KNOX/EAST TENNESSEE HEALTHCARE COALITION

Preparedness, Administrative and Continuity Framework

2026 Version 3.0

Document control	Entry
Plan owner	KETHC active membership; administrative coordination by designated Regional Healthcare Coordinators (RHCs)
Planning basis	FY 2024–2028 ASPR HPP NOFO, TDH instructions, coalition HVA and AAR/IP
Effective date	Pending membership approval
Review frequency	At least annually and after material incidents, exercises, guidance or governance changes
Approval evidence	Meeting date, motion/vote and approved minutes to be entered after adoption
Related documents	Current Bylaws, MOU, Response/Coordination Plan, Information Sharing Plan, Resource Management Plan, 2026 COOP, HVA, annexes, AAR/IP

Revision record

Date	Version	Change	Status
09/14/2021	Prior	Preparedness/Administrative and Continuity Plan	Approved (historical)
10/16/2026	3.0 draft	Comprehensive 2026 HPP alignment, modernization and companion-plan crosswalk	Proposed; pending review

Use and information handling

This is a coalition administrative preparedness framework, not an independent facility emergency operations plan and not a substitute for the KETHC COOP or Response/Coordination Plan. Mark and share restricted contact lists, sensitive facility vulnerabilities, protected health information, and security details according to applicable law, source-agency policy, data-sharing agreements and the KETHC Information Sharing Plan. Do not presume all plan contents are classified or designate them “FOUO” without an applicable authority.

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Note: This document intentionally uses a simplified contents list to remain stable during member review. Heading navigation is available within Word.

1. Mission, purpose and applicability

1.1 Mission

The Knox/East Tennessee Healthcare Coalition (KETHC) assists the health care community and emergency response partners to jointly prepare for, respond to and recover from disasters through collaborative planning, information sharing, training, exercises and coordinated resources to protect health and support the Knox/East Tennessee health care system.

1.2 Purpose and boundaries

This plan establishes coalition-wide governance and administrative preparedness processes: member engagement, risk-based priorities, training and exercise planning, program oversight, gap assessment, grants coordination, readiness measurement and improvement tracking. It is applicable to coalition activities within the Region 2 geographic service area and to mutual-aid coordination beyond the region when authorized.

Region 2 counties in the KETHC Region include; Scott, Campbell, Claiborne, Hamblen, Grainger, Union, Morgan, Anderson, Jefferson, Cocke, Knox, Roane, Loudon, Blount, Sevier and Monroe counties.

1.3 Authorities, guidance and plan hierarchy

Planning shall be consistent with the ASPR FY 2024–2028 Hospital Preparedness Program (HPP) Notice of Funding Opportunity (NOFO) and current recipient/budget-period guidance, the active ASPR Health Care Preparedness and Response Capabilities for Health Care Coalitions, applicable TDH instructions, National Incident Management System (NIMS), and relevant CMS emergency preparedness requirements applying to member organizations. The coalition supports, but does not replace, member-specific compliance responsibilities.

This preparedness plan governs the planning cycle. During response, the KETHC Response/Coordination Plan and relevant annexes guide coalition coordination; the Information Sharing Plan guides information exchange; the Resource Management Plan governs requesting, tracking and return of resources; and the COOP governs continuity when KETHC coordination capabilities are disrupted. Current bylaws and MOUs govern member authority and agreements and supersede conflicting administrative descriptions here.

2. Governance, membership and partnerships

2.1 Membership and representation

KETHC membership is open to qualifying healthcare, public health, EMS, emergency management and related partners consistent with current bylaws and MOU. The coalition

shall maintain representation from healthcare, emergency management, EMS and public health as a minimum and intentionally recruit long-term care, home health, behavioral health, specialty care, critical infrastructure, supply-chain and community partners serving populations most impacted by disasters.

Active member eligibility, voting rights, quorum, electronic voting, meeting cadence and approval authorities are determined by the current bylaws.

2.2 Decision-making and roles

- Active membership/governing body: approve coalition plans and priorities through the currently authorized process; review performance and improvement progress.
- RHCs/advisory/administrative support: convene partners, maintain records, coordinate with TDH, RMCC and partners, monitor HPP tasks and facilitate response coordination under the approved plans.
- Member organizations: retain their own command authority, legal obligations, staffing, patient care, facility decisions and resource ownership.
- RMCC and public safety/public health partners: support communications and regional coordination within existing authority; do not acquire KETHC voting or activation powers merely through mention in this plan.

