be performed at minimum for client care and business financial stability.

External events considered in this plan are those events that occur outside the influence or control of our CMHC. These events have the potential to impact staff, citizens or communities within our catchment area. These events may affect our ability to conduct normal day-to-day operations.

 An internal event is limited to circumstances which only impact CMHC personal, equipment or facilities, and may or may not be the result of an external event. This type of an event may also affect our ability to conduct normal day-to-day operations.

This COOP and our Emergency Operations Plan may be utilized simultaneously. It is the policy of the CMHC to continuously review and update both plans through scheduled activities such as training and drill exercises. COOP planning is simply “good business practice”.

# Plan Activation

This COOP is applicable to a wide range of potential emergencies or threats regardless of cause. These include, but are not limited to:

* Natural disasters (tornado, fire, flood, winter weather event).
* Pandemic influenza.
* Accidents.
* Technological failures.
* Workplace violence.
* Events related to foreign or domestic acts of aggression.
* Mass staff turnover, internal strife, labor disputes, etc.

The COOP can be activated based on the potential scope of the incident. The CEO in consultation with the Administrative Management Team (AMT) and advisors will determine whether COOP activation is necessary, and will oversee the activation of any portion of the COOP.

## Administrative Management Team (AMT)

The AMT is tasked with making assessments concerning disaster related actions and provides input in determining a course of action. This team will be designated with Incident Command positions. Additional positions can be added as needed.

| **Administrative Management Team (AMT)** |
| --- |
| **Title** | **Individual** | **ICS Position** |
|  |  | Incident Commander |
|  |  | Operations |
|  |  | Planning |
|  |  | Logistics |
|  |  | Finance |
|  |  | Security |

# Plan Maintenance

This COOP is reviewed and updated annually, reflecting the changes in State Statutes, CMHC staffing, KDADS contractual issues, clinical and emergency management procedures.

| **COOP Plan Maintenance Schedule** |
| --- |
| **Activity** | **Tasks** | **Frequency** |
| Plan update and certification.  | * Review entire plan for accuracy.
* Incorporate lessons learned and changes in policy and philosophy.
* Manage distribution of plan updates.
 | Annually (January of each calendar year or as needed).  |
| Maintain and update Orders of Succession. | * Obtain names of current incumbents and designated successors.
* Update Delegation of authorities.
 | Annually. |
| Maintain checklists.  | * Update and revise checklists.
* Ensure annual update/validation.
 | Annually or as needed.  |
| Update rosters for all positions.  | * Confirm/update information.
* Validate K-SERV entries.
 | Annually.  |
| Appoint new members of the Relocation Team (RT). | * Personnel identified as mission essential by AMT.
* RT members notified.
 | As needed. |
| Maintain alternate work site readiness.  | * Check all systems.
* Verify access codes and systems.
* Pre-position Go-Kits.
* Identify personnel with key access to alternate location facilities.
 | Annually or as needed.  |
| Review and update CMHC personnel roster.  | * Review for accuracy
* Incorporate new hires, if required.
 | Annually or as needed.  |
| Monitor and maintain equipment at alternate sites.  | * Train users and provide technical assistance.
* Identify additional personnel with key access.
 | Ongoing.  |
| Train new members.  | * Provide an orientation and training class.
* Schedule participation in training and exercises for COOP related events.
 | Annually.  |

## Authority to Implement Plan

The CMHC CEO has the overall authority for the plan and will coordinate with various other key personnel to oversee implementation, maintenance, evaluation and revisions of the plan. Other key staff may include, but not limited to:

* Medical Director.
* Clinical Director.
* Chief Financial Officer.
* Department Heads.
* Directors.

Modify as appropriate

# Concept of Operations

Concept of Operations is a verbal or graphic statement that clearly and concisely expresses what the CMHC CEO or designee intends to accomplish and how it will be done using available resources.

This COOP will be activated when routine operations are threatened or become disrupted. Operational changes may require employees to perform duties in support of Essential Functions as directed by supervisors. An employee may be asked to work in a different location, for a different supervisor, and perform different tasks. Non-essential functions will be deferred until time or circumstance permits.

Concept of Operations consists of the following sub-tasks:

* Objectives.
* Assumptions.
* Essential Functions.
* Order of Succession.
* Emergency Delegation of Authority.
* Warnings or External Notifications.
* Internal Notifications.

## Objectives

This COOP helps ensure a viable capability exists to continue Essential Functions when the plan is activated. The objectives of this plan are:

* Protect clients, staff, facilities, equipment, records, and other assets.
* Ensure the continuous performance of the Essential Functions and operations during an emergency.
* Reduce disruptions to operations.
* Provide for a time-phased implementation of the COOP to mitigate the effects of the emergency and shorten the crisis response time.
* Identify and designate principals and support staff to be assigned or relocated.
* Facilitate decision-making for execution of the COOP and the subsequent conduct of operations.
* Achieve a timely and orderly recovery from the emergency and resumption of all services.

## Assumptions

Assumptions are used in the planning process to identify potential worst case scenarios that would involve either the loss of staff or staff being diminished. These assumptions should also include events that impact our facilities rendering them, and equipment, unusable. Assumptions need to address both short-term and long-term implications.

Threats or actual emergencies can adversely impact normal operations either through disruption of services, access to facilities, or both. The primary impact of a disaster will be one that affects employees who perform critical operations.

General assumptions include:

* Emergencies and threatened emergencies will differ in priority and impact.
* Structural integrity of facilities has been compromised.
* Loss of equipment.
* Mutual aid with other CMHCs located outside the area affected by the emergency or threat will be available as necessary to help provide Essential Functions.

In this plan, we assume that absenteeism in any disaster will increase due to:

* Personal injury/illness or incapacitation of staff or family members.
* Inaccessibility of clinical locations.
* Employees under home quarantine or isolation as a result of state ordered curfew.
* Employees caring for children dismissed from schools.
* Employees self-quarantining out of safety concerns.

## Essential Functions

Essential Functions are those activities that must be performed under any circumstances to ensure the welfare of their clients and the financial stability of the organization. Essential Functions are prioritized based on life-threatening, health, urgent business and other considerations.

We have taken into account needed policy and decision making authorities in determining the Essential Functions and personnel needed in each area. See the Emergency Delegation of Authority Section.

