
# Response and Recovery Plan

**June 2024**

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# 1.0 Coalition Overview

The Mid-South Emergency Planning Coalition (MSEPC) is a forum for the health care community to interact with one another and with other response agencies and community partners at a county, regional, and state level. MSEPC activities are based on the capabilities identified by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (ASPR). The MSEPC coordinates trainings to assist health care responders in developing the necessary skills and improves health care response through coordinated exercises and evaluation.

The MSEPC is a multi-agency coordinating group that assists the health care community and other emergency response agencies to jointly prepare for, respond to, and recover from disaster events and public health emergencies. The MSEPC serves as a cooperative alliance of health, response, and other governmental agencies, along with other community partners in the region through collaborative planning and information sharing among a broad range of health care partners to protect, promote, and improve the health and prosperity of people in the Mid-South and across the state.

## 1.1 Mission

The mission of the MSEPC is to support the development of cooperative partnerships that promote and enhance the well-being of the community's healthcare system through coordinated disaster preparedness, education, public information, response/recovery activities, and sharing of resources.

## 1.2 Coalition Boundaries and Information

The MSEPC is comprised of healthcare facilities, public health, emergency medical services (EMS), emergency management, and other support agencies, across a three-state, six-county region known as the Mid-South. The Coalition's primary function is to work as a regional unit to create and implement effective frameworks to respond to local emergency incidents and public health issues that affect member organizations in Shelby, Tipton, Fayette, and Lauderdale counties in Tennessee, DeSoto County in Mississippi, and Crittenden County in Arkansas. To achieve this, the Coalition uses grant funds and donations to identify healthcare emergency preparedness needs for the community and sets goals in which to meet those needs. As partners, the Coalition members work together on community hazard assessments, drills, exercises, resource sharing, and acquiring equipment and technology that can better serve them as healthcare providers and emergency responders.

## 1.3 Organizational Structure and Governance

The Coalition background and governance structure is explained fully in the MSEPC Bylaws and Preparedness Plan. The Coalition updates their Hazard Vulnerability Assessment (HVA) annually, which informs preparedness, planning, training, and exercise efforts. Membership is comprised of regional hospitals, public health, emergency management, emergency medical services, long-term care, outpatient providers, homeland security, and other healthcare-related response partners. Full membership information and all referenced documents can be obtained from the MSEPC website (www.midsouthepc.org). Plans are reviewed annually and updated as needed, and the website is updated as needed.

Each healthcare coalition employs a readiness and response coordinator as required by ASPR. These positions are responsible for facilitating the planning, training, exercising, operational readiness, financial sustainability, evaluation, and ongoing development of the HCC as well as leading, participating in, or supporting the response activities of the coalition according to their plans. For the MSEPC, this position is fulfilled by the Coalition's Executive Director. Fellow HCCs within Tennessee fulfill this position with a Regional Healthcare Coordinator (RHC). For purposes of this plan, all responsibilities included as performed by an RHC will be locally performed by the MSEPC Executive Director unless otherwise noted.

# 2.0 Purpose of Plan

The MSEPC Response Plan is an operational resource tool for health care response partners to reference in disaster planning, response, and recovery efforts. It provides resources for emergency preparedness and guidance for integrating the emergency medical response with other incident management partners. The purpose of this plan is to provide general guidelines and an overview for response activities to natural and manmade events that threaten the healthcare system within the Mid-South region and beyond.

## 2.1 Scope

This plan was developed to support the operational activities of the MSEPC and describes the role and functions of the MSEPC as it actively works with members including hospitals, regional health jurisdictions, emergency medical services, emergency management, etc) under ESF-8 of the TEMP. The plan and its appendices address general coalition governance and authorities, planning and purchasing processes, operational concepts, inter-agency communication, resource sharing and allocation, patient tracking, the Healthcare Resource Tracking System (HRTS), ReadyOp, and training and exercise components.

The collaborative planning developed through the Coalition is invaluable for a well-coordinated response among health care partners, however, each member of the HCC has its own plans, and members respond to emergencies in accordance with their organizations' plans.

## 2.2 Administrative Support

This plan was initially approved by Executive Board members and shared with all Active HCC members for their review and input prior to its final adoption. It is then reviewed by all Active Coalition members annually, at minimum, or at such time a gap is identified that should be immediately addressed following a real-world event or exercise.

During each routine annual review, attention will be paid to identifying gaps and developing strategies to address these issues, planning for exercises to evaluate the effectiveness of corrective actions, and considering the need for further revision of this plan based on findings.

This plan will be maintained by the MSPEC and shared with various Coalition partners including EMS, emergency management, and others as necessary. The Executive Director of the MSEPC will provide direct administrative support to the document.

# 3.0 Planning Assumptions

An emergency event or other healthcare system disruption could overwhelm the capacity and capability of MSEPC healthcare partners and resources (staff, supplies, equipment). Development of this plan assumes the following:

- Depending upon the magnitude of the incident, this entire plan or parts of it may be activated within single or multiple regions.
- Many victims requiring treatment and those seeking medical assistance will result in a reduction in the overall level of patient care.
- A member organization or the community can be affected by an internal or external emergency that has impacted operations up to and including the need for a facility to evacuate.
- Healthcare system partners will activate their emergency operations plan, staff their command centers, and coordinate closely to ensure continuation of critical services.
- Emergency response will require the participation of many healthcare system partners, as well as coordination with communal, government and non-governmental agencies to ensure a successful response. Roles and responsibilities of medical response partners are guided by the Shelby County ESF-8 Plan.
- State and federal resources may not be available for 72-96 hours after incident onset.
- Hospitals may cancel elective procedures, discharge non-critical patients, convert private rooms to semi-private rooms, establish alternate care facilities, and take other steps necessary to increase their surge capacity.
- Disaster mental health partners from psychiatric facilities and coordinated by the American Red Cross and state and local public health will provide support for behavioral health programs during a disaster event.
- Regional One Health, the regional trauma center, will continue to receive trauma and other patients requiring specialty services during an incident.
- Smaller hospitals may become overwhelmed quickly during mass casualty or highly contagious events and may require staffing and logistical support.
- Hospitals will have to hold and care for acute injuries that they would ordinarily transfer to a more specialized facility, including pediatrics.
- Processes and procedures outlined in this Response Plan are designed to support, and not supplant, individual healthcare organization emergency response efforts.
- The use of National Incident Management System (NIMS) consistent processes and procedures by the HCC will promote integration with public sector response efforts.
- Except in unusual circumstances, individual healthcare organizations retain their respective decision-making sovereignty during emergencies.
- This plan is based on certain assumptions about the existence of specific resources and capabilities that are subject to change. Therefore, flexibility is built into this plan. Some variations in the implementation of the concepts identified in this plan may be necessary to protect the health and safety of patients, healthcare facilities, and staff.

# 4.0 Concept of Operations

The process outlined below describes the basic flow of a response to disaster and emergency situations with the steps and activities that may need to be accomplished. Not all steps and activities will apply to all hazards.