2.3 Committee structure

The coalition uses Planning, Exercise, Training/Equipment, Budget and Sustainability committees or equivalent active structures, subject to current bylaws and member decisions. The Planning Committee coordinates periodic plan/annex review and AAR/IP follow-up; the Exercise Committee designs and evaluates exercises; the Training/Equipment Committee prioritizes learning and equipment needs; the Budget Committee reviews funding proposals; and Sustainability addresses partner engagement, continuity of capabilities and future funding. The Advisory Board report recommendations to voting membership; a committee recommendation is not automatically a coalition approval.

2.4 External partners and incident management

KETHC is a multiagency coordination partnership, not a stand-alone incident command, regulatory agency or EMS dispatch provider. Member facilities and response agencies operate through their own incident command structures. KETHC supports coordinated ESF-8 situational awareness, referrals, patient movement coordination, and mutual aid with KCHD, ETRHO, KEMA and county EMAs, TDH, Region 2 EMS partners, the RMCC, and neighboring coalitions as appropriate.

3. Preparedness cycle and regional risk assessment

3.1 Assessment and priority setting

At least annually, collect member and regional hazard/risk information, validate the regional Hazard Vulnerability Assessment (HVA), examine member capability and supply-chain vulnerabilities, and identify populations and services disproportionately affected. Validate and document methodology, participants, scoring date and membership approval as applicable. The 2026 HVA lists communication/telephony failure, IT outage, seasonal influenza, inclement weather, and patient elopement, surge and workplace violence among its highest ranked hazards.

3.2 Identify gaps and communities most impacted

Supplement member surveys with AAR/IP evidence, service and access data, EMS/transport gaps, workforce availability, supply chain, utility dependencies, CMS EMPOWER and CDC Social Vulnerability Index where appropriate and lawfully available. Include rural/isolated communities, long-term care residents, children, people with disabilities or hearing impairments, people dependent on electricity or durable medical equipment, and communities with limited transportation or communications access. Record measurable mitigation decisions rather than only general outreach.

3.3 Annual cycle

Phase	Required product / decision	Owner or contribution
Assess	Approved/current HVA, readiness and supply chain assessment, gap register	Planning Committee, member representatives
Prioritize	Ranked objectives, capability gaps, communities most impacted and cost estimates	Planning/Budget Committees
Plan and implement	Plan/annex changes, training, acquisitions, agreements, project leads	Relevant committee and active membership
Exercise and improve	Exercise objectives and evaluation; AAR/IP with owners/dates	Exercise Committee, participating agencies
Monitor	Quarterly progress review and annual update to workplan	RHC administrative support and member leadership

4. Planning, operational integration and specialty priorities

4.1 Core operational planning

Maintain coordinated but separately controlled response, information sharing, resource management, medical surge, patient movement and continuity plans. Each plan should identify triggers, responsibilities, 24/7 contact/access mechanisms, partner coordination, decision pathways, accessibility considerations, backup procedures and a review cycle. Plan updates shall reconcile related annexes rather than create conflicting operational instructions.

4.2 Patient surge, movement and tracking

Coordinate planning with EMS, hospitals, RMCC, emergency management and specialty networks for patient distribution, transfer and evacuation, including pediatrics, trauma, burn, obstetrics/neonatal, behavioral health and high-consequence infectious disease needs. Plans should address receiving-facility capability, transportation resources, diversion/limited-access constraints, reunification, tracking and accessibility. Use HRTS for regional facility/resource status and event communications and ReadyOp statewide triage/patient tracking where authorized; these systems have different roles and are not interchangeable. Plan for downtime and duplicate-record avoidance and avoid transmitting unnecessary patient identifiers over broad coalition channels.

4.3 Specialty and community considerations

Review the coalition specialty care annexes for chemical, pediatric, burn, radiological and high-consequence infectious disease events and align with relevant TDH and ASPR expectations. Coordinate with long-term care, home health, disability-service organizations, public health, behavioral health and family assistance partners. Include accessible communication formats and feasible resources such as mobility equipment, emergency cooling and heating support, and patient reunification procedures under privacy safeguards.

5. Communications, cybersecurity and data stewardship

5.1 Operating communications framework

The Information Sharing Plan and operational channel guide are the controlling sources for channel assignments, routing, recipients, approvals and sensitive-information handling. Use TNHAN for official alerting/confirmation, HRTS event and status boards for healthcare resource situational awareness, RMCC for regional medical communications coordination, ReadyOp for patient tracking, Membership Works for member administration, and telephone, email, conferencing and radios as appropriate.