Essential Functions are defined and prioritized by the CEO or administrator. Listed below is a guide for routine operation/functions that are essential and will not be suspended or discontinued. Non-essential functions can be deferred, as authorized in this COOP, by the CEO or designee. (See section on Reconstitution regarding specifics on the termination process for the COOP and orderly return to normal business.)

Essential Functions would include, but not limited to:

* Emergency assessments for hospitalization.
* Medication services for current clients.
* Business functions-billing, AR, payroll.
* Maintaining confidential client records/PHI.
* Alternate facility operations.
* Redundant communications.
* Crisis Counseling Programs.

**Each CMHC needs to develop their own list of Essential Functions and prioritize them based on importance.**

| **Essential Functions** |
| --- |
| **Priority** | **Function** | **Staff Member Responsible** | **Number of Staff Required** |
|  | Building and Client Safety. |  |  |
|  | Personnel Safety – Security. |  |  |
|  | County Notification of Plan Activation. |  |  |
|  | KDADS Notification of Plan Activation. |  |  |
|  | Communications. |  |  |
|  | Employee Notification. |  |  |
|  | Triage. |  |  |
|  | Phone Triage. |  |  |
|  | Walk-In Triage. |  |  |
|  | Hospital Screens. |  |  |
|  | Medication Management. |  |  |
|  | Triage to Determine Level of Medication Need. |  |  |
|  | Medication Evaluations. |  |  |
|  | Access to Meds Samples, Refills, Planners. |  |  |
|  | Delivery of Medication if Necessary. |  |  |
|  | CIAC Staff to CIS to Consolidate Access. |  |  |
|  | Phone Contacts to Clients. |  |  |
|  | Phone Support of On-Going Clients. |  |  |
|  | Court Ordered Treatment. |  |  |
|  | Court Ordered UA. |  |  |
|  | IT Computer Access. |  |  |
|  | Human Resources Support. |  |  |
|  | Maintenance.  |  |  |
|  | Accounts Receivables. |  |  |
|  | Account Payable. |  |  |
|  | Records Request – Critical. |  |  |
|  | Scanning of Critical Documents. |  |  |

### Essential Tasks

Every Essential Function is comprised of individual tasks that are required to complete the function. These tasks can be used to identify staffing, equipment required, spacing for relocation, and single points of failure. Single points of failure are defined as either the loss of personnel or equipment with no redundancy that would prevent this function from being completed.

Identifying essential tasks can help determine immediate replacement costs needed to complete the function, number of personnel required to ensure the continuation of the Essential Functions, spacing requirements if relocation is required and identification of non-essential staff.

## Order of Succession

The Order of Succession for each staffing level (listed below) is at least two-deep to ensure continuity of Essential Functions. Cross-train other employees who could take over for key employees if they are unable to work for an extended period of time. In the absence of staff in key positions, this chain of succession shall be implemented. The chain of command is distributed to all members of the CMHC.

### Emergency Delegations of Authority

All authorities specific to each position are transferred to the emergency designee unless otherwise specified. When a succession occurs, the duties and authorities of the position are transferred to the incoming appointee, as the authority rests in the role being assumed unless otherwise stipulated.

Some emergency authorities cannot be anticipated in advance and may change based on the context of each emergent situation. Any modifications or new delegations of authority needed in a given situation will be authorized by the CEO or designee as needed during the emergency. It is possible that in certain extreme conditions delegation of authority may need to be assumed if communication with the normal point of authority is disrupted and waiting would result in direct harm to individuals in need of support and services. In this instance, the authority may be exercised and the appropriate persons notified once communication is re-established.

|  |
| --- |
| **Succession: Executive Management**  |
| **Title** | **Individual** |
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| --- |
| **Succession: Disaster Coordinators** |
| **Title** | **Individual** |
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| --- |
| **Succession: Administrative Support** |
| **Title** | **Individual** |
|  |  |
|  |  |

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| --- |
| **Succession: Operations Manager**  |
| **Title** | **Individual** |
|  |  |
|  |  |
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| **Succession: Finance**  |
| **Title** | **Individual** |
|  |  |
|  |  |
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| --- |
| **Succession: Information Technology**  |
| **Title** | **Individual** |
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|  |  |
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|  |  |
| **Succession: Maintenance Section** |
| **Title** | **Individual** |
|  |  |
|  |  |
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| --- |
| **Succession: Quality and Risk Management**  |
| **Title** | **Individual** |
|  |  |
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| --- |
| **Succession: Children Services** |
| **Title** | **Individual** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Succession: Community Support Services**  |
| **Title** | **Individual** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Succession: City Center / Homeless Program**  |
| **Title** | **Individual** |
|  |  |
|  |  |
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| --- |
| **Succession: Crisis Services / SCOAP**  |
| **Title** | **Individual** |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **Succession: Out-Patient Services**  |
| **Title** | **Individual** |
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|  |
| --- |
| **Succession: Addiction Treatment Services**  |
| **Title** | **Individual** |
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| --- |
| **Succession: Communications**  |
| **Title** | **Individual** |
|  |  |
|  |  |
|  |  |

If the CEO and succession of command are unavailable, the senior available provider shall assume duties of the CEO in the interim period.

## Warnings or External Notification

The Disaster Coordinators have requested that their names and contact information be added to the notification and warning lists of each of the county emergency management departments, emergency communications/dispatch centers, public health departments, and other response organizations in our catchment area.

The Disaster Coordinators are responsible for receiving available emergency communications and for contacting the Emergency Manager of each catchment county for follow up, if appropriate.

Upon learning of an actual or potential emergency situation that may affect staff or facilities, the Disaster Coordinator is responsible for making appropriate internal notifications (see below).

External warning communications systems include hardline telephones, cellular telephones, television networks, public radio, emergency radio systems used in the catchment area, weather alert networks and the internet.

## Internal Notifications

The CMHC has an internal list of all employees with their contact information (See Attachment 2). The calling tree plan follows the supervisory chain. Supervisors are expected to maintain current contact information in the event a calling tree is initiated.

CMHC employees are encouraged to contact their supervisors by phone, watch local news and access the county website for additional information in the event of an emergency.

# Phases of Implementation

This COOP is based on four different phases (see below). Some events may produce emergencies that impact a small area or a single facility, while others may result in a more severe and widespread emergency. Any of these triggers may activate this COOP or parts thereof.

