KNOXVILLE/EAST TENNESSEE HEALTHCARE COALITION
Infectious Disease Surge Annex

Final Version
Approved by KET HC
6-8-2021

Record of Changes

Date	Section/Pages Revised	Revision	Entered By
1/12/2021	All	1st Draft	R. Newsad
3/19/2021	All	RHC and RMCC Draft	W. Roberts, UT
3/25/2021	Added SME info	SME Draft Revision 1	Sandy Monday
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5/27/2021	All	HCC Board Review Final Draft	J. Brinkley
6/08/2021	All	KET HC Approved	J. Brinkley

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Knox/East Tennessee Healthcare Coalition Infectious Disease Surge Annex

Executive Summary

This infectious disease (ID)-focused operational annex complements the Healthcare Coalition's (HCC) Response Plan. It is intended to be a high-level, incident-specific response plan, identifying the experts and specialized resources that exist within the HCC or external to the HCC that are available. Each facility is encouraged to develop more detailed policies/procedures that support their individual operations, but that level of detail is not necessary in this annex. This Annex does not replace other county or local emergency operations plans or procedures, but rather builds upon the existing plans and their annex. This annex contains plans for the following core elements:

- Indicators/triggers and alerting/notifications of a specialty event
- Initial coordination mechanism and information gathering to determine impact and specialty needs
- Documentation of available local, state, and interstate resources that can support the specialty response and key resource gaps that may require external support (including inpatient and outpatient resources)
- Access to subject matter experts (SMEs) – local, regional, and national
- Prioritization method for specialty patient transfers (e.g., which patients are most suited for transfer to a specialty facility)
- Relevant baseline or just-in-time training to support specialty care
- Evaluation and exercise plan for the specialty function.

Subject Matter Experts for this Annex Included:

Name	Title
Sandy Monday, RN, ICP, CIC, CHEP	Infection Prevention, Roane Medical Center

1. Introduction

1.1 Purpose:

The purpose of this annex is to provide a framework for a "whole of community" response to infectious disease outbreaks. It also provides more specific guidance for HCC members, regional partners, and other sectors of our region.

1.2 Scope:

This ID Healthcare System Annex is a critical component of the Healthcare Coalition's infectious disease readiness, response, and recovery. This planning process is a collaborative between hospitals, community-based healthcare facilities, public health departments (particularly with local and state infection prevention teams), emergency medical services (EMS), emergency management agencies, and other community organizations. There are currently 268 members in the healthcare coalition. The communication and incident response structures established in the HCC's response plan also apply to infectious disease outbreaks calling upon the necessary resources and activations as warranted by the event.

The Tennessee Department of Health (TDH) Emergency Support Function #8 (ESF 8) *Base Response Plan, the TDH Pandemic Influenza Plan, and the TDH Ebola/Highly Infectious Disease Annex* support the planning for this HCC ID Annex. The referenced plans can be obtained on a need-to-know basis from the appropriate Regional Hospital Coordinator. Other plans that may be involved in ID outbreaks include:

- The County and Regional Medical Countermeasures Point of Dispensing Plans
- The Regional ESF 8 Base Response Plan
- The Regional Mass Fatality Plan
- The TDH Regional Volunteer Management Plan
- The TDH Personal Protective Equipment Cache Deployment Plan
- The TDH Antibiotic Cache Deployment Plan
- The TDH Highly Infectious Disease Transport Plan
- The TDH Strategic National Stockpile Plan
- The TDH Chemical, Biologic, Radiological, and Nuclear Plan
- The Tennessee Disaster Mental Health Plan
- The HHS Region IV Ebola Viral Disease and Other Special Pathogen Coordination and Transportation Plan
- The State of Tennessee Emergency Management Plan (TEMP)

- Guidance for the Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency as declared by the Governor of Tennessee

1.3 Overview/Background of HCC and Situation:

The Knox/East Tennessee Healthcare Coalition (KETHC) primary boundaries include the following counties: Scott, Campbell, Claiborne, Hamblen, Grainger, Union, Morgan, Anderson, Jefferson, Cocke, Knox, Roane, Loudon, Blount, Sevier, and Monroe.

KET HCC participates in an active network of healthcare coalitions across Tennessee as well, through the Regional Hospital Coordinators (RHCs) and Regional Medical Communications Centers, which permits planning, response, and recovery activities to also occur outside of our geographical boundaries.

Coalition Membership is open to all healthcare organizations and jurisdictions and emergency management related organizations within the coalition's geographic area as outlined in the KET HCC Bylaws.

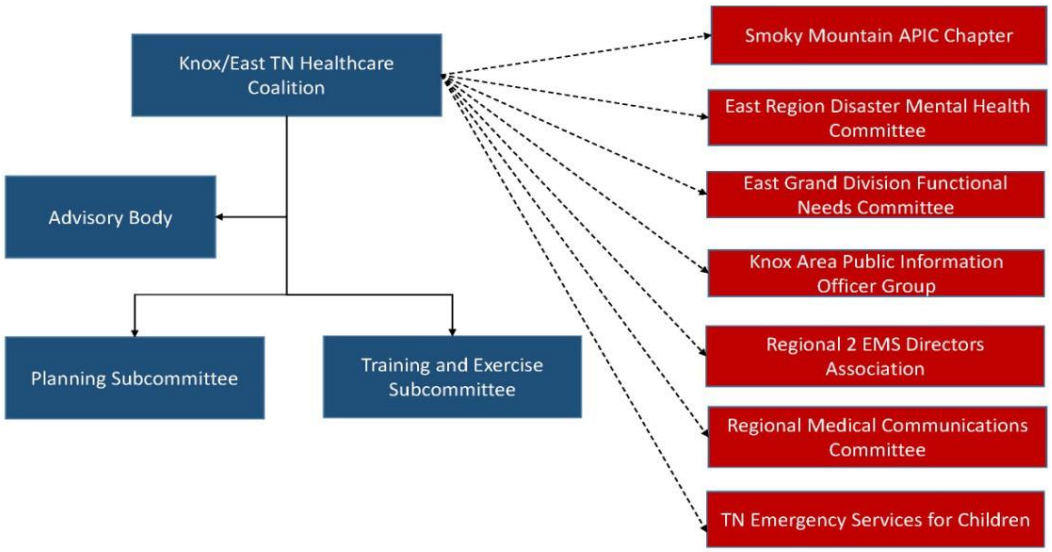
Membership details can be found in the KET HCC Bylaws and in the KET HCC Memorandum of Understanding.

To meet required Healthcare Preparedness Program capabilities and deliverables, the KET HCC must maintain an internal structure to support coalition activities and operations. Specific roles and responsibilities by membership type are described in the KET HCC Bylaws to include member guidelines for participation and engagement as well as policies and procedures for making changes and delegation of authority.

Participating organization executives formally endorse their organization's participation in the KET HCC through signing our KET HCC Memorandum of Understanding. KET HCC newsletters are developed to engage healthcare and governmental executives and other stakeholders. Executives are encouraged to participate in KET HCC meetings or send feedback through their KET HCC organizational representative. Furthermore, most participating organizations incorporate KET HCC activities into their internal emergency preparedness/response meetings and structure, which includes executive input and oversight.