## 4.1 Role of the MSEPC in Events

The overall role of the Coalition in an emergency or disaster event includes, but is not limited to, the following:

- Promote a common operating picture through shared information.
- Assist with resource management between partner entities, particularly within the healthcare sector for healthcare resources.
- Support patient tracking.
- Support evacuation activities.

## 4.2 Emergency Management

Emergency Management in Tennessee operates at the county level under the larger umbrella of the Tennessee Emergency Management Agency (TEMA) at the state level. TEMA's responsibility is to coordinate disaster response and recovery efforts across the state. TEMA develops and updates the TEMP which provides the foundation for all disaster and emergency response operations conducted within the state. Within the TEMP are Emergency Support Functions (ESFs). Each ESF details the lead agency and support agency roles in disaster response. ESF-8, Public Health and Medical Services, provides the mechanism for coordinated State assistance to supplement regional and local resources in response to public health and medical care needs for potential health and medical situations. ESF-8 is coordinated by the Department of Health primarily through the Emergency Service Coordinators (ESCs).

TEMA is divided into three grand divisions across the state, West, Middle, and East. The MSEPC falls within the TEMA West Region, along with our Coalition partners to the east, the West Area Tennessee Coalition of Healthcare (WATCH). The WATCH Coalition encompasses all other West Tennessee counties outside of the MSEPC boundaries.

TEMA regions were established to support and improve services to the local emergency management directors and agencies. Services include technical guidance, information on federal and state requirements for emergency management, updates on laws and regulations, technical advice on grants, NIMS and other reports required for federal funding, information on other training, and a rapid avenue to submit requests for state or other external mutual aid or assistance.

All county emergency management plans are required to mirror the TEMP in terms of structure and purpose. The county offices of emergency management will facilitate interagency coordination, provide centralized situation assessment and public information, coordinate the mobilization of local government resources in

response to an emergency, and coordinate community disaster recovery. If responding agencies, including the hospitals, have exhausted critical resources available through routine channels and through mutual aid, local EMA will request resources from the State Emergency Operations Center (SEOC) at TEMA. TEMA will coordinate emergency assistance to local jurisdictions from state agencies, other counties, other states, or the federal government.

The Shelby County Emergency Management and Homeland Security Agency is the county emergency management agency (EMA) office within the MSEPC. The City of Memphis Office of Emergency Management handles many city-level emergencies within Memphis, including those associated with healthcare facilities of the MSEPC, and works closely with Shelby County when any county-level assets are required. A list of all county EMAs can be found at https://www.tn.gov/tema.html under the Region information.

## 4.3 Healthcare System Partner Roles and Responsibilities

Response actions of the MSEPC healthcare partners would reflect that of a Multi-Agency Coordination (MAC) System. Within a MAC, each entity operationally responds within its own organization and/or discipline's incident command structure but works together to incorporate facilities, information systems, and internal and external communication systems. A MAC coordinates interagency cooperation, mutual aid agreements, common procedures, terminology, training and qualifications into an integrated common operating system that ensures effective interagency and inter-jurisdictional coordination.

### 4.3.1 Emergency Medical Services

The Region 8 Emergency Medical Services (EMS) coverage area includes Shelby, Fayette, Tipton, and Lauderdale Counties within Tennessee. Within these boundaries, the EMS services are comprised of the following elements:

- 8 Primary EMS Providers
- 6 EMS Providers with ALS and BLS capabilities
- 9 EMS Providers with only BLS capabilities
- 2 Specialty EMS Service Providers
- 2 Air-Ambulance Service Providers

The EMS Division has an important role in state government disaster planning and operations. The Division's specific responsibilities are described in the TEMP. EMS Division responsibilities include:

- Ensure continuity of normal 911/EMS operations during events.
- Verify deaths and injuries when occurring in a disaster
- Determine where patients were transported and by what means
- Produce official state casualty reports.
- Provide initial damage assessment and help to any health care facility damaged or disabled in a disaster. This includes reporting to TEMA and the Division of Health Care Facilities.

- Help local ambulance services manage the consequences of a mass casualty event. This includes contacting other services for help, identifying staging areas for responding ambulances, distributing patients to hospitals within the region, and emergency evacuation of health care facilities.

The EMS Director is the primary ESC for ESF-8 in the SEOC. The EMS Consultant is the regional representative for ESF-8 Coordination. Additionally, the Regional Medical Communications Center (RMCC) falls under EMS leadership within the state of Tennessee. This serves as the 24/7 communications coordination center during events. The RMCC has communication capabilities to reach Coalition hospitals, EMS, other RMCCs, and local and state EOCs. RHCs generally respond to the RMCC during events to perform the information sharing and resource coordination roles of the healthcare coalition.

### 4.3.2 Public Health

The role of public health is to support, as the lead agency for ESF-8, the response to a public health or medical disaster within their jurisdiction. Each jurisdiction's emergency planning efforts are led by an Emergency Response Coordinator (ERC) who is responsible for developing the Health Department's All Hazards Emergency Operations Plan detailing lead responsibilities of public health during natural or manmade emergencies. Through the ERC, each public health jurisdiction is responsible for coordinating with other public health agencies, the Tennessee Department of Health (TDH), health care practitioners, hospitals, veterinarians, other health care professionals, and disease-reporting agencies for disease surveillance and control activities.

The Shelby County Health Department (SCHD) is the only recognized local public health department within the MSEPC. Because boundaries of the MSEPC reach into the West Region of TDH (Fayette, Lauderdale, and Tipton counties), the ERC for the SCHD will make appropriate notifications to and stay in close contact with the ERC at the West Region Office concerning any public health related threats or resource requests within the MSEPC boundaries. Because of several overlapping counties, the MSEPC Executive Director will make appropriate notifications to and stay in close contact with the RHC at the West Region Office concerning any healthcare facilities within the West Region due to the potential need for West Region resources such as healthcare facilities, EMS services, RMCC support, or other healthcare related requests the MSEPC may not be able to fulfill.

TDH maintains the State Health Operations Center (SHOC) that assists with coordinating medical response at the state level, working closely with the ESF-8 Coordinator at the SEOC. Additionally, each public health jurisdiction maintains a regional health operations center (RHOC) to support local public health coordination efforts during events.

### 4.3.3 Hospitals

There are 25 acute care hospitals in the Mid-South region. This includes the region's only Level 1 Trauma Center, the region's only ABA-Verified Burn Center, the region's only Comprehensive Pediatric Referral Center, four private mental health hospitals, four acute care rehabilitation hospitals, and a Veteran's Affairs Medical Center. Overall, there are approximately 3,500 acute care hospital beds in the Mid-South region.

During an emergency, hospitals are responsible for providing secondary triage and assessment, basic decontamination, emergency care/treatment, and isolation/quarantine of patients. Each hospital has an emergency response plan to address internal plan activation, emergency staffing, surge capacity including

additional bed expansion, isolation patient management, acquisition of additional supplies/equipment/pharmaceuticals, emergency evacuation, shelter-in-place, fatality management, and coordination with the local EMA and other hospitals in the region.

