ADAP Emergency Preparedness Guide

for State AIDS Directors and
AIDS Drug Assistance Programs

February 2016

NASTAD

Purpose Statement

This guide is intended to assist AIDS Drug Assistance Programs (ADAP) that function within state health or social service departments to prepare emergency plans in response to possible disasters; in particular, the guide's provisions are intended to ensure continued access to HIV medications for individuals served by ADAP. The guide should be used in collaboration with existing emergency plans of state health departments or broader state governmental agencies.

ADAPs provide life-saving HIV treatments to low income, uninsured, and underinsured individuals living with HIV in all 50 states, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, the Federated States of Micronesia, American Samoa, and the Republic of the Marshall Islands. Since the advent of highly active antiretroviral treatment (HAART) in 1996, AIDS deaths have declined and the number of people living with HIV has markedly increased. ADAP has played a critical role in making antiretroviral treatments more widely available.

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Emergency Planning Rationale for ADAP Program Administrators

Disasters are hazards, either natural or human made, intentional or unintentional—or a combination of both—whose impact on a community can cause injury (morbidity) and death (mortality). Disasters by definition are public health emergencies (e.g., Hurricane Katrina, pandemic influenza) since the entire community is at risk and the interventions considered are made on a population basis rather than an individual one ((i.e., leave one's home to find safety (evacuation), or to remain at one's home for safety (shelter-in-place)). Disasters may disrupt the public health infrastructure, interrupting access to health care. For these reasons, individuals living with HIV are extremely vulnerable during and after disasters.

This ADAP Emergency Preparedness Guide (Guide) is intended to provide ADAP program administrators with a template to assist them in developing or refining an emergency plan for their ADAP and the clients the program serves. This Guide will not provide state specific details, but rather provide an overview of important considerations for all ADAPs in planning for a disaster and determining how to continue critical program functions.

Most disaster response events are managed at the local level and coordinated through the state emergency management department. While the vocabulary and framework utilized in the Guide may be foreign to ADAP staff, an effective response to emergent disasters requires a basic understanding of federal and state disaster response plans.

An ADAP emergency plan should focus on details specific to its programs and clients, understanding that local, state, and federal emergency response teams will have responsibility for broader disaster concerns (e.g., shelter, food, water). It is important that ADAP program officials work in concert with state and local officials to ensure that the critical functions of the ADAP are included in state emergency preparedness efforts. Furthermore, the ADAP should have a thorough understanding of the role of the National Response Plan (NRP). To accomplish this integration, ADAP program administrators should participate in state emergency management pre-events and dialogues and actively advocate on behalf of their clients to ensure that access to medications and care are considered priorities.

Phases of Disaster Management and Emergency Preparedness

There are three critical and interconnected phases of disaster preparedness: planning, response, and recovery. A strong planning phase will ensure that the response and recovery phases occur in a timely and efficient manner. This Guide focuses on helping ADAPs translate emergency preparedness planning into ADAP operations. It also must be noted that ADAPs work in concert with their state oversight departments and that planning at a higher level must be incorporated into the activities engaged in by any one ADAP. Successful disaster preparedness planning that avoids common and frustrating pitfalls includes active participation in the larger state planning process and resulting plan.

Planning

The planning phase refers to the pre-event activities that take place in order to respond to an emergency or disaster. The planning phase is the most critical phase of emergency preparedness and strong planning will lead to a more effective response. Creating a Continuity of Operations Plan (COOP) is essential to the planning stage. The COOP lists the necessary response activities of departments and agencies to ensure that essential functions are carried out. The plan must be developed in concert with all of the entities/individuals who will play a role in assuring that access to medications and care continues following a disaster.

Response

The response phase refers to the event phase of a disaster. An efficient and effective response is predicated on a comprehensive, well-tested plan. ADAP program administrators need to understand that a federal and state system of emergency response is in place and will guide the overall disaster response. They should work to ensure that their clients are designated as vulnerable or "special needs" for immediate reaction of these larger systems.