1. **Activation Phase**: Are Essential Functions impacted? Is staff safety or the facility compromised? Is the catchment area under an impending threat that could harm the staff or facility? Does the event require COOP activation? Activating the COOP may not require the implementation of the remaining phases. However, the rest of the phases are interrelated.
2. **Relocation Phase:** Can normal operations be continued out of the facility, without unnecessary risks or increased liability?Determine if relocation is necessary. This phase is only appropriate if the CMHC facilities are compromised beyond use. It addresses the relocation to a site suitable to restart vital mental health services. It addresses the identification of alternate location(s) if required, and may include the use of like facilities from non-affected CMHCs through mutual aid.
3. **Alternate Facility Operations Phase:** How to conduct business at alternate location. This phase focuses on establishing functions after relocation and addresses the resumption of vital mental health services. It also addresses mutual aid requests from non-affected CMHCs if required.
4. **Reconstitution Phase**: The identification of returning to the facility or finding a permanent replacement location.This phase may pertain to the facility, reinstitution of non-essential functions or necessary staffing levels. Some events may require reconstitution of one or more facilities. This phase addresses staff augmentation with assignment details, and accountability of staff, as well as development of plans and schedules for reconstitution (return to normal operation).

## Phase I - Activation

The activation or partial activation of the COOP can be caused by a variety of reasons. The chart below is intended to expedite the decision making process and help determine the level of activation required.

### Decision Process

The decision to implement portions of the COOP can be made using the following matrix:

| **Decision Matrix** |
| --- |
| **Level of Emergency** | **Impact on Agency** | **Actions** |
| I | Forecast of a severe man-made or natural event that potentially impacts citizens in the catchment areas.  | Limited COOP activation. Staff briefed on event. Appropriate staff placed on alert. |
| II | Disruption of up to 12 hours, with little effect on services or impact to Essential Functions or critical systems and no loss of staff.  | Limited COOP activation (based on need). |
| III | Disruption of 12-72 hours, with minor impact on Essential Functions and no loss of staff.  | Limited COOP activation (based on need). |
| IV | Disruption to one to two Essential Functions or to a vital system and/or loss of small numbers of staff for no more than three days.  | May require movement of some personnel to an alternate work site or location in the primary facility for less than a week. |
| V | Loss of satellite facility within the catchment area. | May require movement of some personnel to an alternate work site.  |
| VI | Disruption to one to two Essential Functions or to the entire agency (with possible loss of some staff) with potential of lasting for more than three days but less than fourteen days.  | * May require activation of orders of succession for some key personnel.
* May require movement of some personnel to an alternate work site or location in the primary facility for more than a week.
 |
| VII | Disruption to the entire agency and/or reduction in staff by 40-50% with the potential for lasting at least fourteen days.  | * Requires activation of orders of succession for some key personnel.
* Request mutual aid from non-affected CMHCs.
 |
| VIII | Primary facility destroyed. | * Require movement of personnel to an alternate work site(s) or location(s).
* Identify new facility for permanent operations.
 |

The AMT shall review this COOP after each Level change. This may include the implementation of additional level criteria and actions and may require adjustments to the plan as necessary.

## Notification

Based on sound business need, all departments or divisions shall:

* Select positions that are subject to on-call and/or emergency callback.
* Maintain a list of the classification titles of these positions.
* Provide this list on an annual basis to the Office of Human Resources.
* Employees shall be notified in advance in writing of being subject to on-call and, to the extent practicable, emergency callback.

### Emergency Callback

Emergency callback of an employee who has left the work site and is requested to respond on short notice to an emergency work situation in order:

* To avoid significant service disruption.
* To avoid placing employees or the public in unsafe situations.
* To provide emergency services.
* To respond to emergencies within the county or catchment areas.

## Phase II - Relocation

The decision for relocation should be made quickly to provide staff and clients with minimal interruption of necessary services. The following tasks should be considered in the initial 12-hour period following activation of the COOP plan when moving to an alternate location(s).

 Additional tasks may be required depending upon CMHC compositions and functions.

* The establishment of the Relocation Team (RT) with explicit instructions of where and when to report.
* Activate plans, procedures, and schedules to transfer Essential Functions, personnel, records and equipment to the alternate facility(s).
* Implement staffing plans and procedures in the event of a Pandemic.
* Notify County Emergency Manager(s), local ESF 8 lead and KDADS Behavioral Health Services of COOP activation.
* Begin the process to provide information concerning metal health functions and how to access them during a disaster.
* Coordinate information and instructions to the public.
* Brief and assign duties to staff of Essential Functions to be conducted.
* Maintenance of critical services to current clients.
* Provide services to meet the acute mental health needs arising from a disaster.
* Provide logistical support to the CMHC staff.
* Conduct operations in support of Essential Functions.
* Continuation and re-evaluation of Essential Functions.
* Maintenance of medical records.
* Determination of mutual aid requirements.

### Alternate Facility Locations

If required by the circumstance, the determination of which alternate facilities are activated will be made by the CEO or designee and will be based on the incident or threat. The list of facilities has been evaluated based on existing capabilities and the capacity to perform the mission Essential Functions. The alternate facility(s) is/are capable of providing:

* Adequate space.
* Site transportation and parking.
* Interoperable communications.
* Security.
* Logistical support.
* Accessible to lodging.
* Sustain operations for 90 days.
* Accommodate approximately 25 individuals, depending on the location.
* The site(s) must be able to support operations for up to 15 personnel (advance team).
* Must be operational within three (3) to twelve (12) hours, if necessary.
* Accommodate approximately 25 individuals within twenty-four (24) to forty-eight (48) hours.
* Telephones.
* Computers.
* Facsimiles.
* Copiers.
* Furniture to support the RT and augmented staff.
* Private consultation rooms if required.
* Reception area/Waiting room.

|  |
| --- |
| **Alternate Facility Information** |
| **Facility Name** | **Address** | **Point of Contact Information** | **Facility Phone Number** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

### Relocation and Advance Team

CMHC personnel who are relocated under this Plan to an alternate location are known as the Relocation Team (RT). The RT consists of an advance team, if required, and follow-on personnel.

Since the alternate facility may have limited space and support capabilities, the membership of the RT may be restricted to personnel with the skills and experience needed for mission Essential Functions. All other CMHC personnel who are not designated RT members may be directed to remain at or return home pending further instructions or to report to another location to perform Essential Functions.

The RT members will deploy and relocate to a previously identified alternate facility and establish an operational capability within 12 to 24 hours of activation.