As patient numbers increase beyond the capacity of the impacted hospital, they will:

- Activate their internal Emergency Operations Plan (EOP).
- Contact the RMCC.
- Coordinate response efforts through the MSEPC.
- Maintain current bed availability through the Healthcare Resource Tracking System (HRTS).
- Share information and resources as outlined in the MSEPC Bylaws and Memorandum of Understanding (MOU).

### 4.3.4 Non-Hospital Facilities

There are more than 125 skilled nursing homes, assisted living facilities, surgical centers, home health agencies, hospice agencies, dialysis centers, primary blood providers, durable medical equipment providers, and other healthcare partners within the MSEPC. Most of these facilities have, at best, limited resources to participate in emergency preparedness and response planning. The MSEPC is working to broaden input from these providers through intentional outreach, meetings, and surveys.

Since joining the Coalition beginning in 2017, there is expanding participation from these partners in emergency planning. Many have strengthened their preparedness and response plans through the completion of facility specific HVA's and annual participation in community wide exercises with fellow Coalition partners.

Long term care and assisted living facilities, along with some ambulatory surgical centers, are including in their response plans the ability to accept hospital transfers from acute care facilities to free up bed space for surge patients. The ambulatory surgery centers have also agreed to take minor injuries directly from a mass casualty scene whenever available.

To accommodate these offers, all applicable facilities have been onboarded into (HRTS) to ensure more broad bed availability information and enhanced resource coordination with this sector of the healthcare system.

### 4.3.5 Medical Reserve Corps

The Medical Reserve Corps Program (MRC) includes over 200,000 volunteers in over 800 units across the country, ready to respond to emergencies and building resiliency in thousands of local communities through prevention, preparedness and public health activities.

MRC units play a large role in increasing health literacy, supporting prevention efforts and eliminating health disparities. The MRC unit in Shelby County is comprised of currently more than 2,000 active medical and non-medical volunteers and is housed in the Shelby County Health Department. MRC volunteers actively work with local organizations to support community public health response efforts. Some of the recent and ongoing activities include:

- Dispensing vaccines/medications for mass prophylaxis at POD (Point of Dispensing) clinics.
- Educating the community about emergency preparedness at health fairs.

- Participating in community-wide disaster drills and exercises.
- Serving as first aid staff at community events.
- Serving as nursing/medical staff during shelter operations.
- Staffing call centers when the EOC is activated.

MRC volunteers will support and assist the SCHD in staffing 20 identified POD sites, 10 shelter sites and providing mass vaccinations and other critical public health services during a declared disaster or public health emergency.

Volunteer information is maintained in the statewide, web-based registry called Tennessee Volunteer Mobilizer (TVM). It is designed to serve as a single, centralized source of information to ease the intra-state, state-to-state, and state- to-federal deployment or transfer of medical professionals and other volunteers. A part of the federal Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), TVM gives Tennessee the ability to quickly identify and assist in the coordination of volunteers in an emergency.

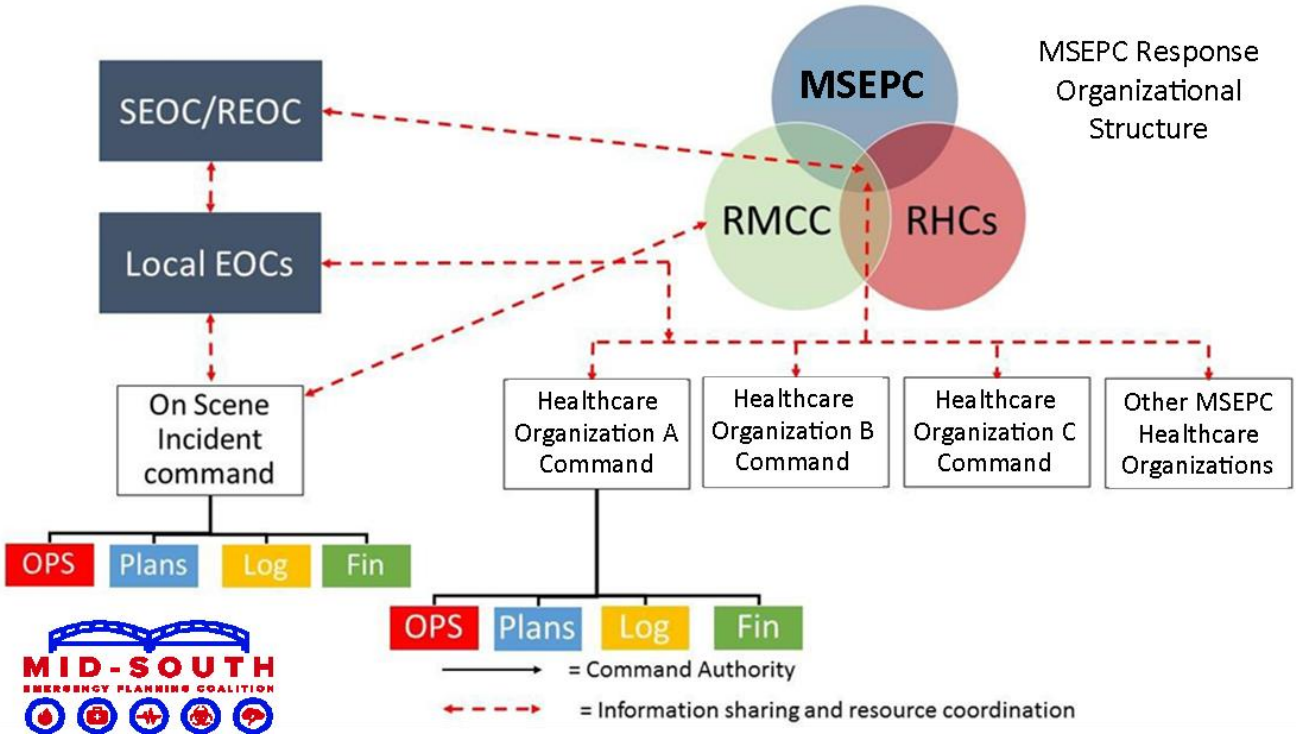
### 4.3.6 Other Partners

The MSEPC works closely with both governmental and non-governmental partners during preparedness and response planning activities. Representatives from many of agencies listed below regularly attend quarterly Coalition meetings and participate in annual community-wide exercises.

Supporting agencies of the MSEPC response include, but are not limited to, the following:

- Shelby County Emergency Management and Homeland Security Agency
- Shelby County Fire Department
- Shelby County Mayor's Office
- City of Memphis Fire Department
- City of Memphis Office of Emergency Management
- City of Memphis Mayor's Office
- City of Bartlett Fire Department
- City of Germantown Fire Department
- 164th Air National Guard
- United States Coast Guard
- Tennessee Department of Health
- Tennessee Emergency Management Agency
- Tennessee Department of Environment and Conservation
- The American Red Cross – Mid-South Chapter
- Children's Emergency Care Alliance
- Tennessee Emergency Medical Services for Children (TN EMSC)

## 4.4 Coalition Response Structure




The MSEPC is not an independent response body. Rather, each member of the Coalition has a primary organization to which they are accountable, and each member oversees their own response structure as indicated by the black solid lines on the organization chart above. The MSEPC serves as an information and resource coordination body for the healthcare community within its region – as a multi-agency coordination system. Each healthcare organization must staff an Incident Commander and/or Liaison Officer to communicate with the RHCs and the RMCC during events. Accordingly, the RHC role and the RMCC must be staffed during response operations. Together, these entities form the MSEPC response operations positions. Furthermore, the RMCC interacts directly with on-scene responders to provide information to MSEPC partners during events. Finally, the MSEPC communicates with local and state EOCs through the RMCC and RHC during response operations, with the RHC communicating with and providing situation awareness to the ESF-8 ESC.