Recovery

The recovery phase refers to restoring the affected areas and public health infrastructures as efficiently as possible to a new sense of normalcy, not necessarily equal to that of the previous preexisting state of operations. Recovery will be a principal function and dependent on the impact of the disaster, the strength of the plan and the execution of the response.

This Guide focuses only on the planning stage of disaster management and provides ADAPs with the basic components to be included when creating a state specific ADAP emergency plan. It is important to note that emergency planning can be very tedious and detailed. ADAP program administrators should determine from the beginning how specific the ADAP emergency plan will be in order to keep the planning process timely and manageable. A detailed plan is beneficial but may not be appropriate or feasible for every state.

Six Major Components of the Emergency Planning Phase

This Guide details the six major components of the emergency planning phase:
1. Conduct a risk assessment
2. Identify key partnerships and stakeholders
3. Assess differences in evacuation versus shelter-in-place
4. Develop an emergency plan for staff (individuals and families)
5. Develop an emergency plan for clients
6. Create a Continuity of Operations Plan (COOP)

Following each section there is a brief recap and a list of resources available to address the specific planning component. It is recommended that the reader initially review the entire Guide. Worksheets and a weekly planning guide appear in the final section and appendices.

1. Conduct a Risk Assessment

Hazards are the potential threats that can negatively impact a community and can be natural, human-made (intentional or unintentional) or a combination of both. To create the strongest plan, ADAP program administrators should determine what kind of hazards pose the greatest risks in their state and regional areas. Some hazards that can be considered are:

Natural	Intentional (Terrorism)	Technological
Hurricane	Biological Agent (Anthrax)	Power outage
Flooding	Chemical Agent (Sarin)	Chemical Plant Accident
Blizzard	Radiological Agent (Dirty Bomb)	Nuclear Plant Meltdown
Pandemic Influenza	Shooting/ bombing	Transportation Accident
Wildfires		
Earthquake		

<p style="text-align:center; color:red;">Hazard + Vulnerability = Risk</p>

Once the most likely hazards for the state and its regions are identified, ADAPs should evaluate which of their systems and/or processes are vulnerable in an emergency situation. Some program areas to consider are: data back-up; a system for maintaining contact with displaced or immobilized clients; medication distribution system; vendor payment process; and staff communication.

Once the hazards are identified, ADAP program administrators should develop preliminary contingency or back-up response plans to address vulnerabilities. It is impossible to plan for every contingency but knowing where the greatest vulnerabilities exist and focusing resources on those will help mitigate potential losses in program function. Contingency plan examples could be:

- Can the ADAP acquire a generator in case of power outage?
- Is program data stored off site in case the main system is disabled or destroyed?
- If medication distribution is mail order only, are there local pharmacies that can provide medication if mail is interrupted?

Once the ADAP has determined the most likely emergencies to impact their programs, the next step is to identify the program activities that are absolutely necessary to continue providing medications and other ADAP services to clients. Often this list of priority activities is referred to as the "mission critical functions." To create a comprehensive list, ADAPs should dissect the step-by-step procedures for getting medications dispensed to clients.

ADAP program administrators should also identify the resources necessary to re-establish the mission critical functions once a disaster has occurred. Scenarios that address risk could be as simple as setting up an alternative work location for staff in the event of an emergency at the main location or activating the emergency plan created by a contract pharmacy or pharmacy benefits manager (PBM). Other solutions to functional operation establishment may be more

complex, making it necessary to redistribute the work load and program functions to multiple units within the division.