The below chart reflects all staff members who have been identified as performing an Essential Function at an alternate location. Some of these members may be deployed ahead of the rest of the staff to open the facility. These staff members are referred to as the Advance Team and should be organized using the Incident Command System. This will ensure areas of responsibility and authorities have been taken into account. The individuals identified below in the right-hand column have been designated as being on the Advance Team. If members of the advance team have only the function of establishing off-site operations and are not listed as essential personnel, their task column will be blank.

A COOP activation will not, in most circumstances, affect the pay and benefits of either the RT members or other CMHC personnel.

|  |
| --- |
| **Relocation Team***Check if assigned to Advance Team* |
| **Name** | **Task** | **On Advance Team** | **ICS Position** |
|  |  |  |  |
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#### Advance Team

In the event that the Advance Team is deployed prior to the rest of the RT members, upon their arrival at the alternate facility, they will begin providing support for the following functions:

* Maintain or establish communications.
* Report the arrival status of team members to the CEO or AMT.
* Prepare the facility for the arrival of the remaining members of the RT.
* Prepared the facility to operate within 12 hours.
* Provide adequate spacing and equipment for arriving staff members.
* Ensure check-in procedures for arriving staff are followed.
* Research availability of lodging for the RT if necessary.

#### Relocation Team

If no Advance Team is deployed, the RT will accomplish the tasks assigned to the Advance Team and facilitate the following tasks:

* Monitor and assess the status of the situation that required the relocation.
* Account for CMHC personnel or mutual aid staff as they arrive.
* Continue CMHC mission Essential Functions as established in the COOP.
* Establish and maintain contact with the CEO or AMT.
* Disaster Coordinator, if on RT, will establish and maintain contact with the County Emergency Operations Center(s) (EOC) if necessary.
* Plan and schedule daily operations.
* Prepare and disseminate reports to County EOC and KDADS as required.
* Complete tasks assigned by the AMT.

### Augmentation Staff

Personnel not identified as mission essential will be assigned to the Augmentation Staff. To ensure the continuous performance of mission Essential Functions, it is imperative to have a current Augmentation Staff Roster that can be called upon by the CEO or AMT when needed.

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| **Augmentation Staff** |
| **Name** | **Normal Duties** | **COOP Assignment** |
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### Go-Kits

Go-Kits are necessary in quickly re-establishing services at alternate facilities. Go-Kits may contain such items as software, databases, publications, laptops, etc. Any special resource requirements for the CMHC personnel will need to be addressed. It is strongly encouraged that critical items and data be pre-positioned at the alternate facility instead of being stored at the main facility. RT members may be at home when the order is given for relocation and access to Go-Kits may be difficult or impossible.

If Go-Kits are maintained in one location and that facility has been compromised, it could affect the CMHCs ability to perform Essential Functions at alternate locations.

### Personal Preparedness

* Personal Items – RT members will bring appropriate personal items and changes of clothing if required. Casual attire will be appropriate at the alternate facility. All employees should bring identification.
* Medical Support – An adequate supply of medicines, hearing-aid batteries, and eyeglasses should be part of the items included in the “personal go-kits.”
* RT members should ensure that refrigerators are at the alternate facility for medication needing refrigeration.

### Deployment and Departure Procedures / Administrative Procedures

The following actions establish general administrative procedures to allow for travel to the alternate facility. Specific instructions will be provided at the time a deployment is ordered.

* The CEO or designee will direct the deployment of the RT (including the Advance Team) to the alternate facility if required.
* Advance Team members should attempt to retrieve Go-Kits, if not pre-deployed, from the main facility if possible.
* The remainder of the RT members will immediately begin deployment to the alternate facility.
* RT members will use privately owned vehicles for transportation to the designated facility.
* HR policy will determine if employees are compensated for mileage to alternate location if out of county.
* During duty-hours, CMHC staff deemed non-essential at the time of an emergency notification will be directed to await further instructions.
* HR policy will determine pay and benefit status of employees designated as non-essential and not currently being utilized.
* At the time of notification, information will be provided on safe routes that should be used as well as other appropriate safety precautions.
* Instructions will be provided for usage of CMHC operated vehicles.
* HR policy will determine compensation if lodging and per diem is required for relocation.

## Phase III - Alternate Facility Operations

The CEO, with advice from the AMT, will direct the closure and cessation of operations of the affected facility. The CEO or designee will notify the County Emergency Manager(s) and KDADS of the situation and the location of the alternate facility.

### Personnel Coordination

If necessary, the RT will continue transition management of the Essential Functions until the affected facility(s) is/are restored or permanently relocated.

Following activation and deployment of the RT, the AMT may request additional Augmentation Staff at the alternate facility, if space is available. All requests for augmentation by the RT must be coordinated through the AMT. During COOP operations personnel not identified as members of the RT will be provided information on their status by receiving a call from their supervisor or HR.

 The CEO may request mutual aid support from other CMHCs outside the affected area. Mutual aid deployment compensation will be in accordance with existing polices unless otherwise specified.

### County Notification

County Emergency Managers and other appropriate agencies within the CMHC catchment area shall be notified in the event of relocation or when an emergency situation affects the ability of the CMHC to deliver essential services.

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| **Emergency Manager Contact Information** |
| **County** | **Emergency Manager Name** | **Contact Information** |
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### Logistics

#### Operational Hours

The hours of operation at the alternate facility will be determined by the Incident Command Team. However, it is expected that the RT will operate office hours Monday through Friday, 8:00 am to 4:30 pm. The CMHC should not need to operate more than normal work hours; however, in the event of expanded coverage, a schedule including augmentation staff will be established for this purpose, if necessary.

CMHCs that provide 24-hour service may have to revise the Staff Duty Officer Roster while operating at the alternate facility.

#### Pre-Positioned Resources

Procedures and checklists for pre-positioning resources should be identified by the AMT and included in this section of the COOP.

#### Establishment of Communications

The Communications Team will conduct yearly tests at the identified alternate facilities to determine the capability of hardwired phones to be rolled to those locations and ensure there are sufficient data ports if wireless communications is not available. This will also include the installation and monitoring of the crisis lines. The team, if necessary, will provide the CEO with a list of additional communication requirements necessary to continue Essential Functions at the alternate location(s).