# 5.0 SYSTEM RESPONSE & RESOURCE COORDINATION

Effective healthcare and medical response requires coordinated and integrated emergency management systems from the individual healthcare organization up to the federal response partners. Healthcare systems must coordinate effectively with one another and integrate with other response partners during an emergency. Healthcare system response is based on the US Department of Health and Human Services Medical Surge Capacity and Capability (MSCC) model of tiered emergency management.

The MSCC handbook can be accessed at:
http://www.phe.gov/Preparedness/planning/mscc/handbook/Pages/default.aspx.

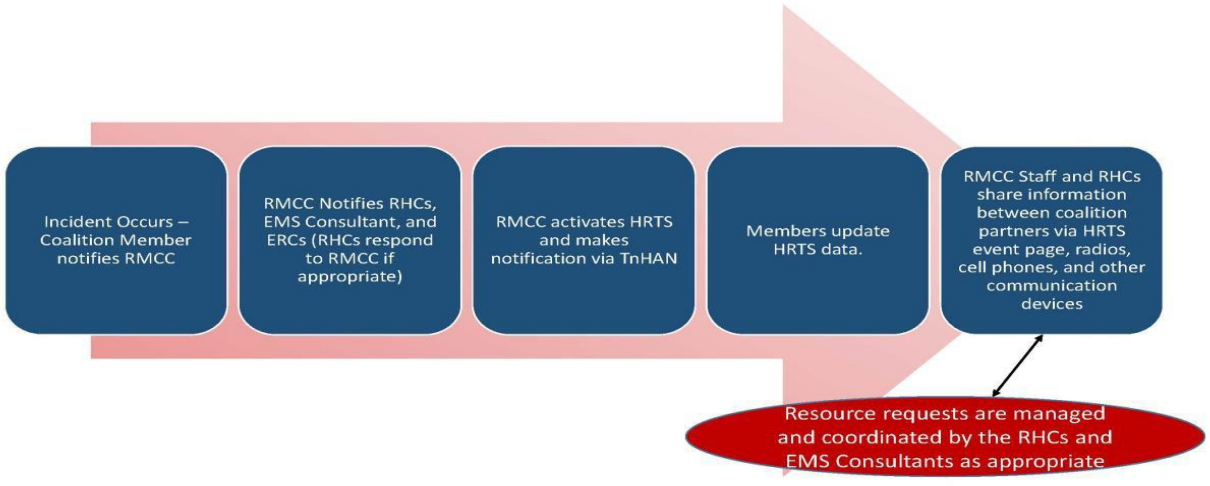
## 5.1 Incident Recognition

The MSEPC will be notified or become aware of an event that will trigger response via various avenues described below:

- A request to activate or monitor by a Coalition member or partner.
- Multi-jurisdictional outbreak as notified by the SCHD.
- Awareness through open source media, notification by a partner, notification by a local, state, or federal entity.
- Any substantive statewide alert message requiring action from public health and/or healthcare.

## 5.2 Activation

Following incident recognition, public health (ERCs, RHCs, and EMS Consultants) will coordinate to determine the level of activation required from monitoring to a fully staffed response with public health representatives deploying to the local or regional EOC, RHCs to the RMCC, and EMS Consultants to the scene, when applicable.




Then the following activities may occur:

- RMCC will activate HRTS to alert regional hospitals and partners of the event.
- Placing HRTS in disaster mode triggers hospitals & health care system partners to evaluate the level of response required and enhances situational awareness.
- Availability of facilities to receive patients will be monitored through HRTS by the RMCC, RHC, and the EMS Consultant.
- Resource coordination will be managed via the RHC, ERC, EMS Consultant, and local and state emergency management utilizing HRTS and WebEOC (for emergency management).

## 5.3 Notification and Information Sharing

The Mid-South Emergency Planning Coalition (MSEPC) Executive Director, or Executive Board members, when necessary, will utilize pre-established public health systems to share emergency information, warnings, and situational awareness across medical disciplines, jurisdictions, and Coalition members during public health and medical emergencies. This is typically accomplished via notification systems such as ReadyOp and the Healthcare Resource Tracking System (HRTS). Additionally, information may be passed to Coalition members via email or direct phone call, when necessary.

MSEPC essential information elements to be shared include:

- Bed Availability (HRTS)
- Resource Capabilities (HRTS)
- Organization and Service Capabilities (HRTS)
- Facility Status (form shared via ReadyOp and HRTS message board). This form allows the MSEPC and the RHC to quickly identify the facility status of mission critical systems such as electricity, water, and medical gases.

The MSEPC Executive Director, with support from the Executive Board, will serve as the lead coordinator for public messaging efforts for medical emergencies involving MSEPC membership collectively, MSEPC owned assets, or MSEPC sponsored events.

The Shelby County Health Department (SCHD) Public Information Officer (PIO) will serve as the lead coordinator for public messaging efforts for any public health related events or issues. The SCHD PIO does not serve as an official spokesperson for any agency other than SCHD but may utilize pre-existing contacts to coordinate public messaging efforts. This may occur through the processes outlined in item number one above or through a formally established Joint Information Center.

All MSEPC healthcare partners will utilize their own existing, internal and external public messaging processes to share facility specific information during a medical emergency. If additional information is needed, the Executive Director may be consulted, or facility public information representatives can consult with the SCHD PIO.

## 5.4 Mobilization

When necessary, RHCs will request the mobilization of key MSEPC healthcare organization decision makers. This is most often done via region-wide conference call but can occur face-to-face. However, most efforts are coordinated through communications via the HRTS event message board and to Coalition members not on HRTS via ReadyOp and the MSEPC membership distribution list.

# 6.0 Incident Operations

## 6.1 Initial MSECP Actions

- Establishing points of contact with jurisdictional authorities and other entities.
- Gathering initial information and sharing it with responding HCC members.
- Establish operational period and initial goals to include creation of an incident action plan for the Coalition.

## 6.2 Ongoing MSEPC Actions: Resource Coordination

### 6.2.1 Bed Tracking

HRTS is used daily by hospital, EMS, long term care, and RMCC's. Hospitals are encouraged to update their facility status, bed availability, and off load status each day by 4:00 p.m. EMS and Long-Term Care update available services and facility information weekly. All facilities are typically given an expectation of updating frequency (e.g. every 30 minutes, 60 minutes, 3 hours) during active HRTS events.