KET HCC integration with existing state, local, and member-specific incident management structures is described in the KET HCC Response/Coordination Plan, along with ESF 8

integration details.



1.4 Assumptions:

As evidenced by past outbreaks, including SARS CoV2 - COVID 19, a systemic planning approach for infectious disease outbreaks is needed to coordinate staff and resources from various components of the healthcare and community support system. Novel viruses or mutated influenza strains periodically emerge to cause global epidemics, known as pandemics. Novel viruses typically result directly from a mutated animal virus or out of reassortment of an animal virus with a circulating human influenza virus. Such viruses can circumvent normal immune defenses, and lead to a high rate of morbidity and mortality.

Novel viruses or mutated influenza viruses with pandemic potential are transmitted from person to person in the same manner as seasonal influenza. Typically, by large respiratory droplets caused by coughing, sneezing or by touching contaminated environmental surfaces and subsequently touching one's mouth, nose, or eyes.

Vaccines, antiviral medications, immune system boosters, and advanced medical care have proven to be most effective in reducing morbidity and mortality from novel pathogens. Additional response strategies have been proven to be successful in reducing

the impact of past pandemics. The proper use of masks, social distancing, handwashing along with special precautions by healthcare workers have been effective in reducing the impact of pandemics. Assumptions to be considered in a large ID outbreak include:

- The CDC Emerging Infection Disease Plan states that no one knows what new disease(s) will emerge
- Little information on which to base protective actions may be available during the early phases of a potential pandemic and information will evolve as an extended outbreak progress
- The response to a pandemic or large outbreak will require significant HCC integration and the use of virtual coordination mechanisms
- Public health agencies have an overall responsibility for epidemiologic investigations, contact tracing, social distancing protocols, isolation, and quarantine orders according to state laws as well as for issuing overall guidance on infection prevention and control precautions
- Tennessee State Emergency Management has the overall responsibility for command and control when State declarations are enacted
- A pathogen which can be spread by asymptomatic carriers will create additional challenges and will require special countermeasures
- Patient care may be better accomplished with the integration of telemedicine/telehealth consultations
- Staffing at coalition facilities may be challenged by illness, fear of illness, or family obligations (e.g. child/family care if schools are out). Healthcare workers are a high-risk population during most infectious disease incidents; the implementation of effective infection prevention measures and associated training are necessary for workforce protection across the coalition
- Families of patients will place a strain on the healthcare system through information-seeking about loved ones or concerns about exposure/illness. Family members may have also been exposed and may pose a risk to healthcare workers and others in the community
- Testing and laboratory confirmation may be limited or not be timely at the beginning of an incident involving a novel pathogen

- Cases will require laboratory confirmation unless authorities no longer require testing to meet the case definition

- EMS transportation may be limited and have extended off-load times at healthcare facilities due to overcrowding

- A new vaccine for a pandemic can be expected to take at least a year to reach much of the national population, possibly much longer, and may require considerable logistical resources for administration

- Current antiviral medications may not be effective against a novel virus strain

- Large ID outbreaks may require federal Centers for Medicare and Medicaid Services waivers, Food and Drug Administration (FDA)-issued Emergency Use Authorizations, and other regulatory adjustments that may affect healthcare operations and HCC options

- Healthcare facilities and vendors may become overwhelmed with the treatment and disposal of biohazard material; waste management guidance may be modified, as necessary, to support the health and medical system while maintaining safe handling and patient transport

- Transportation of highly infectious patients will require additional precautions to protect providers and patients

- Supply chain issues will occur in a widespread outbreak and may have dramatic effects on clinical care

- The coalition should plan to request, receive, and distribute Strategic National Stockpile (SNS) assets in accord with jurisdictional public health and emergency management processes. These may include personal protective equipment (PPE), ventilators, and medical countermeasures

- Comprehensive and well-coordinated public health control and community mitigation strategies (e.g., mask-wearing, contact tracing, individual vaccination, quarantine and/or isolation, community-wide cancellation of events, visitation policies) are primary methods for controlling and stopping the spread of infectious diseases

- Should antiviral medication or antibody treatments be effective in reducing the effects of a novel virus strain, it will likely be in short supply and distribution may have to initially go to those who are most at risk

- With a large infectious disease outbreak, critical infrastructure workers can expect an increased workload, due to increased absenteeism

- Non-pharmaceutical interventions such as social distancing and placing a limitation on large gatherings may significantly reduce the impact of an outbreak during a severe outbreak, but may not be closely adhered to by the public

- The first wave of an infection strain could affect a community or large geographic area for weeks or months

- Significant economic disruptions may be expected with greatest impact on the economically vulnerable

- Timely processes for external communications (to include liaisons and spokespersons) and internal communications may need to be developed (to include a way for employees to obtain the most up-to-date information on the event). The media will play an integral role in the response based on the information to be shared, the intensity of how it is shared, and where they are physically positioning themselves (i.e., media staging areas)

- Large-scale infectious disease outbreaks may require the recruitment of volunteers, retirees, and trainees to support and relieve healthcare workers

- During large ID incidents, individual healthcare facilities may face fatality management challenges that require support from other coalition members

- Health concerns, difficult work environments, economic impact, and stresses of community mitigation measures may present behavioral health challenges among healthcare staff and the general public

- Subsequent waves of infection may be expected

2. Concept of Operations

2.1 Activation

Activation of this annex, or any portion thereof, is determined on a case-by-case basis. The decision to activate will be determined by consensus of the HCC executive board in consultation with the Local Health Officer(s) and the State Epidemiologist with input from local healthcare facilities, local epidemiologists, EMS leadership, and other healthcare system stakeholders. Generally, this annex could be activated when a healthcare facility has exceeded or reasonably anticipates exceeding its resources, capability, or capacity due to an infectious disease outbreak. Overwhelmed providers recognizing a surge ID incident should contact regional public health (the Emergency Response Coordinator, (ERC), the Regional Hospital Coordinator (RHC), or regional Emergency Medical Services (EMS) Consultant) who will coordinate with health officers and the HCC to determine the level of activation required. This can vary from monitoring the situation to a fully staffed response with public health representatives deploying to areas needed for the response. In some cases, at the smallest hospitals and counties in the region, the surveillance and contact tracing requirements alone could overwhelm immediate local resources.

2.2 Notifications

During an infectious disease outbreak, the RHC or Regional Medical Communications Center (RMCC) may activate the Healthcare Resource Tracking System (HRTS) (the TDH statewide system that helps track the availability of hospital, EMS, and long term care (LTC) resources). This system has been in use since 2007 and has been used to alert HCC members and response partners of hundreds of emergency events. Placing HRTS in disaster mode triggers HCC members & health care system partners to evaluate the level of response required and enhances situational awareness

Notification to HCC members can also be made via the Tennessee Health Alert Network (TNHAN), and/or with website membership management tools. Essential information elements of information to be shared may include:

- Bed Availability (HRTS)
- Resource Capacities, and Capabilities (HRTS)
- Organization and Service Capabilities (HRTS)
- A facility status form can be uploaded as needed on the HCC website or onto the HRTS system. This allows the HCC members and regional responders the ability to quickly report and identify member status of mission critical systems such as electricity, water, and medical gases

2.3 Roles and Responsibilities

Hospitals

The HCC has a regional memorandum of understanding (MOU) regarding staff and supplies with all member facilities. Each hospital has an emergency response plan (EOP) to address internal plan activation, emergency staffing, on-loading and off-loading of patients, isolation patient management, acquisition of emergency supplies, equipment, and pharmaceuticals, emergency evacuation, business continuity, shelter-in-place, fatality management, and coordination with their local office of emergency management and other hospitals in the region. Hospital emergency departments have been supplied with pediatric supplies and coalition-wide exercises have been conducted to assess current readiness to manage surge events.