In the event that the main facility has been destroyed and phones are not capable of being rolled to the alternate locations, the communications team will establish temporary new numbers to be utilized by the staff and separate lines to be used by the public. The Public Information Officer (PIO) will release the new numbers to the public.

RT members will begin to retrieve pre-positioned information and data, activate specialized systems, or equipment needed. Communications will be established by using any of the following:

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| **Communication Systems** |
| **Service** | **Current Provider** | **Special Notes** |
| Hard Lines  |  |  |
| Fax Lines  |  |  |
| Data Lines  |  |  |
| Mobile Radios |  |  |
| Cellular Phones  |  |  |
| Facebook  |  |  |
| E-mail  |  |  |
| Internet  |  |  |
| Twitter  |  |  |
| Public Service Announcements |  |  |

After the deployment of the RT to a designated alternate location, the Communication Team will disseminate information regarding communication and IT issues to RT members upon arrival at check-in.

## Phase IV - Reconstitution Phase

Reconstitution is the process by which personnel resume normal operations from the original or replacement primary facility and is conducted after the emergency or disruption ceases and is unlikely to resume. Reconstitution involves the actual transfer of materials, personnel, supplies, and equipment to the original facility, a new permanent facility, or the resumption of normal personnel/staffing/management and function at any facility.

The CEO or designee has the authority to close the alternate site and return to the original facility, or in the case of a long-term inoperable facility, to authorize the acquirement of a new facility. Consultation with the administration of the Executive Committee of the CMHC Board of Directors may be required in the event of acquiring a new facility.

Reconstitution procedures will commence when the CEO determines that the emergency situation has ended and is unlikely to recur. Once this determination has been made, one or a combination of the following options will be implemented, depending on the situation:

* Continue to operate from the alternate facility.
* Begin a return to the affected facilities that were abandoned, and reconstitute from remaining CMHC resources.
* Begin to establish a reconstituted CMHC office in some other facility.

Within 24 hours of an emergency relocation, the AMT will initiate an assessment of, and operations to salvage, restore, and recover CMHC facilities or catchment offices after the approval of law enforcement and emergency services has been granted. The RT will transition management of mission Essential Functions from the alternate facility to the CMHC main office.

The logistics of the return will be determined by the Incident Command Team with each team member taking responsibility for their department or area. Emergency Services, including crisis screenings and emergency medication evaluations will be provided at an alternate site during this time.

Employees will be notified of the return via a calling tree. A recorded phone message will be used to inform clients of the return to the facility or a new location. Press releases and Public Service Announcements (PSA) will be used to notify the public of the return to normal operations.

The CEO and CFO will be the authorizing authority on material purchases required to re-equip new facilities for operational readiness if necessary.

 It is important to organize personnel for an orderly return to normal operations. Timeframes for terminating devolution are dependent on the nature and intensity of events/incidents that activated this Plan.

# Financial Considerations

The CFO will disseminate information related to local travel and temporary duty stations when the COOP is activated if necessary. Specifics may need to be provided at the time of an event, but general information about transportation, lodging, credit cards and food is provided below:

* Provide the CEO or AMT an expected cost expenditure (obtained from mission essential tasks for each Essential Function) to equip personnel at alternate locations.
* Transportation - To the extent possible, RT personnel are encouraged to use their privately owned vehicles to commute to a pre-identified alternate location.
* Lodging – To be determined on a case-by case basis by the CEO or CFO.
* Dining – Use standard meal allowances for reimbursement where applicable.
* Program Charge Cards – Contact list for charge card numbers and authorizations.
* CEO or CFO authorizes credit card purchases for non-cardholding staff.
* Keep financial operations functioning.
* Develop an emergency expenditure process that identifies the procedures and personnel authorized to procure equipment and resources necessary to perform Essential Functions.

## Employee Leave and Compensation During a Disaster

Develop sick leave policies for staff that are non-punitive, flexible and consistent with public health guidance to allow and encourage staff with suspected or confirmed influenza to stay home.

The following polices address employee compensation and sick-leave absences unique to a disaster situation. These policies shall become effective at the discretion of the CEO/HR to meet the immediate CMHC needs.

Leave for an employee who is a victim of a disaster. Leave may be available under this policy to an employee who has sustained severe or catastrophic damage to or loss of his/her primary personal residence, or has been ordered to evacuate that residence, as a result of a natural or man-made emergency or disaster. An employee requesting such leave must meet all criteria noted below:

* The event resulted in a formal declaration of a State or Federal Emergency.
* The employee or immediate family members require hospitalization.
* The employee’s primary personal residence was located in the officially declared disaster area.
* The employee’s primary residence is temporarily or permanently uninhabitable as formally documented by disaster relief organizations or insurance companies.

The immediate supervisor has discretion for authorizing the use of Disaster Leave for an employee who is a victim of a disaster in the increments and up to the maximum permitted as noted previously.  In cases for which it is impossible to request leave in advance (e.g., immediately following a disaster when communications are unavailable), paid leave may be granted retroactively by the supervisor upon written request. The CMHC will not pay for expenses incurred by the individual in recovering from the personal effects of a disaster.

Policies and procedures need to be developed for staff not utilized during relocation due to space limitation or they not considered mission-essential. The policy also needs to address staff assigned to work from home due to the event, or in the case of a pandemic event, when employees are instructed to not report to work.

# Records Management

Each department needs to access their records, databases, and vital files. This should include restricted or sensitive data. Department should:

* Determine which documents are necessary to perform Essential Functions and activities and to start normal operations after the emergency ceases.
* Back-up this data and if possible, store the information in different formats at more than one location if using an in-house server.
* Prioritize the records based on:
	+ Information required for emergency operations.
	+ Legal and financial records.
	+ Sensitive and restricted information.
	+ Operations and reports.
	+ Other.
* Develop a data base for vital record management.

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| **Records Management** |
|  **Vital Record** | **Form of Record (Hardcopy or Electronic)** | **Pre-positioned at Alternate Location** | **Hand-carry to Alternate Location** |
| Network Email. |  |  |  |
| Psych Consult. |  |  |  |
| Personnel Contacts. |  |  |  |
| Time Records. |  |  |  |
| Accounts Receivables. |  |  |  |
| Account Payable. |  |  |  |
| Vendor Information. |  |  |  |

# Testing, Training and Exercise Program

Training will be conducted at new employee hire and on an annual basis. The COOP may be included in the employee handbook with the Disaster Response Plan.