The purpose of the system is to provide situational awareness to assist hospitals, RHCs, EMS Consultants, and RMCC controllers in managing the following:

- Regional notifications, alerts, and incident communications.
- Availability of beds and services within hospitals, including isolation beds and Alternative Care Facilities (ACF).
- Inventory of critical equipment and supplies, including, ventilators, antidotes, decontamination units and personal protective equipment (PPE).
- Movement of patients between hospitals.
- Coordination of EMS.
- Communications with hospitals in the region and other RMCCs within the state.

### 6.2.2 Patient Tracking

MSEPC will utilize ReadyOp – the TDH patient tracking system – to track all patients associated with a mass casualty event. MSEPC partners will be provided training on a quarterly basis. Also, the MSEPC partners will be notified of a patient tracking activation during events through HRTS, ReadyOp (notifications), and/or the MSEPC distribution list.

## 6.3 Ongoing MSEPC Actions: Emergency and Redundant Communication Systems

The MSEPC has several alternate forms of communication available. Preferred forms of communications may vary by discipline. The alternate forms are listed below in approximate priority of preferred and attempted use.

### 6.3.1 Landlines and Cellular telephones

Both methods of communication, although convenient, have proven to be unreliable forms of communication in a disaster, especially a weather related one. Landlines and cellular phones are utilized regularly as part of preparedness planning but not as part of redundant communication exercises.

### 6.3.2 ReadyOp

ReadyOp is a web based alerting system that provides for timely dissemination of emergency and health related information by telephoning, emailing and texting. The SHOC, RHOCs, EMS partners, RMCCs, MSEPC healthcare partners, and limited local EOC staff are activated with this system.

### 6.3.3 Healthcare Resource Tracking System (HRTS)

HRTS provides a means of communication between the hospitals, the RHCs, EMS, and RMCCs during a disaster event by means of the message board or event pages.

### 6.3.4 Regional Medical Communications Center (RMCC)

The communication resources of the RMCC are vast and robust and key to MSEPC communication efforts in emergencies. They maintain every type of radio communication capability available (VHF, UHF, 800, HAM, Winlink). They ensure communication channels are capable between all hospitals and EMS providers. Additionally, they can communicate with state and local EOCs, other RMCCs across the state, and many other agencies.

### 6.3.5 Satellite telephones

The SHOC and each RHOC are equipped with satellite phones. Some hospitals have satellite phones as well. These would be used if all other forms of communication failed.

### 6.3.6 Amateur radios

The RHOC, SHOC, RMCCs, local EMAs and hospitals are equipped with amateur radios. Amateur radios may be used for communication between health care facilities and local, county, and state emergency organizations. The MSEPC hospitals conduct a monthly hospital net call to test equipment and systems. The Amateur Radio Emergency Service (ARES) is a communication service consisting of licensed operators that have voluntarily registered their qualifications and equipment for duty in public service. Local ARES Emergency Coordinators are listed at http://tnarrl.org/wp/?page_id=23 .

### 6.3.7 Hospital and EMS Emergency Radio System

The Division of EMS coordinates provision of effective and rapid delivery of emergency medical services to the general population and operational radio communications between ambulances and hospitals. The Division maintains liaison with emergency service agencies and the Tennessee Emergency Communications Board concerning access of emergency medical services through the 911 emergency-telephone system. Special radio systems and frequencies are used to dispatch ambulances and provide for medical communications between the ambulance and hospital.

### 6.3.8 TDH Mobile Operations Center (MOC)

TDH houses one MOC in the West Region (located at the Jackson Fire Department in Madison County. The MOC can be mobilized if needed by contacting the Region 7 RMCC or the West Region ERC. The MOC communication

abilities include: an extensive radio system consisting of the following ten public safety radios: low-band, VHF high band, TEMA - compliant external Motorola Data Communications (MDC) board two-way radio (UHF), 700/800 MHz, aircraft, CB radio, Bearcat digital scanner, National Oceanic Atmospheric Administration (NOAA) weather radio, amateur all band, and marine. The MOC also has a specialized satellite and cellular based voice and data broadband system. Eight Cisco Voice Over Internet phones (VoIP) consisting of satellite and cellular based broadband are available. The unit houses a 1,000-fiber optic cable that allows hook up to an outrigger to provide additional workspaces. Audio-visual inputs are available from digital satellite, local TV and computers. The electrical system can be powered from an onboard diesel generator or shore power input cord.

### 6.3.9 Tennessee Disaster Support Network

TDH maintains as part of their public access website, the Tennessee Disaster Support Network (TDSN): http://health.state.tn.us/CEDS/TNDisSup/keyword. Because individuals with special needs may be disproportionately affected by a disaster, the TDSN offers resources to help meet those needs before, during, and after a disaster. This web-based resource also has materials for agencies and providers who work with special needs populations. In addition, this website could be utilized to post important information for the public.

### 6.3.10 Emergency Alert System (EAS)

Tennessee has established procedures for issuing emergency messages or safety advisories to the public utilizing major media (radio/television). At the state level, TEMA and the National Weather Service (NWS) have the authority to activate the EAS. Local authorities may initiate EAS messages through the appropriate radio stations for their operational area.

# 7.0 SURGE CAPACITY

Healthcare system partners operate within the context of this plan and authority is derived through regional agreements, authority given under various legislative actions, Tennessee Code, and Executive orders. In general, Coalition members strive to reach at least 20% (700 beds for the approximate 3,500 staffed acute care beds in the region) surge, which is accomplished with coordinating resources between healthcare coalition partners to include hospitals, long-term care, home health and other agencies. Triggers will vary depending on the event; they can be acute events such as a mass casualty incident or less overtly recognized such as a disease outbreak. Nevertheless, the plan may be activated at the request of a Coalition member organization.

Surge capacity may be identified early with specialty patients such as pediatric or burn patients. The initial course of action for hospitals experiencing surge capacity issues is to contact the RMCC, as they have regularly-utilized referral options in place associated with their additional role as the region's air medical critical care transport. They have pre-established contacts with the closest burn, pediatric, and other specialty centers. If needs cannot be met through these channels or are specific to the region, the RHC should be contacted. The RHC will then convene each hospital and other pertinent organizations to develop a course of action to address the immediate needs.

Healthcare partners experiencing equipment and supply shortages may utilize established agreements and relationships with other agencies and/or vendors included in the MSEPC MOU. Additionally, each healthcare organization has emergency delivery agreements established with suppliers of fuel for back-up generator power, medical supplies, laundry service, medical gases, blood, food, potable water, medical equipment rental, service equipment, etc. If an internal or external disaster results in a shortage of essential supplies, 24/7 contacts can be made with the appropriate suppliers. Similar agreements are in place for other healthcare partners within the MSEPC.

## Activation of Tennessee Guidelines for Ethical Allocation of Scarce Resources

For events that exceed the scope of local, regional, and state resources, Tennessee has developed a crisis standards of care (CSC) plan entitled: "Guidance for Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee." The MSEPC understands that CSC may be invoked following both a Governor's Proclamation and an Executive Order.