Crisis standards of care procedures are available to facility administrators for decision making per state guidance found in the document titled *Guidance for Ethical Allocation of Scarce Resources During a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee.*

Non-Hospitals

Depending upon the infectious agent involved in an outbreak, the very young or elderly may be more at risk. The HCC has worked with several governmental and non-governmental agencies in a grassroots effort since 2010 to assist childcare providers in developing emergency response plans. This effort has helped families and childcare facilities prepare for and recover from disasters in a way that ensures that infants, toddlers, and older children stay safe and secure. These partners have been integrated into the ESF 8 response structure.

The HCC also works closely with LTC and other healthcare providers to monitor and control infectious disease outbreaks. The HCC has a LTC subcommittee that meets regularly to prepare for healthcare emergencies.

EMS

EMS in the region is comprised of the following major elements:

- 32 service providers
- Approx. 315 Ambulances
- 2 AmbuBus, one in Anderson County and one in Jefferson County
- 1 State EMS Coordinator

In addition to ground transportation, the region has access to air transports provided by the University of Tennessee Medical Center, (UT) Lifestar service. UT Lifestar has 5 Rotor wing units. UT Lifestar has an air transport base located in Knoxville as well as Morristown, Sevierville, Rockwood, Jacksboro, and Sweetwater.

HCC and other Regional Response Coordinators

- During an outbreak surge event, the availability of facilities to receive patients will be monitored through HRTS by HCC members, the RMCCs, the RHC, and the EMS Consultant

- Regional Health Operations Centers (RHOC) will be activated as needed depending on the event severity

- Resource coordination will be managed by the RHC, the ERC, EMS Consultant, and local and state Emergency Management utilizing HRTS and WebEOC (for emergency management)

- Inter-regional movement of patients would be coordinated through EMS and the applicable RMCCs

- Surveillance and infection control will be managed by the regional epidemiologist(s) (EPI)

- HCC members and healthcare leaders will conduct conference calls as needed during outbreaks to maximize resources and coordinate communications and response

- The HCC membership and Executive Board will work broadly with partners to maximize the use and building lasting readiness with any supplemental funding for ID responses

Lead State Supporting Agency:

The TDH - Division of Communicable and Environmental Disease and Emergency Preparedness (CEDEP) is responsible for providing statewide public health planning and support for large ID outbreaks. The State Epidemiologist, the Deputy State Epidemiologist and the Emergency Preparedness staff supports preparedness and response activities with healthcare coalitions, regional and local health departments, and other stakeholders. As the state lead for ESF 8, TDH coordinates with the Tennessee Emergency Management Agency to activate the TEMP to the appropriate level. Through the TEMA

ESF structure, TDH and TEMA coordinates with other state departments and partners to provide support to HCCs. TDH provides Information Technology (IT) support through various established channels to collect essential elements of information to provide situation awareness to responders and HCC members.

Other Supporting State Agencies:

State of Tennessee agencies that support TDH and HCCs in the detection and management of large ID outbreaks within the State of Tennessee are:

- Department of Agriculture
- Department of Environment and Conservation
- Department of Military
- Department of Human Services
- Department of Commerce and Insurance – State Fire Marshall
- American Red Cross
- Department of Mental Health and Substance Abuse
- Department of Safety
- Tennessee Emergency Management Agency
- Tennessee Bureau of Investigation
- Department of Education
- Tennessee Higher Education Commission – Board of Regents
- Department of Intellectual and Developmental Disabilities
- Department of Corrections
- Department of Transportation

Federal and other Supporting Agencies:

The federal department that provides public health laboratory, epidemiologic and medical support during significant infectious disease outbreaks is the Department of Health and Human Services (HHS), including the Centers for Disease Control and Prevention (CDC) and the Assistant Secretary for Preparedness and Response (ASPR).

The Emerging Infections Program (EIP) is a population-based network including the Centers for Disease Control and Prevention and state health departments, working with collaborators (academic centers, local health departments, infection control practitioners, and other federal agencies) to assess the public health impact of emerging infections and to evaluate methods for their prevention and control. The Tennessee Emerging Infections Program (EIP) is a collaborative

effort of the Communicable and Environmental Diseases and Emergency Preparedness section of the Tennessee Department of Health, the Vanderbilt University School of Medicine, the Department of Health Policy, and the Centers for Disease Control and Prevention.

2.4 Operational Mission Areas

No single intervention used in isolation may dramatically reduce transmission during a pandemic. However, significant reductions can be achieved by combining targeted use of interventions with effective medications for vaccination, treatment, and prophylaxis.

Reducing the number of persons infected in a short period will "flatten the curve" and reduce the surge burden on the healthcare system while minimizing the impact of a pandemic on the economy and society. Example treatment strategies:

- Isolation and treatment, with effective medications, of at-risk persons with confirmed or probable exposure to a highly contagious agent. Isolation may occur in a healthcare setting or at home depending on the severity of an individual's illness and/or the current capacity of the healthcare infrastructure

- Should effective treatment medication or a vaccine become available, priority for early distribution should follow CDC guidelines

(For additional information see – TDH Novel Virus/Pandemic Influenza Response Plan)

(Also see – The CDC Emerging Infectious Disease Plan)

2.4.1 Surveillance

During an outbreak, the HCC coordinates with regional EPI(s) to continually estimate the severity and spread through active and passive surveillance collected from multiple sources. Comprehensive surveillance and epidemiologic research plans will be implemented during the initial days/weeks of the outbreak based on the event. HCC members will:

- Maintain and enhance surveillance systems as needed

- Assist in case-based investigation of infections in humans and animals.