5.2 Resilient communications and reporting

Maintain two or more independent alert routes and offline contact rosters. During network loss, shift to telephone, radio, alternate sites and documented manual status forms; establish an agreed reporting interval and method to reconcile offline entries after systems recover. Clearly distinguish alerts from acknowledgments and request follow-up for nonresponders. Confirm RMCC TACN and backup radio operational details in a restricted operational annex.

5.3 Cybersecurity and extended downtime

Annual readiness assessment and exercises shall address ransomware, EHR and cloud application failures, telecommunications outages and compromised access credentials. Maintain escalation contacts, least-privilege access, secure backups, alternate meeting and records access, manual patient/resource documentation, trusted out-of-band verification, recovery dependencies and information security incident reporting. Coalition staff shall follow the host organization and TDH cybersecurity procedures; technical remediation remains the responsibility of the system owner.

6. Resource coordination, funding and sustainability

6.1 Resource readiness and accountability

Maintain a controlled inventory and request process for coalition equipment and partner assets, with verified custodian, location, condition, deployment restrictions, transport arrangements, maintenance and return procedures. Track deployable generators, communications equipment, cooling assets, mobility resources, training equipment and other caches according to ownership agreements; confirm insurance, training requirements, asset tags and maintenance responsibilities. Requests and expenditures must follow the approved Resource Management Plan, membership decisions, fiduciary controls and any applicable state rules.

6.2 Funding and grant stewardship

The HPP funding stream flows through the eligible recipient, Tennessee Department of Health, with coalition fiduciary functions historically supported by the Tennessee Hospital Association / THERF. Funded activities must be allocable, allowable, approved, documented and tied to current grant requirements and regional readiness gaps. Different funding sources, including Rural Health Transformation funds if available, carry separate conditions and shall not be treated as interchangeable with HPP. Record sustainability and maintenance costs before purchase.

6.3 Budget process

Use documented HVA and gap findings to collect proposals, determine priority, verify eligibility and life-cycle costs, circulate proposals according to the bylaws, approve by authorized member vote, and submit through the required TDH/fiduciary workflow. Document purchase approval, inventory control, deliverables, reimbursement, disposition and monitoring.

7. Training, exercises and improvement management

7.1 Training program

Set a yearly training plan with clear audiences, prerequisites, objectives, attendance, competencies and evaluation. Priority areas should reflect communications, HRTS/TNHAN, ReadyOp patient tracking, NIMS/HICS, medical surge and transfer coordination, cyber downtime, specialty care, accessible messaging and equipment operations. Record completion, refresher needs and cross-training to reduce single-person dependencies.

7.2 Exercise program

Maintain a multiyear exercise schedule aligned with HPP/TDH deliverables, with the Medical Response and Surge Exercise (MRSE) and other required activities scheduled according to current award instructions. Use HSEEP-consistent objectives and evaluation, participation records, documented strengths/gaps, AAR/IP and corrective action assignment. Include cyber/extended downtime, communication redundancy, patient movement/tracking and at-risk community needs. Real-world incidents can inform improvement but do not automatically replace a required exercise without state approval.

7.3 Improvement tracking

Maintain one master improvement register with issue, source event/exercise, linked capability, action, lead, target date, current status, evidence of closure and validation method. Planning Committee reviews open actions routinely; active membership reviews systemic risks and funding needs. Apply lessons from recent communications exercises, real-world water-supply and diversion incidents, patient tracking, mass-casualty and hazardous materials exercises, with incident-specific data retained in their AARs.

8. Administrative operations and records

8.1 Meetings and approvals

Meetings, electronic participation, voting, quorum, minutes and committee decisions follow the latest adopted KETHC bylaws. Prepare agendas and meeting materials in a timely and accessible manner; record decisions, conflicts of interest when applicable, actions and

follow-up. During emergency disruption, use COOP procedures for administrative continuity and document any emergency approval pathway allowed by governance.

8.2 Records and privacy

Maintain secure and accessible current copies of bylaws, agreements, membership roster, plans and annexes, HVA/gap assessments, budgets, inventory records, grant files, training data, AAR/IPs and approval minutes. Assign document owner, revision date, retention rule and access level; retain one controlled master. Practice restoration and offline access for mission essential records. Patient-level records remain in authorized clinical/patient-tracking systems under governing privacy and security rules.