The use of Crisis Standards of Care (CSC) could occur suddenly or may result from a slow escalation of an event. The Health Commissioner, in consultation with the Governor's Office, can make the declaration with the details for the situation. The public and health providers will be notified through Tennessee Emergency Management Agency and ESF 8 communications systems as well as other public communication channels.

The Tennessee Department of Health Mission Coordination Group (MCG) will provide expert advisory input for guidance implementation. The MCG is a standing core group composed of the Commissioner of Health, the Chief Medical Officer, the State Epidemiologist, the Emergency Preparedness Program and Medical Directors. Additionally, the Commissioner may appoint Subject Matter Experts (SMEs) appropriate to the situation to assist in determining policy, objectives, strategies, plans, and priorities for overseeing response activities for and recovery from a disaster that may cause this guidance to be initiated.

A local decision to implement the TN Guidance for Ethical Allocation of Scarce Resources guidelines should be based upon the degree of the public health emergency and available healthcare capacity. Specifically, Guidance for Ethical Allocation of Scarce Resources may be initiated only after all the following conditions have been met:

- Surge capacity is fully employed within healthcare facilities and the healthcare coalition(s)
- Attempts at conservation, reutilization, adaption, and substitution have been performed maximally
- Critically limited resources have been identified (e.g., ventilators, antibiotics)
- Infrastructure resource needs have been identified (e.g., isolation, staff, electrical power)
- Resources and/or infrastructure needs cannot be met by local and regional health officials
- Requests for federal and state resources cannot be timely met.
- The appropriate institutional committee has reviewed and recommends initiation of the Guidance for Ethical Allocation of Scarce Resources.

It is imperative that all healthcare coalitions and hospitals work together as much as possible to maximize all available resources. It is recognized that within individual regions and institutions, the criteria for implementation of these guidelines may occur at different times.

The guidance is available on the Coalition website. Additionally, MSEPC partners are encouraged to ensure internal plans address CSC and a method of implementing the plan (to include a pre-established ethics committee) is in place.

The MSEPC maintains an inventory of medical surge equipment resources. The RHC is responsible for coordinating the regional surge supplies for additional medical surge resource requests. Regional surge supplies that are in limited quantity will be provided on a first come, first serve basis unless the RHC has regional intelligence that indicates they will better be served elsewhere. If the CSC plan has been activated, the RHC will follow the guidance by the convened CSC ethics committee. For large quantity resources (such as surgical masks), the MSEPC will provide resources based on regional bed and/or staff percentages.

Additionally, state and federal resource support should be requested through the requesting organization's local EMA. The RHC may assist in facilitating the request.

## 7.1 Trauma Round Robin

Due to the extreme incidents of trauma across the Mid-South region, local hospital systems, the RMCC, and local primary EMS services have instituted a practice known as "trauma round robin". This takes place any time the Level 1 trauma center is at capacity.

When this happens, the RMCC notifies all EMS services and four local hospitals that have agreed to take trauma patients in the interim. EMS services coordinate with the RMCC to re-route trauma patients to the trauma round robin facilities until they are notified that the round robin has been canceled.

## 7.2 Alternate Care Facilities (ACFs)

ACFs are facilities or structures designed to temporarily augment the existing healthcare infrastructure during an emergency or to temporarily replace damaged facilities. An ACF Plan is the responsibility of each healthcare facility. The ACF can be located at an off-site location, internal hospital space, on-campus facility (preferably a licensed health care facility) or a community-based alternate care site for a Federal Medical Station (FMS). This model allows a flexible and timely response by the medical community to patient surges and may serve as a framework to support a massive medical response. It is designed to augment existing medical systems, not replace them. This site is to be activated when hospital capacities have been reached and projections suggest casualties will continue to accumulate.

### 7.2.1 Facility Sponsored Alternate Care Facility

The ACF should be operated in cooperation with the TDH, but public health does not typically run ACFs. The ACF must be organized with support and commitment from local and regional hospitals and other healthcare organizations. Therefore, staffing, management, and administration must come from healthcare system partners. The Alternate Care Facility Plan must consider ownership, command and control, staffing, scope of care to be provided, criteria for admission, standard operating procedures, safety and security, housekeeping and other complex considerations.

### 7.2.2 Coalition Sponsored Alternate Care Facility

MSEPC has acquired an Alternate Care Unit (ACU) that can be deployed locally (within MSEPC boundaries) or across the state upon request and Executive Board approval. The ACU is staffed with medical volunteers including at least one licensed physician at all times. The ACU can be deployed as a response to an emergency or placed proactively at scheduled events to prepare for the potential of a mass casualty incident.

The MSEPC ACU can accommodate up to 40 non-ambulatory patients at one time and more if ambulatory. The entire asset includes all equipment necessary to run three complete units simultaneously and a single trailer for transport. A formal MOU between MSEPC and the Memphis Fire Department has been created, detailing maintenance and deployment procedures for the ACU. Further deployment details can be found in the Alternate Care Unit Deployment Plan.

### 7.2.3 Federal Medical Station (FMS)

The FMS is a federal asset that contains cache of medical supplies and equipment that can be used to set up an ACF for non-acute medical care or quarantine. Each FMS has beds, supplies and medicine to treat up to 250 patients for three days. The MSEPC will serve as the liaison to the FMS. The MSEPC may be asked to provide information as to the existing regional situation.

## 7.3 Evacuation and Relocation

MSEPC members must individually maintain evacuation and relocation plans and ensure they are coordinated with the MSEPC. During a facility evacuation, MSEPC will activate and provide information sharing and resource coordination support just as with any other event. The evacuating organization should first make every effort to decompress their patients. After decompression, generally, bed and transport resources within our region and neighboring regions will be identified via HRTS. The RMCC, RHC, and EMS Consultants will work

to provide the resource information to evacuating and receiving organizations and transport organizations. The evacuating organization will utilize the bed and transport information provided and will work with the lead EMS transport organization to make patient destination decisions. Patients will be tracked utilizing ReadyOp as referenced earlier in section 6.2.1.

# 8.0 Healthcare System Critical Issues

The MSEPC strives to create planning, preparedness, response, and recovery documents that address many healthcare system critical issues. Often times these issues, such as care for functional needs populations (FNP), pediatrics, behavioral health, decontamination, and fatality management, are successfully incorporated into annual community wide exercises. Any updates to existing plans are made based on the results of such exercises.

## 8.1 Security

Most hospital and healthcare organization emergency response plans indicate a reliance on local law enforcement, Tennessee Highway Patrol, and/or other agency contracts for facility security during a large-scale event. Building and personnel security procedures are addressed in individual emergency response plans. Requests for security support should be sent through the local county EMA first, through the use of ESF-8 contacts.

## 8.2 Functional Need Populations

The delivery of health and medical care in a mass casualty event should address how the functional needs of several groups within the general population can be met. These needs may vary including providing for alternate means of decontamination for babies and other non-ambulatory persons; having translators available at intake centers; and providing mental health assessment resources within the healthcare setting.