- Assist in assessing contacts of ill persons to determine human-to-human transmission and risk factors for infection

- Conduct reporting according to regional, state, and national requirements
- Report status to identify whether state or federal assistance is required to support surveillance systems, laboratory, and medical treatment
- Share health alert information HCC-wide: what to report, how to test for pathogen, how to communicate with regional public health
- Coordinate with public health and private labs
- Assist in establishing and conducting HCC-wide testing protocol and procedures.
- Share consistent HCC-wide patient/community/provider information

(For additional information see –Annex C: Disease Surveillance, TDH Novel Virus/Pandemic Influenza Response Plan)

2.4.2 Safety and Infection Prevention

- Identify training needs and sponsor appropriate training in use of Personal Protective Equipment (PPE) and other infectious disease safeguards/protocols specific to the event for healthcare providers. (Lead: HCC)
- Coordinate with healthcare facilities to ensure availability of sufficient quantities of PPE to address outbreak response requirements. (Lead: RHC; Support: HCC, TDH)
- In concert with TDH, ensure linkages exist with adjacent state and county public health authorities to address cross-border outbreak issues, including contact tracing, cross-border use of healthcare facilities, etc. (Lead: ERC; Support: HCC, RHC, TDH)
- Coordinate with medical facilities to identify available isolation beds within the region and implement strategies to address anticipated shortfalls. (Lead: RMCC; Support: HCC, RHC)
- Coordinate with TDH and healthcare facilities to develop protocols to properly isolate persons under investigation to limit transmission prior to laboratory diagnosis. (Lead: EPI; Support: HCC, TDH)
- Coordinate with TDH and healthcare facilities to develop protocols to limit exposure of staff to patients presenting with nonspecific symptoms (e.g. cough) during an

outbreak involving a highly infectious disease until diagnosis can be confirmed. (Lead: EPI; Support: TDH, HCC)

2.4.3 Non-Pharmaceutical Interventions

Proper use of multiple non-pharmaceutical interventions can significantly decrease human to human transmission during an outbreak. CDC focuses interventions on nine specific priority program areas: antimicrobial resistance; foodborne and waterborne diseases; vector-borne and zoonotic diseases; diseases transmitted through blood transfusions or blood products; chronic diseases caused by infectious agents; vaccine development and use; diseases of people with impaired host defenses; diseases of pregnant women and newborns; and diseases of travelers, immigrants, and refugees.

- Voluntary home quarantine of household member(s) with confirmed or probable case(s) or with other members of their ill family members. Consideration should be given to combining this intervention with the use of prophylactic medications, if sufficient quantities of effective medications are available and a viable distribution plan is in place

- Dismissal of students from school (including public and private schools as well as colleges and universities) along with the cancellation or postponement of school-based activities. The closure of childcare programs coupled with protecting children and teenagers through social distancing in the community should be considered as steps to protect the public. Closing of individual schools with high rates of infection should be considered during a moderate outbreak. When considering these actions, secondary consequences should be considered. The impact on parents who miss work to care for children at home, could place a financial strain on families and be an added stress to the community.

The use of social distancing measures and personal hygiene measures for adults in the community and the workplace are essential steps that should be taken. In the event of a severe outbreak cancelling large gatherings may be considered. Examples include:

  - Modification of patient care and waiting areas

  - Alteration of workplace environments such as working from home

  - Diligently cleaning work surfaces

  - Emphasizing healthy personal habits such as frequent hand washing

- Cough etiquette and decreasing the social density within the work environment
- HCC-wide consistent use of masks and other measures such as limiting healthcare facility visitation to help prevent ID transmission based on the event

2.4.4 Surge Staffing

- If applicable, enroll adult educators, obstetrical, and pediatric health-care providers, including pharmacies, to promote vaccine access to persons in at-risk groups
- Identify and vaccinate critical infrastructure personnel
- Identify personnel that can be cross trained and deployed to various healthcare facilities across the HCC to assist in triaging, testing, visitor assistance, vaccine administration, etc

(For additional information see – Annex H: Volunteer Management, TDH Novel Virus/Pandemic Influenza Response Plan)

(Also see - The TDH Regional Volunteer Management Plan)

2.4.5 Supply Chain, Supplies, Personal Protective Equipment

- Coordinate with local and/or regional public health coordinators regarding the potential receipt and distribution of Strategic National Stockpile countermeasures, as appropriate
- Assess impact on medical care facilities; identify whether medical resources are sufficient to manage ill persons and conduct case-based control efforts; determine if state or federal assistance is required and coordinate according to ESF 8 guidance.
- Disseminate HCC-wide protocols for resource requests from the State and/or other external sources
- As received, disseminate protocols, information, and contacts to verify masks and respirators for healthcare use are FDA approved. Share information for possible device disinfection and reuse
- Serve as liaison between public health agencies and facilities for vaccine storage, supply, and distribution requirements as needed for the event

- Prepare facilities for receipt and allocation of HCC and State cache items

(For additional information see – The TDH Personal Protective Equipment Cache Deployment Plan)

2.4.6 Support Services

Support services may include both healthcare and/or non-healthcare resources required to support the care of infectious disease patients. This may include: dialysis providers, blood banks/blood product providers, laboratory services, infection prevention/control, waste and material management, food and dietary services, and environmental services.

(For additional information see – (The State of Tennessee Emergency Management Plan)

2.4.6.1 Laboratory

- Assess and optimize laboratory capacity to detect and characterize the infectious disease agent
- Coordinate activities with state/local veterinary diagnostic laboratories as needed
- Share confirmatory samples with the state, CDC, and the U.S. Department of Agriculture (USDA) as needed
- Report status to help determine if state or federal assistance is required to support laboratory activities

(For additional information see – TDH CONOP Ebola/Highly Infectious Disease Appendix)

(Also see – Annex B: Laboratory Diagnostics, TDH Novel Virus/Pandemic Influenza Response Plan)

2.4.6.2 Waste Management, Decontamination

- Share guidance HCC-wide on proper packaging, shipping, handling, treatment, and storage of generated waste
- If needed, request additional waste storage containers from vendors or through the ESF resource request process
- If needed, utilize the statewide biowaste disposal contract through TDH

- Identify HCC-wide guidance for reprocessing and reusing PPE, if necessary
- Share resources through the region-wide MOU if facility capabilities are overwhelmed
- Work with TEMA to identify regional locations for sequestering waste, if necessary

(For additional information see – TDH CONOP Ebola/Highly Infectious Disease Appendix)

2.4.7 Patient Care/Management

- Activate the region-wide HCC MOU to share resources
- Consult with TDH and HCC SMEs to develop and disseminate strategies to maintain safe patient care when system is overwhelmed
- Develop and provide guidance HCC-wide on triage protocols to healthcare facilities
- Coordinate and share telemedicine resources HCC-wide
- Develop and disseminate guidance and resources HCC-wide to activate alternative negative pressure treatment areas
- Disseminate protocols HCC-wide on decontamination and disinfection procedures for various types of facilities – acute care, ED, clinics, skilled nursing
- Request and deploy behavior health resources to support community care and staff needs *(See: Behavior Health, section 2.5.1)*
- Coordinate with Health Facility Administrators, EMS, the RMCC, and Health Officers to disseminate guidance on Emergency Department wait time reporting, closures, etc, through the use of HRTS and other tools
- Identify or reconfigure alternate care sites, patient waiting, triage, and treatment areas to decrease ID transmission potential
- Provide Hospital Administrators with the latest version of the *Guidance for the Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency as declared by the Governor of Tennessee* and conduct HCC-wide conference calls to discuss implementation, if warranted

2.4.8 Medical Countermeasures

- The HCC will work with regional and state responders to update state and local plans based on local conditions to meet MCM distribution goals
- If applicable, refine vaccine distribution and administration plans if a campaign will be initiated, including mass vaccination initiatives and coordination with pharmacies and other groups, as appropriate
- Ensure that all potential vaccinators are registered with the state and are authorized. Review policies and procedures regarding training of non-traditional vaccinators
- Confirm vaccine providers have access to the TDH Immunization Information System (IIS) or alternative systems
- Review training, capacity, and capabilities of vaccine providers for use of the IIS or alternate systems for mass vaccination clinics