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| **COOP Training and Exercise Plan** |
| **Program** | **Method** | **Audience** | **Frequency** |
| Annual Review.  | Classroom and Study Materials. | AMT.  | At-least annually.  |
| Transfer of Authority and termination of devolution.  | Workshop. | AMT. | At-least annually.  |
| Special Team Orientation.  | Workshop.  | Special Teams.  | Upon completion of the plan and when necessary to replace key personnel.  |
| Orientation.  | Personal. | New Employees.  | Within 30 days of hiring.  |
| Refresher.  | Workshop and Individual.  | All Employees.  | Annual.  |
| COOP Training and Exercises (to include relocation to an alternate facility and establishment of communication systems).  | Workshop and Exercises. | Relocation Team.  | Annual.  |

# Pandemic Annex

The most serious challenge that the CMHC will likely face during an influenza pandemic is to keep operations functioning despite increases in call volume, workforce shortages and absenteeism, supply chain disruptions and other threats to continued operations. The foundation of a viable COOP program is the development and documentation of a COOP plan that provides for the continued performance of an organization’s Essential Functions under all circumstances.

It is important to recognize that a severe influenza pandemic will likely have a significant mental health effect on Kansas’ citizens, responders and government officials. During the times between pandemic waves, behavioral health professionals may be needed across all sectors of society to promote resiliency and provide crisis counseling and stress management opportunities for individuals. Considering the likely economic impact workers will face as a result of a severe pandemic, behavioral health providers will potentially be called upon by industry to assist with individuals being returned to work, or with workers displaced because of reductions in work load.

A Pandemic Influenza (PI) event is anticipated to have far-reaching psychosocial consequences for a large proportion of the population. Interventions will be directly targeted to affected communities; to physicians and other front-line health care workers; and to populations such as special needs populations, children, the homeless and the homebound and those who may be especially vulnerable to mental health consequences of a PI event.

A major part of the recovery process will be dealing with the impacts of influenza-related deaths. The need for psychosocial support and mental health needs will be significant, since most people will have either suffered from illness themselves or lost family members, friends, and co-workers to pandemic influenza. Therefore, in addition to recovery activities that are required after any emergency, recovery from pandemic influenza will require considerable resources devoted to psychological needs.

# Introduction

Experts agree an influenza pandemic is inevitable. Influenza viruses are unique in their ability to cause sudden illness among humans in all age groups on a global scale. The importance of influenza viruses as biologic threats is due to a number of factors including the high degree of transmissibility, the presence of a vast reservoir of novel variants (primarily aquatic birds) and the unusual properties of the viral genome. The infamous “Spanish flu” of 1918-19 was responsible for more than 20 million deaths worldwide, primarily among young adults. Mortality rates associated with recent pandemics of 1957 and 1968 were reduced in part by the use of antibiotic therapy for secondary bacterial infections and aggressive supportive care of infected patients. However, these later pandemics were associated with high rates of morbidity and social disruption. Although the 2009 H1N1 pandemic influenza virus had a low pathogenicity, mortality was reduced in part due to national implementation of community disease mitigation measures developed as part of pandemic influenza planning. The Centers for Disease Control and Prevention (CDC) estimates the economic loss associated with the next severe pandemic will be in the billions of dollars.

# Background

Influenza is an illness caused by viruses that infect the respiratory tract of humans. Signs and symptoms of influenza infection include rapid onset of high fever, chills, sore throat, runny nose, severe headache, nonproductive cough, and intense body aches followed by extreme fatigue. Influenza is a highly contagious illness and can be spread easily from one person to another. It is spread through contact with droplets from the nose and throat of an infected person during coughing and sneezing. The period between exposure to the virus and the onset of illness is usually about two days, although it can range from 1-5 days. Patients are most infectious during the 24 hours before the onset of symptoms and for 3-5 days after onset of illness. Influenza is highly contagious and persons who are sub-clinically infected (show no signs of illness) can transmit the virus. Influenza is not an endemic disease, but in the northern hemisphere annual epidemics usually occur from December through April.

There are two types of influenza viruses that cause significant disease in humans: type A and type B. Only influenza A has been known to cause pandemics. Influenza A viruses are composed of two major antigenic structures essential to the production of influenza vaccines and the induction of immunity: hemagglutinin (H) and neuraminidase (N). Influenza A viruses are unique because they can infect both humans and animals; most influenza A viruses are considered to be avian in origin. Worldwide avian influenza control efforts are coordinated by the World Organization for Animal Health. The state animal agency (i.e., Kansas Department of Agriculture, Division of Animal Health (KDAH) would play a role in these efforts.

# Fundamental Elements to Prevent Influenza Transmission

Preventing transmission of influenza virus and other infectious agents within the facility requires a multi-faceted approach. Spread of influenza virus can occur among client’s, providers, and visitors; in addition, providers may acquire influenza from persons in their household or community. The core prevention strategies include:

* Administration of influenza vaccine.
* Implementation of respiratory hygiene and cough etiquette.
* Adherence to infection control precautions for all patient-care activities and aerosol-generating procedures.
* Implementing environmental and engineering infection control measures.

Successful implementation of many, if not all, of these strategies is dependent on the presence of clear administrative policies and organizational leadership that promote and facilitate adherence to these recommendations among the various people within the facility, including client’s, visitors, staff and providers. These administrative measures are included within each recommendation where appropriate. Furthermore, this guidance should be implemented in the context of a comprehensive infection prevention program to prevent transmission of all infectious agents among client’s, staff and providers.

## Take Steps to Minimize Potential Exposures

A range of administrative policies and practices can be used to minimize influenza exposures before arrival, upon arrival, and throughout the duration of the visit to the facility. Measures include screening and triage of symptomatic client’s and implementation of respiratory hygiene and cough etiquette. [Respiratory hygiene](http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm) and cough etiquette are measures designed to minimize potential exposures of all respiratory pathogens, including influenza virus, in facilities and should be adhered to by everyone – client’s, visitors, staff and providers – upon entry and continued for the entire duration of stay in the facility.

# Planning Assumptions and Considerations

The provision of mental health/psycho-social support to workers is especially important during a pandemic. Healthcare workers will be under constant stress due to their increased risk of contracting influenza, the likely inordinate increase in the number of patient deaths, and the possible alteration of standards of patient care necessitated by the pandemic. In addition, staff may experience the stress of ill persons at home or recent death of a family member and/ or friend. The necessity of working while wearing PPE and the possibility of quarantine can also take a toll. Plan for downsizing services but also anticipate any scenario which may require a surge in CMHC services.