During public health emergencies and disasters, it is the responsibility of the TDH to take the lead in ensuring the FNP receive necessary and appropriate shelter and healthcare throughout the course of the event. During such events, it is often the case that damage will occur, within one or more communities, to the infrastructure of healthcare systems (including physical structures/facilities) that provide services to the FNP. In such circumstances, it will be necessary for non-impacted communities to be involved in absorbing the needs of the FNP of impacted communities. Among potential absorption solutions, displaced persons in the FNP could be admitted to unaffected, neighboring healthcare facilities that have vacancies and/or the capacity to receive such persons. Such facilities generally possess many of the resources necessary to provide care and shelter to the FNP. Public Health, in carrying out its role and responsibilities, would initiate, coordinate, manage, and oversee the implementation of any such absorption system.

Populations recognized as having functional needs in a mass casualty event include but may not be limited to the following:

- Children
- Persons with Physical or Cognitive Disabilities
- Persons with pre-existing mental health and/or substance abuse problems
- Frail or immune compromised adults and children
- Non-English speakers
- Persons with dementia/Alzheimer’s or reduced activities of daily living
- Homeless and Transient Populations

All hospitals address functional needs populations in their individual emergency response plans, including but not limited to communication, mobility, behavioral and mental health, and age-related issues. Hospitals will coordinate with other agencies such as public health and ESF-6 (Mass Care and Sheltering) agencies to develop protocols on the transfer of patients between mass care shelters and healthcare organizations. Other non-hospital healthcare organizations within the MSEPC should consider FNP when developing their internal plans.

The National Response Framework (NRF) and the TEMP tasks ESF-8 to assist ESF-6 with sheltering individuals who have special medical needs. ESF-6 will remain the primary ESF for all shelter operations. The Tennessee Medical Assistance Shelter will support a catastrophic event, such as an earthquake along the New Madrid fault line, or any other event that would result in the need to open and operate mass care shelters in the Mid-South region or West Tennessee. It could also be utilized to support a more localized event such as a devastating flood or large-scale tornado event requiring the evacuation of a community or healthcare facility.

## 8.3 Pediatric Emergency Care

The State of Tennessee has developed comprehensive regulations concerning the readiness of all hospitals with emergency departments to care for the pediatric population. Under these regulations, known as "The Pediatric Emergency Care Rules," there are four levels of pediatric care including hospitals that have been designated at the highest level, Comprehensive Pediatric Emergency Care Facilities. These facilities can provide comprehensive specialized pediatric medical and surgical care to all acutely ill and injured children. Le Bonheur Children's Hospital in Memphis is the only such facility in the MSEPC. They also partner with the Tennessee Emergency Medical Services for Children (TNEMSC) Foundation and the Southeast Regional Pediatric Disaster Surge Network.

The TNEMSC Foundation is dedicated to ensuring public and professional education, provider training, research, and advocacy regarding injury prevention, disaster preparedness, and quality family- centered, emergency and critical care services for Tennessee's children, and thereby, promoting the development of all aspects of the EMSC continuum in Tennessee. TNEMSC provides educational programs and advice to health care providers, including emergency medical responders, nurses, and physicians that care for children being treated for either an injury or acute illness.

Tennessee also participates in the Southeast Regional Pediatric Disaster Surge Network. This is a regional network of hospitals, public health agencies, emergency management agencies, emergency responders, private practitioners, and volunteer agencies that effectively cooperates to meet the medical care needs of pediatric populations during an emergency or disaster in the states of Tennessee, Florida, Mississippi, Georgia, Alabama and Louisiana.

MSEPC has developed a Pediatric Surge Annex to the Response Plan to further address these issues.

## 8.4 Behavioral Mental Health

The State of Tennessee has a Tennessee Disaster Mental Health Response Plan to facilitate coordinated state, regional, and local mental health planning, intervention, and response efforts relative to disasters of any type in order to maintain quality of care, safety, and security for survivors, their families, disaster responders, and volunteers. The plan provides for behavioral health information, referrals, telephone support counseling, psychological first aid, crisis counseling, and spiritual care. Requests for assistance will be made through the ESC

at the SEOC. Additionally, in the region, disaster mental health partners from psychiatric facilities are coordinated by the American Red Cross and state and local public health will provide support for behavioral health programs during a disaster event.

Note: The Regional Disaster Mental Health Plan for the Mid-South is currently under review. The current plan from 2014 should be used in the interim.

## 8.5 Medical Evacuation and Sheltering in Place

Healthcare facilities and providers should have a Medical Evacuation Plan and a plan for the receipt of evacuated patients from other healthcare facilities. This plan must address the decision-making process to determine whether sheltering-in-place or evacuation is best for the patients and staff. The evacuation plan should be based on the personnel, equipment and systems, planning, and training needs to ensure the safe and respectful movement of patients and the safety of personnel. This plan may be a separate plan or the required elements of the plan may be incorporated into the healthcare facility EOP.

## 8.6 Pharmaceutical Resources and Caches

The Shelby County Medical Countermeasures (MCM) Dispensing and Distribution Plan provides guidance in planning for responder safety and distribution of medical countermeasures in a public health emergency such as an anthrax attack. Presently, medical countermeasures are located centrally with TDH.

The state pharmaceutical cache must ensure a sufficient supply of Ciprofloxacin, Doxycycline, and Amoxicillin to provide adult and pediatric prophylaxis for three (3) days to hospital personnel (including medical staff and ancillary staff), patients and their families.

Statewide, the cache contains enough antibiotics to treat a population of 500,000 for three (3) days. Additionally, TDH maintains an agreement with a pharmaceutical supplier to provide the necessary medications to meet the needs of Tennessee residents.

In the event of a man-made incident or naturally occurring disease outbreak that requires distribution of antibiotics for prophylaxis or treatment, TDH will oversee countermeasure distribution. Once TDH identifies the need for medical countermeasures, the RHC, working in conjunction with the TDH central office staff, will direct the appropriate amount of antibiotics to be distributed to the affected hospital(s) and healthcare organizations based on the prevention and treatment recommendations of TDH at the given time.

Each participating agency within the MSEPC has been encouraged to participate in SCHD's Closed POD program. Once approved, participating facilities would receive any medications or supplies directly to their pre-determined location to distribute to their employees and their employees' families. Each facility, regardless of their participation in the Closed POD program, should maintain a plan that includes their employees' ability o receiving lifesaving medications and/or supplies should they be necessary and made available by the government.

## 8.7 Patient Decontamination

All hospitals have access to either a portable or fixed decontamination system for managing adult and pediatric patients as well as healthcare personnel who have been exposed during a chemical, biological, radiological, nuclear, or explosive incident. While gross decontamination may occur at the scene before transport to the hospital, hospitals must be prepared to decontaminate those patients that present to the emergency room. Therefore, hospitals must have the capacity to decontaminate more than one patient at a time and be able to decontaminate both ambulatory and non-ambulatory patients. The decontamination process must be integrated with local, regional, and state planning.