(For additional information see – Annex F: Pandemic Vaccine Administration, TDH Novel Virus/Pandemic Influenza Response Plan)

(Also see – Annex A: Antiviral Drug Distribution, TDH Novel Virus/Pandemic Influenza Response Plan)

(Also see - TDH Strategic National Stockpile Plan, and the TDH Antibiotic Cache Deployment Plan)

2.4.9 Community-Based Testing

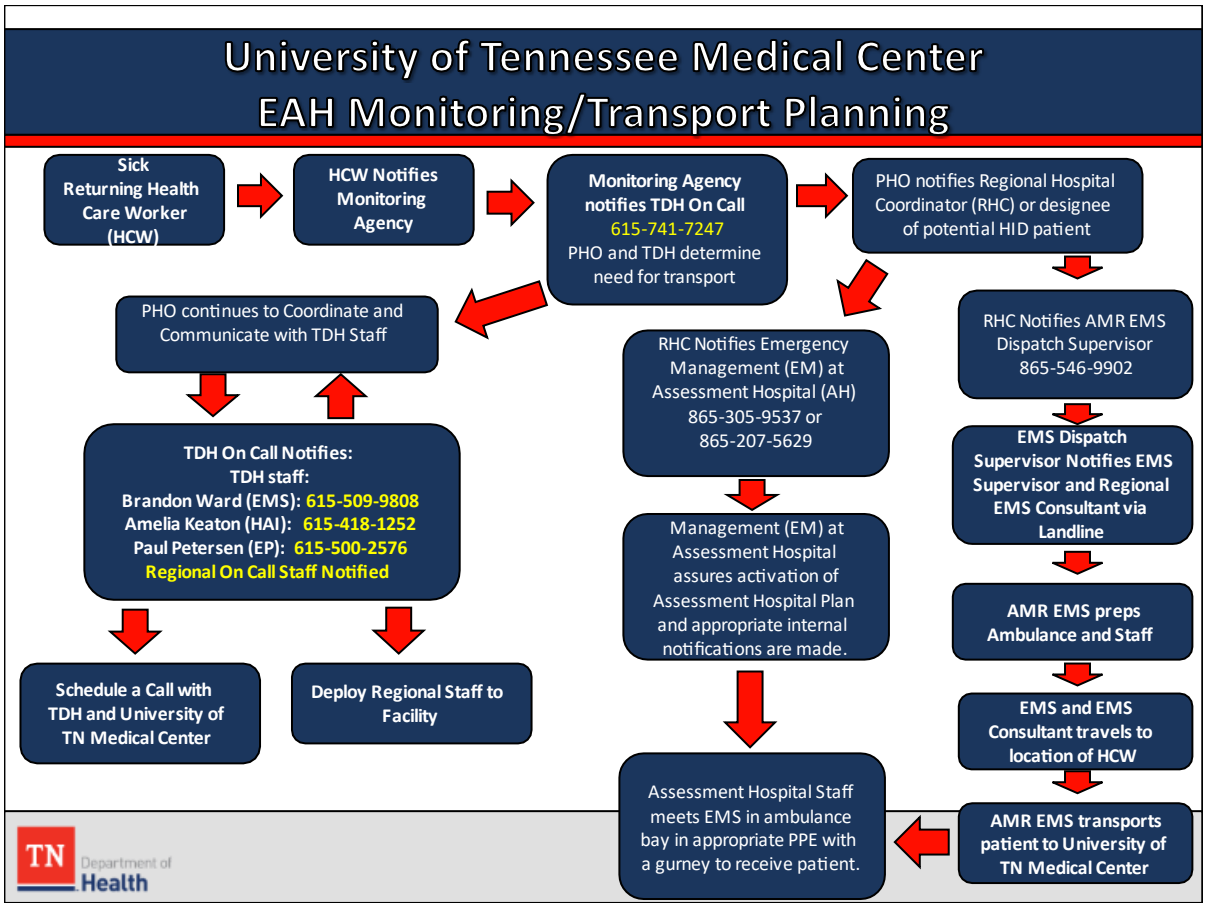
- Assist in developing and disseminate safe specimen collection protocols to be implemented HCC-wide
- Disseminate information HCC-wide for symptoms indicating the need and level of testing
- Disseminate information for specimen packaging and shipping protocols and disseminate HCC-wide
- Coordinate with hospital laboratory and local testing resources HCC-wide to maximize testing surge capacity

- Support HCC partners with community testing sites
- Communicate and update confirmatory testing requirements and standards to local laboratories and healthcare organizations as the outbreak and testing option evolve
- Develop procedures and communication channels to quickly share results with response partners, patients, and contacts

(For additional information see – Annex F: Pandemic Vaccine Administration, TDH Novel Virus/Pandemic Influenza Response Plan)

2.4.10 Patient Transport

EMS surge events are coordinated by the State EMS Consultant and the RMCC. TDH licenses EMS services and requires minimum training and equipment for each service. TDH sponsors and deploys "EMS Strike Teams" to meet surge events both within and out of the state. TDH also trains and equips a network of EMS services to provide transport for highly infectious disease patients (typically a person under investigation for Ebola viral disease). Plans have been developed for patient transfers to the Ebola Assessment Hospitals in the state along with plans for a transport to the Ebola Treatment Center in Atlanta. The diagram below describes the in-state process:



(For additional information see – TDH CONOP Ebola/Highly Infectious Disease Appendix)

(Also see - The HHS Region IV Ebola Viral Disease and Other Special Pathogen Coordination and Transportation Plan

2.4.11 Mass Fatality

The definition of a mass fatality incident is one that results in more fatalities than the local resources can handle utilizing standard of care and processes. When this number is exceeded the incident will be considered a mass fatality and the regional/state response plan can be implemented at the discretion of the county in which the incident occurs. The County Medical Examiner/Death Scene Investigator (ME/DSI) is the legal authority to conduct victim identification, determine the cause and manner of death, and manage death certification. The ME/DSI is also responsible for other medical/legal activities, such as notification of next of kin.

County Medical Examiners are public officials who investigate deaths as authorized by Tennessee Code Annotated (TCA) 38-7-104. The medical/legal death investigators in each

county have been approved by the County ME and appointed by the County Commission and will follow rules and regulations as denoted in the TCA.

In a mass fatality situation arising from an infectious disease outbreak resources may need to be shared assets among HCC members. Contaminated or contagious deceased victims from an ID outbreak may require decontamination, additional storage areas, or special treatment to protect others.

(For additional information see – Regional Mass Fatality Plan)

(Also see - TDH CONOP Ebola/Highly Infectious Disease Appendix)

2.5 Special Considerations

2.5.1 Behavioral Health

A disaster can have long-term effects on the mental and emotional health. The HCC works directly with the Knoxville/East Tennessee Disaster Mental Health Team, led by the American Red Cross and in the event of need will be activated by the HCC .

Tennessee uses Psychological First Aid through the Red Cross as well as PsySTART (Psychological Simple Triage and Rapid Treatment) to triage mental health needs and to assess and manage the behavioral health impact during a disaster.

