

APPENDIX A: APPLICATION FOR CORE HOSPITAL BIOTERRORISM PREPAREDNESS

CRITICAL BENCHMARKS CHECKLIST AND BUDGET

NETWORK/HOSPITAL WORKPLAN Project Period January 1, 2004 – August 31, 2004

By receiving funds from the Bioterrorism Hospital Preparedness Grant, each hospital, whether funded directly or through a network, is agreeing to work towards the completion of all critical benchmarks outlined below. This checklist will serve as an ongoing measure of the network/hospital's current capacity. This checklist(s) also will serve as the network/hospital's workplan for the project period in that the network/hospitals agree to work toward meeting any benchmarks that are not yet fully met. The asterisked (*) critical benchmarks are those that will need to be addressed in the hospital's bioterrorism plan.

- A multi-hospital application will need to submit separate checklists for all hospitals for which the lead administrative hospital is requesting funding.
- Single-hospital applications will submit one checklist.

HOSPITAL NAME _____

Name of person overseeing completion of this checklist: _____

Contact information: Telephone: _____

Facsimile: _____

Electronic Mail address: _____

Date of Completion: __/__/__

Benchmark	Fully Met	Partially Met	Not Met
A. Planning			
*A.1. The hospital has a designated bioterrorism preparedness coordinator. Please provide the coordinator's: First name: _____ Last name: _____ Title: _____ Work telephone number: _____ 24 hour contact number: _____ E-mail address: _____			
*A.2. The hospital has an emergency response plan.			
*A.2.a. The plan includes a section on biologic emergencies, including a section specifically on smallpox and a contagious respiratory pathogen (e.g. SARS) and is shared with DOHMH.			
*A.2.b. The plan includes a section on the surge capacity response to a mass casualty event and this section has been shared with DOHMH.			
A.2.c. The plan includes a section on chemical, nuclear and explosive emergencies			
*A.2.d. The plan has a mechanism for regular internal review and modification, as needed.			
*A.2.e. The hospital provides regular trainings for employees about the hospital's bioterrorism plan.			
B. Communication			

Benchmark	Fully Met	Partially Met	Not Met
*B.1. Key members of the Hospital, Nursing and Medical Administration; Disaster Committee, Infection Control; Infectious Disease; Laboratory; and the Emergency Department are registered users of the DOHMH broadcast facsimile and/or electronic mail alert system AND the DOHMH's secure, bi-directional extranet communication system, the Health Alert Network (HAN).			
*B.1.a At least one of the fax machines listed in the DOHMH broadcast alert system is in an area staffed 24 hours a day			
*B.1.b. Protocols are in place and have been drilled to ensure rapid distribution (within 12 hours of receipt) of the DOHMH health alerts to all clinical staff (e.g., through a broadcast E-mail, intranet posting, or paper copies delivered through intrahospital mail).			
*B.2. Updated hospital emergency contact information for key hospital staff is provided to the DOHMH Hospital Preparedness Program by phone (212-788-4225), fax (212-788-4278) or e-mail (iescobar@health.nyc.gov) on an annual basis. DOHMH will provide a format for updating this information annually.			
*B.3. The hospital has a system in place for notifying, informing, and mobilizing staff, including physicians, nurses, pharmacists, mental health professionals, and other key support staff in the case of an emergency.			
*B.3.a. The hospital maintains an up-to-date roster of emergency contact information for all staff (e.g., home telephone, fax, beeper and cell phone).			
*B.4. Essential emergency contact numbers for key outside agencies (such as the NYC DOHMH, NYS DOH, OEM, etc.) are clearly posted throughout the hospital in all medical areas including the Emergency Department and medical staff areas.			
*B.5. The hospital has a system in place to distribute essential health care and educational information from the DOHMH to patients and families (e.g., fact sheets on the biologic agents, diseases, exposure risk and treatment options).			
*B.6. The hospital has a designated spokesperson to coordinate communication between the hospital(s), the DOHMH Public Affairs Office, the New York City Emergency Operations Center and the media during an emergency.			
B.6.a. The hospital provides or arranges for risk communication/media communication training for their spokesperson and other key emergency personnel			
*B.7. The hospital has ensured that adequate redundancy is built into their emergency communications capacity and is available for their emergency operations center, emergency department, and key clinical staff.			
*B.7.a. The hospital emergency plans include specifics regarding the types of redundant communication systems that will be used (e.g., two-way or 800 megahertz radios, cell phones, broadcast faxes, or e-mail), and the manner in which these will be deployed, especially during a blackout situation.			
*B.7.b. The hospital emergency plans include staffing assignments for oversight and maintenance of internal and external communication during emergencies.			
*B.8. The hospital has Internet connectivity.			