The CMHC has an important role in protecting employee health and safety, and limiting the impact of an influenza pandemic. It is important to work with community planners to integrate your pandemic plan into local and state planning, particularly if your operations are part of the nation's critical infrastructure or key resources. Integration with local community planners will allow you to access resources and information promptly to maintain operations and keep your employees safe.

The following are assumptions that provide a basis for preparedness activities pertaining to pandemic influenza:

* Medical services and mental healthcare workers may be overwhelmed during an influenza pandemic, and medical supplies may be insufficient.
* During a pandemic, the staff will likely encounter some unreliable and possibly false information in the media and on the Internet.
* Mental healthcare workers may not be able to provide essential care to all patients in need.
* Pandemics may have very mild or very severe morbidity, mortality, and economic impacts to individuals and society.
* CMHCs should be ready with a scalable response system.
* Outbreaks can be expected to occur simultaneously throughout Kansas, making mutual aid resources that are usually available in response to other disasters unobtainable.
* Localities should be prepared to rely on their own resources to respond.
* As with many public health emergencies, the effect of influenza on individual communities will be relatively prolonged (weeks to months) in comparison with other types of disasters.
* Anticipating a high attack rate associated with severe pandemic influenza viruses.
* Physical infrastructure may be threatened or destroyed if there is civil disorder.
* In home healthcare workers may be at higher risk of exposure and illness than the general population, further straining the mental healthcare system.
* Effective prevention and therapeutic measures, including vaccine and antiviral medications, will likely be delayed and in short supply.

# Personal Protective Gear

No matter how careful you are, there is a potential for becoming infected in a PI environment. PPE is designed to protect you by forming a barrier between you and potential contamination. Without PPE you are at greater risk of becoming sick or infecting others. Determining equipment necessary to protect staff and client’s prior to an outbreak is essential. Developing these procedures after an outbreak occurs may be too late.

Monitor KDHE to help determine Personal Protective Equipment requirements for the CMHC staff. The below are examples and CMHC specific needs should be identified.

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| **Personnel Protective Equipment Considerations** |
| Task | Notes |
| Determine staffing needs. | Limited to staff with direct contact. |
| Develop HR policy on employee wearing of PPE. | A Health Department declared pandemic requires the CMHC to implement their policy. |
| Develop HR policy on providing clients with PPE. | Home health care clients demanding PPE. If facility remains open, is PPE provided to all visitors of the facility. |
| Determine appropriate PPE for providers. | Masks and gloves will be worn during home visits. Health Department may determine PPE requirements.  |
| Identify suppliers of PPE. | ACME PPE Company. Additional suppliers need to be identified if normal supply channels are overwhelmed by demand. |
| PPE on hand. | (Enter inventory amount here)  |
| Validate and monitor expiration dates of PPE. | Will be conducted quarterly. |
| Procedures to properly collect and dispose of potentially contaminated PPE. | Contracted with local hospital for medical waste disposal. |

## Policy Requiring The Wear Of Personal Protective Equipment By Staff

Insert CMHCs policy regarding the wear of PPE of staff involved in interaction with clients

# Facility Exposure Control

Keep in mind that a Pandemic can strike suddenly, so people may come to work feeling fine and be sick before the day is over. Implement procedures for increasing the frequency and thoroughness of office cleaning in the event of a pandemic such as:

* Disinfecting telephones.
* Disinfecting of public and staff restrooms.
* Discontinue the practice of employees bringing communal food and beverages.
* Consider the wearing of disposable filter masks.
* Implement procedures to properly collect and dispose of potentially contaminated cleaning supplies.
* Segregated waiting rooms for those displaying symptoms.
* Determine if the facility will be closed.
* Determine level of clinical patient care based upon lethality of pandemic.
* Determine clients seen at a clinic based upon visible symptoms.
* Determine HVAC capabilities to ensure airborne contaminants are not spread through ventilation system.

## Before Arrival of clients or VISITORS to a Facility

* When scheduling appointments, instruct client’s and persons who accompany them to inform providers upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry).
* During periods of increased influenza activity:
	+ Take steps to minimize elective visits by clients with suspected or confirmed influenza. For example, consider establishing procedures to minimize visits by client’s seeking care for mild influenza-like illness who are not at increased risk for complications from influenza (e.g., provide telephone consultation to client’s with mild respiratory illness to determine if there is a need to visit the facility).

## Upon Entry and During Visit to a Facility

* Take steps to ensure all persons with symptoms of a respiratory infection adhere to respiratory hygiene, cough etiquette, and hand hygiene throughout the duration of the visit. These might include:
	+ Posting visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) to provide client’s and providers with instructions (in appropriate languages) about respiratory hygiene and cough etiquette, especially during periods when influenza virus is circulating in the community. Instructions should include:
		- How to use facemasks or tissues to cover nose and mouth when coughing or sneezing and to dispose of contaminated items in waste receptacles.
		- How and when to perform hand hygiene.
	+ Implementing procedures during patient registration that facilitate adherence to appropriate precautions (e.g., at the time of client check-in, inquire about presence of symptoms of a respiratory infection, and if present, provide instructions).
* Provide facemasks to clients with signs and symptoms of respiratory infection.
* Provide supplies to perform hand hygiene to all client’s upon arrival to facility (e.g., at entrances of facility, waiting rooms, at client check-in) and throughout the entire duration of the visit to the facility.
* Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these client’s in a separate area while waiting for care.

During periods of increased community influenza activity, facilities should consider setting up triage stations that facilitate rapid screening of client’s for symptoms of influenza and separation from other client’s.

# Information Management

Improved situational awareness through information sharing regarding both patients and resources will enable better management of assets during a pandemic and provide for real time epidemiological analysis. KDHE will utilize the Kansas Health Alert Network (KS-HAN) to communicate relevant pandemic influenza information to CMHCs.

## Internal Information and Communication

In an emergency, accurate, consistent and timely messages are key in notifying and educating the staff. These messages will include notifying and facilitating movement of emergency staff to their assigned duties and stations, and in activating the emergency plan as intended.

Provide training, education and informational material about business-essential job functions and employee health and safety, including proper hygiene practices and the use of any personal protective equipment to be used in the workplace.