PsySTART Tennessee can be found at:https://www.tn.gov/health/cedep/cedep-emergency-preparedness/temarr.html

The Tennessee Department of Health, in collaboration with the Tennessee Department of Mental Health and Substance Abuse Services, has established a Tennessee Disaster Mental Health Strike Team through the Tennessee Federation of Fire Chaplains (TFFC). The TFFC provides training and management of the Strike Team which includes a diverse cadre of Chaplain, Mental Health, and Emergency Service Peer Professionals capable of statewide deployments. The HCC may request the team for service during disasters. The Strike Team provides timely initial referral to Licensed Mental Health Care Professionals — including immediate emergency referrals when appropriate.

(For additional information see - The Tennessee Disaster Mental Health Plan)

2.5.2 At-Risk Populations

- The HCC membership regularly reviews *Empower* and the *Social Vulnerability Index* information provided by HHS
- Local resources will be shared by the HCC to help deliver information to reach at-risk populations where English is a secondary language, the homeless community, people who are homebound, etc

2.5.3 Situational Awareness

- The HCC will use and assist in the enhancement of IT reporting and monitoring systems for timely and consistent situational awareness across response agencies
- The HCC will assist in surveillance and contact notification for persons who may be infected
- The HCC will share information among members and work with regional incident command to maximize available medical resources and personnel
- The HCC will share information among members and work with regional incident command to coordinate testing and laboratory services

(For additional information see – the Regional ESF 8 Base Plan)

2.5.4 Communications

- Incident command (IC) communication will follow the TEMP structure. IC will be activated at the level necessary dependent on the scope of the incident. This could be at the HCC (regional level), state level or federal level
- The HCC will develop or update unified media relations and coordinate with the Regional Joint Information Center (JIC) for the event
- Disseminate risk communication messages across the HCC, including what is known, what is not known, and what is being done by public health officials
- The HCC will provide regular updates to key partners, stakeholders, elected officials, and the media

- The HCC will disseminate messages for travelers, as well as community mitigation messages, on when to seek care, and how to care for ill persons at home as appropriate

- The HCC will disseminate unified communication for volunteers, healthcare professionals, responding organizations, and the general public

- The HCC will disseminate information on consistent measures for social distancing to reduce close contacts

- The HCC will disseminate messages across to address food safety concerns as appropriate from state and federal partners

(For additional information see – Annex E: Communications, TDH Novel Virus/Pandemic Influenza Response Plan)

2.5.5 Jurisdictional Specific Considerations

- The HCC Members Health systems and responders regularly coordinate and conduct patient referrals with facilities in:

    - Northeast Tennessee Healthcare Coalition
    - Southeast Tennessee Healthcare Coalition
    - Knox/East Tennessee Healthcare Coalition

- Members of the HCC and regional responders meet regularly with Kentucky responders to coordinate preparedness activities

(For additional information see – All Hazards Cross Border Notification Plan, Kentucky/Tennessee Public Health Agencies)

2.6 Training and Exercises

Recent ID preparedness training and exercises completed by the HCC have included:

- Full Scale Ebola Exercise, 2014
- Zika Outbreak Investigation Tabletop, 2016
- Candida auris Tabletop Exercise, 2019
- Containment of Multi-Drug Resistant Organisms, 2018

- KETHC Infectious Disease Full Scale Exercise, 2019
- Tennessee Department of Health COVID 19 Tabletop November 2020
- COVID 19 Pandemic, 2020, 2021

The Tennessee Department of Health in coordination with HCCs statewide also conducts the annual FightFluTN event, a statewide training exercise for flu vaccination. This exercise involves all 8 of the statewide HCCs. The goal of this surge exercise is to establish and staff flu vaccination pods in all of the state's 95 counties on the same day to administer free flu shots to the public.

On the exercise date all activities are monitored by the State Health Operations Center (SHOC) and the RHOCs in all counties simultaneously. After action discussions are conducted at various levels and areas for improvement are identified and tasked.

- The HCC will create an after-action report to document lessons learned for each real world or ID exercise

- The HCC will implement lessons learned and work with partners to improve readiness for future response actions

2.7 Deactivation and Recovery

- Create an after-action report to document lessons learned

- Participate in vaccine recovery as appropriate

- Deactivate the HRTS event and suspend local public health emergency declarations

- Return to routine disease surveillance procedures

- Modify community and HCC infection prevention measures as necessary

- Replenish stockpiles or caches

- Assess and optimize laboratory capability for future outbreaks

Appendix A
TDH Legal Authority Policy

I. Purpose:

To lower the peak numbers of cases during a pandemic wave by preventing opportunities for widespread viral transmission in crowded group settings using legal authority granted under Tennessee law.

II. Situation and Assumptions:

A. Principle of social distancing:

In the absence of an effective vaccine, the most effective means of slowing the spread of a pandemic influenza virus are strategies known collectively as "social distancing." Social distancing involves a range of policies designed to prevent opportunities for the virus to spread in crowded settings where people mingle.

Large, crowded gatherings accelerate the spread of the virus through communities, leading to a steep rise in the daily number of cases and deaths. Sharply increasing case counts exacerbate the strain on the healthcare system, further reducing the resources available to seriously ill patients and increasing the likelihood of poor outcomes.

B. Rationale for social distancing:

Given that the current capacity to manufacture vaccine will yield late and limited supplies, social distancing measures will play a central role in minimizing illness and deaths in Tennessee. State-imposed measures will affect discretionary public gatherings and schools (preK-12). The epidemiologic criteria for implementation of such measures will be based on the CDC pandemic intervals. Specific recommendation will be determined by the State Epidemiologist and CEDEP staff and approved by the Commissioner of Health, or designee, upon consultation with the Governor. Such measures shall be implemented by local communities once these criteria are met. Regional and local health departments should conduct outreach to community partners, including public transportation providers, operators of large venues for sporting events and other activities, businesses, education, and faith-based communities to promote additional social distancing policies (resources available at: www.pandemicflu.gov).

C. Mandated versus recommended social distancing measures:

In milder pandemics avoiding crowded public settings may be strongly recommended, rather than mandated. Discretionary public gatherings of less than 100 persons are not expected to be affected by mandatory suspension. Based upon experience with modern quarantine cooperation with Department of Health (TDH) emergency regulations to control disease is expected to be good, though law enforcement support may be used to ensure compliance where necessary; civil arrest is possible pursuant to regulations outlined in 1200-14-4.

D. Legal Authority for Social Distancing:

Pursuant to T.C.A. § 4-5-208, the Commissioner of Health is authorized to issue the emergency rules and regulations he or she deems necessary to protect the public and control the spread of an epidemic disease in the state. The Commissioner, upon consultation with the Governor, may issue emergency rules once a pandemic is imminent establishing the terms and conditions for mandatory suspension of discretionary public gatherings.

In addition to the emergency rule-making procedures, executive orders from the Governor during a state of emergency may be used to authorize such measures.

E. Criteria for implementation:

Social distancing measures will be implemented based on the CDC pandemic intervals. The timing of initiation of various non-pharmaceutical community mitigation interventions will influence their effectiveness. Implementing these measures prior to the pandemic may result in economic and social hardship without public health benefit and over time, may result in "intervention fatigue" and erosion of public adherence. To better identify the optimal time, the pandemic intervals model will be applied as described below.