8.3 Annual review and approval

RHCs and the Planning Committee should coordinate annual document review, verify dependencies and present material revisions to authorized active members. Record meeting date, vote, approved version and effective date. Following approval, distribute a controlled version, retire superseded copies, and update dependent plan references.

9. 2026 implementation workplan

Priority	Proposed 2026–27 deliverable	Suggested lead	Measure / evidence
1	Reconcile Bylaws, MOU, committee and activation authority across plans	Planning Committee / RHCs	Approved governance crosswalk, minutes
2	Refresh HVA, readiness/gap analysis and communities-most-impacted priorities	Planning / members	Current HVA, gap register, action list
3	Validate response, surge, patient movement, information sharing, COOP and cyber downtime	Planning / system owners	Plan review log; controlled annex versions
4	Confirm HRTS, TNHAN, ReadyOp, RMCC and TACN workflow, radio	Exercise / communications partners	Test records, fallback guide

	backup and offline procedures		
5	Conduct MRSE and required drills; capture AAR/IP and corrective actions	Exercise Committee	HSEEP evaluations; AAR/IP tracker
6	Update inventory and asset agreements; assess sustainability and lifecycle costs	Training/Equipment / Budget / THA	Verified assets, approvals, lifecycle plan
7	Reconfirm membership, leadership contacts and underserved-community partners	RHCs / Sustainability	Membership and outreach log
8	Review performance with coalition and adopt 2026 plan revisions	Active membership	Approval minutes and version record

Appendix A. HPP alignment crosswalk

Crosswalk maps this administrative framework to core HPP activity themes; it is not a legal certification that every HPP deliverable has been achieved. Compliance requires review of current TDH award terms, separately approved plans, products and proof of implementation.

ASPR FY24–28 activity group / active capability	Plan linkage	Related evidence to validate
Establish governance / Foundation for readiness	Sections 1–2, 8	Bylaws, membership coverage, meeting minutes, MOU, sustainability work
Assess readiness / Foundation and continuity	Sections 3, 5, 6	HVA, gap/needs assessment, supply-chain/cyber/extended downtime assessments
Plan and implement / Response coordination	Sections 4–6	Response Plan, Information Sharing, Resource Management, COOP and patient movement procedures

Plan and implement / Continuity of care and medical surge	Sections 4–5	Specialty annexes, surge/bed coordination, evacuation and patient movement/tracking
Exercise and improve / All four HCC capabilities	Section 7	MRSE, exercise documentation, AAR/IP, corrective-action evidence
Demonstrate sustainable program management	Sections 6, 8–9	Budget and grants records, inventories, regular review and validation

Appendix B. Companion document alignment

Companion document	Relationship / consistency rule
2026 KETHC COOP	Governs continuity activation, succession, alternate operations, essential functions, system outage and reconstitution; do not duplicate roles or authorize RMCC to activate without confirmation.
KETHC Response/Coordination Plan	Controls incident coordination, ESF-8 interface, reporting and escalation. Member organizations retain independent incident command.
Information Sharing Plan	Controls sharing pathways, restricted information, clinical notifications and backup communications.
Resource Management Plan / asset agreements	Controls requested, approved, tracked, deployed and returned assets and financial accountability.
Patient Movement Plan / ReadyOp instructions	Controls transfer/evacuation and patient tracking workflow; distinguish HRTS from ReadyOp.
Current Bylaws and MOU	Control governance, voting, member status, authority and mutual obligations; update this plan after bylaws/MOU changes.
2026 HVA and AAR/IP log	Source evidence for risk, gap, expenditure and exercise priorities; reassess after significant events.

References and source notes

- KETHC, Continuity of Operations Plan, 2026 working document and prior updated review draft.
- ASPR, FY 2024–2028 Hospital Preparedness Program NOFO and Summary of Changes: https://www.aspr.gov/readiness-response/healthcare-readiness/cooperative-agreements
- ASPR, Health Care Preparedness and Response Capabilities for Health Care Coalitions (active renamed 2024 guidance): https://aspr.hhs.gov/HealthCareReadiness/guidance/Documents/Health-Care-Preparedness-and-Response-Capabilities-for-Health-Care-Coalitions.pdf
- ASPR, Hospital Preparedness Program: https://www.aspr.gov/readiness-response/healthcare-readiness/hpp
- ASPR TRACIE, Healthcare Coalition Preparedness Plan sample: https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-preparedness-plan-508.pdf
- ASPR TRACIE, updated 2026 Health Care Coalition Response Plan reference: https://asprtracie.hhs.gov/technical-resources/resource/4525/healthcare-coalition-response-plan