## 8.8 Highly Infectious Disease Preparedness

MSEPC partner organizations are familiar with statewide highly infectious disease and pandemic influenza plans. SCHD accounts for these issues as part of their emergency planning and response and more details of response procedures can be found in the Shelby County Health Department All Hazards Emergency Operations Plan. MSEPC will facilitate information sharing of guidance and response activities to Coalition partners during infectious disease events. If necessary, resource coordination may be activated as well. As a last resource, CSC will be implemented and the MSEPC will follow the guidance as outlined in the plan.

MSEPC has developed an Infectious Disease Annex to the Response Plan to further address these issues.

## 8.9 Fatality Management

The Shelby County Mass Fatality Plan information is made available to all Coalition partners through the MSEPC website. Hospitals must have a Fatality Management Plan that meets their internal requirements. Organizational plans should consider alternative methods of transport for decedents to the Regional Forensic Center or designated location for medical examiner operations.

Healthcare organization morgue capacity is a premium asset with hospitals and other partners having little to no in-house morgue capacity. Therefore, to supplement the morgue capacity available, the MSEPC, with support from the Regional Forensic Center in Shelby County, maintains two (2) morgue trailers. The trailers are refrigerated and have a capacity of 18 individuals each. Facilities should request these local assets through the MSEPC Executive Director. Additional trailers are available throughout the state and may be requested through the SEOC and the SHOC.

MSEPC also has five (5) portable morgues with an individual capacity of 12 individuals. Four of these morgues are housed within local hospital facilities for quicker deployment. The fifth is stored at the MSEPC warehouse and can be deployed upon request.

Note: The Shelby County Mass Fatality Plan is current under review. A finalized copy will be added where indicated as soon as the plan is appropriately updated and approved.

# 9.0 RECOVERY

Each Coalition member organization should complete an internal recovery plan utilizing guidance in the National Disaster Recovery Framework. As with response, MSEPC will continue to play a role in information sharing and resource coordination through the recovery period by sharing recovery related local, state, and federal resource information, planning, and activities with Coalition members. MSEPC will remain flexible in planning recovery operations and tactics, so that specific event-based needs may be addressed, ensuring a coordinated transition from response to recovery. The MSEPC leadership and member organizations will strive to integrate with pre-incident recovery planning efforts in their communities, identify critical infrastructure dependencies, and meet workforce needs to ensure the healthcare system remains operational following a disaster.

## 9.1 Communication

When it is determined that the situation is contained, through the local EM or the on- scene IC/UC, the RMCC will communicate to health care agencies via HRTS, phone, radio, website and/or other communication methods that the disaster or situation has been contained and the region has returned to a normal state of operation.

## 9.2 Facility Re-Entry Authorization

If a facility has been evacuated because of an event, Hospital Administration, and/or health care agencies in conjunction with lead local, state and/or federal agencies, will authorize re-entry to the facility in accordance with their internal re- entry guidelines.

## 9.3 Additional Potential Coalition Recovery Support Roles

- Data collection and analysis to identify priorities in the reconstruction and delivery of community health care services at the outset of an emergency.
- Collaboration with local, state, and federal infrastructure assessment teams to enhance knowledge of disaster impacts on physical infrastructure and inform future risk mitigation strategies.
- Implementation of emergency management organizations' disaster impact assessments to assess post-disaster community health concerns.
- Facilitate family reunification and information in partnership with participating agencies, as appropriate.
- Facilitate patient repatriation and system operations restoration.
- Support mental health need requests for responding agencies and support community efforts where appropriate.
- Assist HCC members by linking them to resources and information to support processes for reimbursement, reconstitution, and resupply in concert with emergency management activities.
- Utilize current communications practices to identify long-term health care and community health recovery gaps, and assist in community-wide efforts to develop potential strategies to address them when possible.
- Develop and communicate short and long-term priorities to the jurisdiction's government and emergency management functions related to healthcare operations.

- Collaborate with emergency management organizations and government officials to identify opportunities for future mitigation strategies or initiatives to enhance resilience of the physical healthcare infrastructure.

# 10.0 TRAINING

Coalition-wide training of all healthcare system stakeholders will ensure effective use of this Response Plan. MSEPC will continue to host annual community-wide med surge exercises and an annual Coalition Surge Test, as required by ASPR. Additional information about the TDH training program, including MSEPC, can be found in the Tennessee Department of Health Hospital Preparedness Program Multi-Year Training and Exercise Plan.

# 11.0 ACRONYMS

| | |
|---|---|
| ACF: | Alternate Care Facility |
| ACU: | Alternate Care Unit |
| ARES: | Amateur Radio Emergency Service |
| ASPR: | Assistant Secretary for Preparedness and Response |
| CSC: | Crisis Standards of Care |
| EAS: | Emergency Alert System |
| EMA: | Emergency Management Agency |
| EMS: | Emergency Medical Services |
| EOC: | Emergency Operations Center |
| EOP: | Emergency Operations Plan |
| ERC: | Emergency Response Coordinator |
| ESAR-VHP: | Emergency System for Advance Registration of Volunteer Health Professionals |
| ESC: | Emergency Services Coordinator |
| ESF: | Emergency Support Function |
| ESF-8: | Emergency Support Function 8: Health and Medical Services |
| FMS: | Federal Medical Station |
| FNP: | Functional Needs Population |
| HCC: | Healthcare Coalition |
| HPP: | Hospital Preparedness Program |
| HRTS: | Hospital Resource Tracking System |
| HVA: | Hazard Vulnerability Assessment |
| JIC: | Joint Information Center |
| MAC: | Multi-Agency Coordination |
| MCM: | Medical Countermeasures |
| MDC: | Motorola Data Communications |
| MOC: | Mobile Operations Center |
| MOU: | Memorandum of Understanding |
| MRC: | Medical Reserve Corps |
| MSCC: | Medical Surge Capacity and Capability |
| MSEPC: | Mid-South Emergency Planning Coalition |
| NIMS: | National Incident Management System |
| NOAA: | National Oceanic Atmospheric Administration |
| NRF: | National Response Framework |
| NWS: | National Weather Service |
| POD: | Point of Dispensing |
| PPE: | Personal Protective Equipment |
| RHC: | Regional Hospital Coordinator |
| RHOC: | Regional Health Operations Center |
| RMCC: | Regional Medical Communications Center |
| SCHD: | Shelby County Health Department |
| SEOC: | State Emergency Operations Center |

| | |
|---|---|
| SHOC: | State Health Operations Center |
| SNS: | Strategic National Stockpile |
| TDH: | Tennessee Department of Health |
| TDSN: | Tennessee Disaster Support Network |
| TEMA: | Tennessee Emergency Management Agency |
| TEMP: | Tennessee Emergency Management Plan |
| TEMARR: | Tennessee Emergency Medical Awareness, Response and Resources |
| TNEMSC: | Tennessee Emergency Medical Services for Children |
| TVM: | Tennessee Volunteer Mobilizer |
| VoIP: | Voice over Internet phone |

# 12.0 REFERENCED PLANS

MSEPC plans referenced in this document can be found online at https://midsouthepc.org/helpful-resources/ and accessible to members anytime. Additional plans referenced can be requested in writing by emailing info@midsouthepc.org.