III. Concept of Operations:

A. Discretionary public gatherings defined:

Discretionary public gatherings of >100 persons may be included for cancellation during a pandemic wave in a county or neighboring county.

B. Very large discretionary public gatherings (additional considerations):

Very large discretionary public gatherings of >10,000 persons may be subject to cancellation during a pandemic, even in the absence of disease activity in the county where the event is held.

1. Such cancellations will be ordered by the Commissioner or designee (e.g., a Regional Health Officer), upon consultation with the Governor, on a case-by-case basis in light of the pandemic conditions at the time

2. Local pandemic plans should address mechanisms for notification and subsequent approval or disapproval of such events by the Regional Health Officer using criteria established by the Commissioner of Health at the time

C. Exceptions not subject to suspension:

1. Facilities or events where patrons are not intended to mingle, but are seated at separate tables for service (e.g., seated restaurants)
2. Facilities which offer unaffected services in addition to events or venues mandated for closure may continue to offer the unaffected services.
3. Businesses not affected by closure should consider other means necessary to minimize the risks of spreading infection in the workplace.

D. Roles and responsibilities:

The Commissioner of Health, or designee, is responsible for determining when to initiate and lift social distancing measures, upon consultation with the Governor. The Chief Medical Officer (CMO) may make this determination if the Commissioner is unavailable. These decisions will be based upon the recommendations of the State Epidemiologist, using the best available epidemiologic information on pandemic disease severity and spread. The regional health officer is responsible for implementing and lifting mandatory interventions when informed that state criteria for implementation or discontinuance have been met.

Regional and local health departments will communicate information regarding the rationale for and implementation steps of community mitigation measures to workplaces and the public (resources at www.pandemicflu.gov).

F. Criteria for lifting restrictions:

Targeted cessation of community mitigation interventions will occur during the deceleration interval and they will be rescinded during the resolution interval of the pandemic curve. The established criteria may be modified if additional information becomes available indicating the optimal time to lift restrictions. The state will take the following step to provide recovery guidance to businesses, workplaces, and large venues:

- The current interval of the local pandemic curve will be communicated by the Commissioner of Health, or designee, upon consultation with the Governor, to regional and local health departments, the public, and the media.

- The Commissioner of Health, or designee, will also communicate when community mitigation interventions may be rescinded and recover plans initiated.

- During recovery, state and federal assistance programs will be available to assist individual victims, businesses, and state and local governments in dealing with the financial ramifications associated with the pandemic as described in Emergency Support Function 15 of the TEMP.

G. Monitoring secondary and tertiary effects of community interventions.

Closing schools and canceling large gathering may have a negative impact on the planning objective of preserving social functioning and minimizing economic disruption. Therefore, it must be balanced with the objective of minimizing morbidity and mortality. In the absence of federal guidance, TDH will work with TEMA to define potential secondary and tertiary effects and develop strategies to monitor them. This will allow community mitigation interventions to be applied in a balanced way and prevent excessive community disruption.

IV. Definitions:

Isolation: to restrict the liberty of a **sick** person reasonably suspected of having a communicable disease to prevent the spread of that disease to others.

Quarantine: to restrict the liberty of a **well** person suspected of having been exposed to a communicable disease until the incubation period has passed or until they become ill and are isolated. This is used to prevent people from spreading disease before they realize they are sick.

Quarantine laws cover both isolation and quarantine as described above and any other restrictions.

Sick people under investigation will be isolated in the hospital, at home, or in an alternative facility. Most people exposed to a probable or confirmed patient will be asked to monitor their own symptoms and will be given instructions about what to do if they develop a fever or respiratory symptoms.

Note:

The legal authority for public health actions are outlined below and have been paraphrased for clarity. These laws and Department of Health (TDH) rules and regulations apply state-wide. Cities or counties may have additional local laws that will apply.

V. Authority to write and enforce new rules and regulations:

Tennessee Code Annotated (TCA) 68-1-201 (2): Commissioner of Health has the power to declare quarantine and prescribe rules or regulations deemed necessary to prevent the introduction of an epidemic disease into the state or to control the spread of an epidemic disease within the state, with the least inconvenience to commerce and travel. TCA 4-5-208: If needed immediately, “emergency rules” can be written and go into effect for up to 165 days. See also 68-5-104 a (2).

VI. Authority to control a communicable disease:

TCA 68-5-104(a) (1) It is the duty of the local health authorities, on receipt of a report of a case, or suspected case…to confirm or establish the diagnosis, to determine the source or cause of the disease and to take such steps as may be necessary to isolate and/or quarantine the case or premise upon which the case, cause or source may be found, as may be required by the rules and regulations of the state department of health.

Tennessee Rules and Regulations 1200-14-1-.15: It is the duty of the local health officer, Commissioner, or their designated representative (upon getting a report of a communicable disease case or a suspected case) to:

A. Confer with physician, hospital, laboratory, or person reporting

B. Collect specimens necessary to confirm diagnosis or identify source of epidemic or infection

C. Make a complete epidemiologic investigation including but not limited to: review medical and relevant non-medical records, interview affected people and controls, and create a communicable disease field record

D. Implement appropriate control measures which may include: isolation, quarantine, exclusion, disinfection, immunization, disease surveillance, closure of establishment, education, and other measures considered appropriate by medical experts (e.g., Red Book, Centers for Disease Control and Prevention
[CDC]) for the protection of the public's health.

VII. Authority to review medical and non-medical records without delay:

Tennessee Rules and Regulations 1200-14-1-.15(2): Medical and relevant nonmedical records shall be made available when requested, for inspection and copying, by an authorized representative of the Department when investigating a case, suspect case, or epidemic. The original medical records will not be removed from the health facility, and the information will be treated as confidential and sensitive.

VIII. Duty of health professionals to report potential health threats:

Tennessee Rules and Regulations 1200-14-4-.03: any licensed practitioner of the healing arts must report to the Commissioner or a health officer any person they have reason to believe is or may be a health threat to others by potentially exposing them to an infection that causes serious illness.

IX. Legal control measures:

The Commissioner of Health or a designee may take steps to contain the spread of a novel influenza virus with enforcement ranging from unsupervised voluntary measures to court-ordered measures enforceable by law enforcement. The declaration of a state of emergency by the Governor of Tennessee may alter the requirements necessary to quarantine or isolate individuals and would likely streamline actions required for quarantine and isolation by the TDH.

X. Authority to review medical and non-medical records without delay:

Tennessee Rules and Regulations 1200-14-1-.15(2): Medical and relevant non-medical records shall be made available when requested, for inspection and copying, by an authorized representative of the Department when investigating a case, suspect case, or epidemic. The original medical records will not be removed from the health facility, and the information will be treated as confidential and sensitive.

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The Commissioner of Health or a designee may take steps to contain the spread of a novel influenza virus with enforcement ranging from unsupervised voluntary measures to court-ordered measures enforceable by law enforcement. The declaration of a state of emergency by the Governor of Tennessee may alter the requirements necessary to quarantine or isolate individuals and would likely streamline actions required for quarantine and isolation by the TDH.