Benchmark	Fully Met	Partially Met	Not Met
*B.8.a. The hospital is capable of transmitting electronic data to governmental agencies during public health emergencies, especially via the Health Emergency Response Data System (HERDS.)			
B.9. Key staff in the Emergency Department are trained in sending digital photographs and at least one digital camera is accessible at all times. (This benchmark will facilitate urgent consultations of patients with skin rashes that might represent cutaneous manifestations of bioterrorist diseases, especially smallpox.)			
B.9.a. The hospital has successfully sent a digital photo electronically to DOHMH via the Health Alert Network (http://www.nyc.gov/html/doh/html/han/han.html).			
*B.10 The hospital emergency communication plans are exercised at least twice yearly to test multiple internal and external aspects of the plan including the communication equipment and its use, staff mobilization and protocols for disease reporting and information sharing.			
C. Training			
*C.1. Key hospital personnel are trained in the implementation and maintenance of a hospital-wide incident command system.			
*C.2. Staff has access to, and is trained in, the hospital's all-hazards emergency response plan, emphasizing lines of authority and specific staff's roles and responsibilities during disasters, and exercising this plan through regular disaster drills. (See G.)			
C.2.a. The hospital has attendance records for staff completing training.			
*C.3. Appropriate hospital staff (e.g., emergency departments, family medicine, internal medicine, infectious disease and pediatrics) is trained in the diagnosis and treatment of bioterrorist-related diseases described by the CDC as Class A and B agents, including early non-specific prodromes of each disease (See http://www.bt.cdc.gov/Agent/agentlist.asp .) on at least a yearly basis. Template teaching slides are available through the DOHMH, and oral presentations can be arranged on request.			
C.3.a. Copies of the CDC poster on "Evaluating Patients for Smallpox" are placed in the physician work areas where patients with fever and rash may present, including the emergency department and all primary care clinics. (Copies are available by calling DOHMH Bureau of Communicable Disease during business hours at 212-788-4225, sending an email request to: healthSP@health.nyc.gov or through http://www.bt.cdc.gov/agent/smallpox/diagnosis/pdf/spox-poster-full.pdf).			
C.3.b. When distributed, copies of an updated fall 2003 DOHMH SARS poster will be placed in the physician work areas where patients with fever and cough may present, including the emergency department and all primary care clinics			
*C.3.c. The training provided by the hospital includes the management of bioterrorist-related diseases in special populations, such as children, the elderly, and pregnant women.			
*C.3.d. Clinical staff is aware of the legal requirements to			

Benchmark	Fully Met	Partially Met	Not Met
report all notifiable diseases (including all major bioterrorist-related diseases) and any unusual disease manifestation/cluster to the DOHMH, and know where to locate the 24-hour telephone contacts for disease reporting. At least one in-service on disease reporting should be conducted annually for medical staff.			
D. Medications			
*D.1. The hospital has a protocol and timeline for stockpiling a three-day supply of antibiotics (e.g., doxycycline and ciprofloxacin) for all clinical and support staff and all hospitalized patients who would potentially be at-risk, following a bioterrorist event.			
D.1.a. The protocol addresses storage.			
D.1.b. The protocol addresses cycling of inventory.			
D.1.c. The protocol addresses vendor contracts.			
D.1.d. The protocol addresses mutual aid agreements with other networks or hospitals.			
*D.2. The hospital plan includes the protocol for rapid distribution of prophylaxis to hospital employees.			
E. Infectious Disease Outbreak Control			
*E.1. The hospital has identified a rapid assessment response team composed of vaccinated and/or vaccine-eligible staff.			
E.1.a The names, titles, specialty, vaccination status and contact information of the smallpox response team is maintained by the hospital on a database.			
*E.2. The hospital has at least five nurses and/or physicians certified by DOHMH to administer smallpox vaccinations. Training will be provided by DOHMH.			
*E.3. The emergency plan addresses triage procedures for identifying febrile patients with rashes or cough for immediate separation from the waiting room, and rapid medical evaluation and airborne isolation, if needed, in the emergency department, hospital clinics or as a new admission to a medical floor.			
*E.3.a. The emergency plan contains protocols to isolate and care for patients with suspected or confirmed smallpox, SARS, and other contagious respiratory pathogens, using appropriate infection control precautions and isolation facilities that conform to CDC infection control guidelines.			
*E.3.b. The emergency plan provides for adequate PPE (fit tested N-95 or higher masks) to all personnel assigned to work in environments in which they may be at-risk of exposure to contagious respiratory pathogens.			
F. Personal Protective Equipment and Decontamination			
*F.1. All medical care personnel who might potentially care for patients suspected to have diseases spread by airborne transmission are fit tested for N-95 or higher masks and provided proper training on contact, droplet and airborne precautions on at least a yearly basis.			
F.2. Hospital emergency department personnel are adequately trained in PPE use and in emergency decontamination protocols for chemical events, including conducting drills at least once per year.			
G. Bioterrorism/Biologic Disaster Drills			