At a minimum the following issues that should be discussed and disseminated to staff:

• Daily staff meetings will be held, either in-person or conference call, to update staff on the current pandemic situation.

* Identify any unique client requirements.
* Identify provider staffing requirements relating to client care.
* Identify administrative staffing requirements.
* Updates provided to staff from KS-HAN to provide a statewide mental health awareness picture.
* Provide staff with any CDC, KDHE, KDADS or ESF 8 updates.
* CMHC Disaster Coordinator will provide catchment area updates as provided by County Emergency Managers or ESF 8 Coordinators.

• CMHC providers will be provided information and guidelines for safe interaction with their clients.

* The CEO or designee will determine if it is necessary to establish a Family Assistance Center where information can be received and disseminated by means other than personal contact, in order to reduce potential exposure to virus.
* Identify psychological reactions and develop recommendations for positive coping strategies.
* Develop mutual aid strategies among community mental health centers.
* Encourage employees, who are able, to receive flu vaccinations on an annual basis.

## External Public Information and Warnings

CMHCs will have a role in drafting messages and providing services to established clients and the general population during this time. These messages may also address the expectation of deaths at places other than medical care facilities, depending on the severity of the pandemic. The CMHC, through the PIO, will make Public Service Announcements that will include:

* Mechanisms for communication with the public will vary depending on the phase of the pandemic and its impact on Kansas communities.
* Pamphlets and information materials concerning the influenza pandemic.
* Information relative to hours of operation and locations of clinics.
* Personal Protective Equipment (PPE) worn by provider to protect their clients from potential contamination.
* Basic communication materials (such as question and answer sheets and fact sheets) on influenza, influenza vaccine, antiviral medication and other relevant topics in various languages.
* General preventive measures such as “dos and don’ts” for the general public.
* Basic information about influenza (including prevention, symptoms and transmission).
* Information on how to access the virtual Family Assistance Center.

All attachments must be referenced by title in the body of this COOP.

# Attachment 1 – CMHC Organizational Chart

# Attachment 2 – CMHC Employee Contact Information

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| **Name** | **Address** | **Phone Number** |
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| **CMHC Employee Contact Information (continued)** |
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# Attachment 3 – Client Risk Analysis

Each level of risk should have corresponding procedures for dealing with clients both in-home and in a clinical setting. These procedures should also deal with a notification process when a Home Healthcare Worker is entering and leaving a client categorized in medium and high risk. (Insert matrix and procedures here)

The concept of “risk assessment” is of increasing relevance when dealing with the prevention of criminal behavior. This risk can be examined from a number of viewpoints. Mullen (1997: 169) states that the mental illness most consistently associated with the increased risk of violent behavior is schizophrenia. However, among homicide offenders, the incidence of depression at the time of the offence is relatively high. The general literature appears to suggest that mental illness, of itself, does not reliably predict violence (Mullen 1996). However, some symptoms of mental illness are related to risk. Mullen (2000) includes in this category: active symptoms, poor compliance with medication and treatment, poor engagement with treatment services, treatment resistance and lack of insight into the illness.

For the protection of Home Healthcare Staff and visitors to the facility, every client/client should be evaluated on their potential for violence. Develop a matrix for each client that would place them in “Low Risk”, “Medium Risk”, and “High Risk” categories. At least 3 staff members should evaluate each client to use the mean average for determining client status.

# Attachment 4 - Homebound Client Evacuation

The below are concerns that should be taken into consideration when developing policies and protocols concerning homebound client evacuations. (Insert policies, procedures and protocols in place of the below criteria)

In many cases mental health workers may be the only outside contact with homebound clients. In the event of a disaster where evacuations are required only mental health professionals may be aware of the client’s inability to self-evacuate.

Every county Emergency Manager is required to have a plan that identifies and assists special needs populations in evacuation and sheltering. In many cases, due to confidentiality restrictions, mental health homebound clients are not included in these county emergency plans.

The following considerations should be addressed as part of this COOP:

* A continually and easily accessible (hard copy in case power is out) updated roster of homebound clients.
* Determination by the CMHC if staff is physically going to be involved in the relocation of homebound clients. If the decision is to be actively involved in relocation the following needs to be considered.
	+ Each client needs to be evaluated to determine the staff requirements for physical relocation.
	+ Transportation requirements.
		- Plans should not be dependent on the availability of first responders.
		- First responders will be occupied with lifesaving efforts due to the event.
		- Determine internal transportation assets in relation to the number of homebound clients.
		- If internal transportation assets are insufficient then there needs to be a Memorandum of Agreement with an agency capable of providing transportation needs.
	+ Can the client be sheltered with the general population?
	+ Treatment considerations while sheltered.
	+ What is the mental health impact on the client being evacuated and will it require additional staffing.
	+ Medication requirements.
	+ If the client cannot be sheltered with the general population, where are they going to be sheltered?
* Determine how long staff will stay in an evacuation area attempting to convince clients to evacuate.
* Action to be taken in the client refuses to evacuate.
	+ Notify Emergency Manager.
	+ Notify Law Enforcement.
	+ Notify County Health Department.
* Federal law requires that pets are part of the evacuation process and plans should include this potential.
	+ Transportation for pets.
	+ Boarding, feeding and care of pets.
* If CMHCs determine not to be involved in the physical relocation of homebound clients, the following actions should be taken.
	+ Emergency Managers should be notified of the location and limitations of the clients.
	+ Emergency Managers should be notified of any specific sheltering needs outside of the general population sheltering.
	+ If Emergency Mangers are unable to provide support, the following actions should be considered.
		- What agency or individual will make contact with homebound clients?
		- A Memorandum of Agreement must be in-place with an agency to provide transportation needs for homebound clients. (Consider using an agency in a county other than where the homebound client is located.)
		- A Memorandum of Agreement must be in-place with a facility if special sheltering requirements are needed.
		- Work with county Health Departments to develop a plan.

# Attachment 4 – Tornado Sheltering Procedures

(Insert policies, procedures and protocols here)

# Attachment 5 – Fire Procedures

(Insert policies, procedures and protocols here)

# Attachment 6 – Active Shooter Procedures

(Insert policies, procedures and protocols here)

# Attachment 7 – Bomb Threat

(Insert policies, procedures and protocols here)



# Attachment 8 – Building Evacuation (Non Fire)

(Insert policies, procedures and protocols here)