XIII. Voluntary quarantine or isolation :

The first, and usually only, step is to ask affected persons to comply with requests of the health department. Past experience has demonstrated that, the vast majority of affected persons did comply voluntarily.

A. If time permits, a letter explaining the requested action on health department letterhead facilitates voluntary actions. This letter may assist the person in explaining their needs with employers or school and provides a written record of the actions they are expected to take.

B. The person should be given written material and social media postings shall provide information regarding infection control and symptoms, and instructions to prevent exposing others. The department should give a contact phone number and should have instructions for what to do

and where to go in case they need medical attention. Post-exposure prophylaxis may be provided, along with instructions for use.

XIV. Health Directive:

A. Definition:

A public health directive is issued by a local or regional health officer but does not require a court order. It is a written statement of evidence that a person may be a health threat and a statement of actions the health officer is directing the individual to take to cooperate with public health authorities.

B. Steps:

It is not necessary to issue a health directive first if a court-ordered public health measure or temporary hold order is required. However, if a health measure is sought, a health directive should be issued before a petition is filed with the court.

1. A health directive must be issued to an individual (not a group) and is a written statement specifically listing the clinical or epidemiological evidence that the person may be a health threat, and directing them to cooperate with health authorities' instructions to prevent or control a communicable disease. They may be directed to undergo medical examinations and tests, receive education, or to be isolated or quarantined.

2. If non-clinical evidence of possible infection exists, but a person refuses to be examined, one can presume a health threat and a health officer may issue a health directive requiring examination and testing.

3. A health directive is limited to the least restrictive alternative that, based on reasonable medical judgment, will adequately prevent the spread of the disease.

4. A health directive can be issued verbally, but if so, a written one must follow within 3 days.

5. When a health directive is issued, a copy of Tennessee Rules and Regulations, Chapter 1200-14-4, (which outlines communicable disease control health threat procedures) should be attached, and both should be provided to the individual.

6. When a health directive is issued, the affected person has the right to request a review of the decision by the State Chief Medical Officer or designee. The reviewing

official must notify the person in writing of the review decision within 5 business days of receipt of the request.

7. The affected person can also ask that the conditions of the directive be given in the form of a court-ordered public health measure, but the health directive is in force during the time it takes to get the court order.

8. A court-ordered public health measure may be sought against a person who does not or cannot comply with a health directive for any reason

XV. Court-ordered public health measure:

A. Definition:

A public health measure is sought by a health officer to require actions of a person who is considered a public health threat; it is signed by a General Sessions judge following a hearing. Failure to comply with instructions in a court- ordered public health measure is considered contempt of court.

B. Steps:

Tennessee Rules and Regulations 1200-14-4-.06: this order is issued by a court and should be undertaken with the consultation of the TDH or metropolitan attorney for public health. Rapid action is required, and health officers should keep the after-hours contact information of their consulting attorney available at all times. To obtain a court order, the health officer must:

1. File a petition with the General Sessions Court where the affected person lives or is found. An affidavit must include the specific facts of why the order is needed, including clear and convincing evidence that the person is substantially likely to be a health threat to others. It must also state what the person needs to be required to do. The health officer is responsible for making the necessary arrangements to carry out a judge's order.

2. The person may be required to receive education, to be tested, examined, treated, or confined. The person may be isolated in a setting supervised by the department or committed to the Commissioner's custody in an institutional facility or supervised living condition.

3. The court hearing must take place not before 5 business days after the petition is served on the patient.

4. The affected person has the right to come to the hearing and to call and examine witnesses and to have a personally selected physician examine them and the test results presented as evidence. The health

officer is responsible for advising on, preparing for, and overseeing safety precautions at the hearing.

5. The person has a right to an attorney, or, if indigent, a court- appointed one.

6. When a health measure is issued, a copy must be provided to the individual, along with a copy of the Tennessee Department of Health Rules 1200-14-4.

XVI. Temporary hold in an emergency situation:

A. **Definition:**

A temporary order sought by a health officer and issued by a General Sessions judge with an ex parte hearing (a hearing in which only the petitioner is heard), requiring actions of a person considered to be a public health threat. These are usually sought in emergency situations while going through the process of obtaining a court-ordered public health measure.

B. **Steps:**

1. Tennessee Rules and Regulations 1200-14-4-.05. In the case of an emergency, a health officer may petition the General Sessions Court of the county where an affected person lives or is found to order a law enforcement officer to make a civil arrest and take the person to a health care facility for examination, isolation and treatment, or to prevent or restrict access to premises. Health officers should know what procedure to use if such an action must be carried out after hours. This may involve talking with county sheriff's office or a county judge in advance to make them aware of this possibility.

2. The health officer must prepare an affidavit outlining the facts of the situation, why there is reasonable cause to believe the person is an imminent threat to others and what they want the judge to order.

3. This emergency hold can last for no more than 5 business days without a court hearing (unless the affected person consents to delay the hearing) to determine the appropriateness of continuing the hold. At that time, the health officer may petition the court for a public health measure (outlined above). The emergency hold also can be extended for 10 more business days if further examinations or tests need to be completed.

4. When a temporary hold is issued, a copy must be provided to the individual, along with a copy of the TDH Rules 1200-14-4.

Appendix B

Acronyms

ACS	Alternate Care Site
ASPR	Assistant Secretary for Preparedness
CDC	Centers for Disease Control and Prevention
CEDEP	Communicable Environmental Disease and Emergency Preparedness
CSC	Crisis Standards of Care
DSI	Death Scene Investigator
EAH	Ebola Assessment Hospital
EMA	Emergency Management Agency
EMS	Emergency Medical Services
EPI	Epidemiologist
ERC	Emergency Response Coordinator
ESF	Emergency Support Function
FDA	Food and Drug Administration
HCC	Healthcare Coalition
HHS	Department of Health and Human Services
HID	Highly Infectious Disease
HRTS	Hospital Resource Tracking System
IC	Incident Command
ID	Infectious Disease
IT	Information Technology
JIC	Joint Information Center
LTC	Long Term Care
ME	Medical Examiner
MOU	Memorandum of Agreement
PODS	Points of Dispensing
PPE	Personal Protective Equipment

RHC	Regional Hospital Coordinator
RMCC	Regional Medical Coordination Centers
RHOC	Regional Health Operations Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
TCA	Tennessee Code Annotated
TDH	Tennessee Department of Health
TEMA	Tennessee Emergency Management Agency
TEMP	Tennessee Emergency Management Plan
TFFC	Tennessee Federation of Fire Chaplains
TNHAN	Tennessee Health Alert Network
UT	University of Tennessee

Appendix C

References

- Los Angeles County Medical and Health Operational Area Coordination Program, Emerging Infectious Disease Healthcare System Annex Concept of Operations (CONOPS), 2018

- North Georgia Health District Final Draft Communicable Disease Exposure Control (DEC) Plan, 2016

- Northwest Healthcare Response Network, REGIONAL HEALTHCARE SYSTEM EMERGENCY RESPONSE PLAN ANNEX, Regional Acute Infectious Disease Response Plan, 2017