Benchmark	Fully Met	Partially Met	Not Met
*G.1. The hospital participates in at least two NYSDOH HERDS exercises per year.			
*G.2. The hospital participates in hospital preparedness exercises sponsored by the DOHMH or New York City Office of Emergency Management, when invited.			
H. Plans to Ensure Surge Capacity for Personnel Needs			
*H.1. The hospital develops contingency plans for the transfer of staff among hospitals in a network to address mass care needs.			
*H.2. The hospital has mutual aid agreements with other networks/hospitals for staff and supplies.			
*H.3. The hospital has contracts with vendors for equipment.			
H.4. The hospital has protocols in place for managing unsolicited help from undocumented clinicians arriving in a disaster area to volunteer their services.			
*H.5. The hospital's Web site is linked to the DOHMH Medical Reserve Corps at http://www.nyc.gov/html/doh/html/em/mrcorg.html			
I. Emergency Bed Capacity Management			
*I.1. The hospital has emergency evacuation plans for the transfer of non-critical hospitalized patients that ensures maintenance and continuity of appropriate medical care.			
*I.2. The hospital has plans for effective emergency department triage, so that non-ill persons ("worried well") are separated rapidly from those who require emergency medical care.			
*I.3. The hospital has identified facilities or areas of they hospital, not used currently for patient care, which could be outfitted and staffed emergently to increase staffed bed capacity if needed.			
*I.4. The hospital emergency plans address the needs of special populations such as children, the elderly, pregnant women, and those with disabilities.			
J. Laboratory Issues			
*J.1. The hospital is registered as Level A laboratory in the CDC's Laboratory Response Network (LRN). See the CDC's Web site for description of LRN at http://www.phppo.cdc.gov/nltn/pdf/LRN99.pdf .			
*J.2. The hospital laboratory has a protocol in place to coordinate with the DOHMH Public Health Laboratory (PHL) that addresses the need to notify rapidly the PHL and ensure chain of custody when a suspect bioterrorist agent is identified in the laboratory.			
*J. 3. At least one laboratorian from the hospital laboratory has attended a DOHMH training and is certified in specimen packaging and handling			
J.4. The hospital laboratory has posted the 24-hour emergency contact telephone information for the DOHMH Public Health Laboratories.			
K. Security Issues			
*K.1. The hospital emergency plans address methods to minimize points of access and exits to the physical plant during a disaster (e.g., lock-down).			
K.2. The hospital emergency plans address the ability to institute a rapid identification process for staff and emergency workers responding to a disaster or terrorism.			
*K.3. The hospital emergency plans include an internal security plan to be enhanced during a disaster or large infectious disease outbreak			

Benchmark	Fully Met	Partially Met	Not Met
K.4. The hospital emergency plans address training and drills for security and other staff to practice security measures.			
L. Mental Health Issues			
L.1. The hospital has trained and designated staff to provide mental health services or referrals to all patients (medical and psychiatric), present family members or significant others, and hospital staff during an emergency and aftermath.			
*L.2. The hospital has triage protocols in place to refer to other agencies any individuals exhibiting psychological distress in reaction to the incident(s), but have not been physically impacted and are not in need of immediate medical attention,			
*L.3. The hospital has triage protocols in place to refer for treatment any individuals exhibiting physical and/or psychiatric symptoms distinctly as a result of psychological distress during an emergency and aftermath (i.e., anxiety attack, pulmonary distress, etc.),			
L.4. If applicable, the hospital has protocols in place for psychiatric emergency department surge capacity and diversion. (Alternatively, can be added to "H." above).			

PROGRESS REPORT

FOR ANY BENCHMARKS THAT HAVE NOT BEEN FULLY MET BY THE HOSPITAL, PLEASE PROVIDE A BRIEF DESCRIPTION OF HOW THE HOSPITAL PLANS TO ATTAIN THE BENCHMARK AND A TIMEFRAME FOR COMPLETION. You may use the space below, but limit response to two pages.