Risk Assessment Steps Recap

1. Identify the hazard(s) most likely to impact your community
2. Determine program vulnerabilities
3. Develop preliminary contingency plans to address program vulnerabilities
4. Prioritize "mission critical" ADAP functions

Resources

- FEMA Risk Assessment Form
- HAZUS Risk Assessment Software
- American Red Cross Readiness Quotient test

2. Identify and Coordinate Key Partnerships and Stakeholders

Solidifying working relationships and agreements with key organizations and stakeholders *before* an emergency or disaster occurs is much easier than in the midst of one. This planning also expedites the response process once an emergency plan is activated. ADAPs should consider the entities listed below when creating an emergency plan:

Pharmacy wholesaler, PBM, and/or Pharmacy Provider Network	For ADAPs that utilize a Pharmacy Benefit Manager (PBM): ▪ Review and coordinate with the PBM's emergency plan For ADAPs that **do not** utilize a PBM: ▪ Establish the expectations for the medication distribution center/pharmacy network emergency plan ▪ Establish clear expectations of all parties in the event of emergency medication distribution, including: alternative payment and reimbursement strategies; exceptions to individual business rules; and assured access for individuals state-wide ▪ Determine the contingency plans for medication distribution and patient access
In-state partnerships	▪ Cross-Part Ryan White providers (i.e., Parts A, B, C, D, and F) ▪ American Red Cross ▪ Faith-based community programs ▪ Community-based organizations ▪ Other state administered pharmacy benefit programs ▪ Other private or not-for-profit pharmacy benefit programs (i.e., private insurance, manufacturer patient assistance programs or other medication distribution options)
Interstate Partnerships (Other States and Their ADAPS)	▪ Other states—especially neighboring states ▪ Address issues of ADAP client evacuation ▪ Determine how to maintain client enrollment regardless of location ▪ Establish how partnerships with other states will benefit your clients (e.g., expedited ADAP enrollment, data sharing for prescriptions, Medicaid eligibility) ▪ Include agreements between states on client confidentiality forms as possible and appropriate ▪ Develop mechanisms and memoranda of understanding with partners (e.g., to share information on client tracking and access)
Federal Partners	▪ U.S. Department of Health and Human Services (HHS) ▪ Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) ▪ Centers for Disease Control and Prevention (CDC) ▪ Substance Abuse and Mental Health Services Administration ▪ Centers for Medicare and Medicaid Services (CMS) ▪ Housing and Urban Development

	[Department of Homeland Security](#) - Specify the roles federal partners have in responding to a disaster - Consider what level of the federal government (Department or Agency) will have the most appropriate information and resources for a specific disaster - Consider how federal partners can benefit the program during or after a disaster
Strategic National Stockpile (SNS)	- The [Strategic National Stockpile](#) (SNS) is a pharmaceutical stockpile that includes antibiotics and medical supplies. The SNS does not include HIV medications or other chronic disease medications. - Each state maintains a stockpile with a supply of medical supplies, medication, and equipment to assist local and state resources during a disaster or emergency.[1] However, as with the SNS, ADAP program administrators should confirm if this reserve includes HIV specific medications or not. - ADAP program administrators should be mindful of the medications to expect, when to expect medications, and what not to expect, including medications that will not be included (ARVs). - Know ahead of time which specific drugs are or will be available through the stockpile. - For medications not available through the stockpile, determine how the ADAP will be able to access necessary medications.
Other Key Partnerships	[NASTAD](#) can coordinate with peer programs across the nation; can provide resources for conference calls; and/or identify pharmaceutical contacts - Pharmaceutical companies - Access to reserve medications - Swift client enrollment in [patient assistance programs (PAPs) or cost-sharing assistance programs (CAPs)](#) - Determine what role pharmaceutical companies will play in the ADAP's response to a disaster - Know the plans pharmaceutical companies have in place for responding to a disaster - National pharmacy chains (e.g., CVS, Walgreens, Rite Aid) - Memoranda of understanding to provide medications in event of a disaster - Use of distribution center or medication reserves for clients - Medication and administrative distribution methods: - If UPS, FedEx, and/or the U.S. Postal Service are not functioning, determine how the medications and

> other administrative documents can be exchanged between partners and stakeholders

- Media – establish relationships in concert with parent organizational structure to use media to help provide information to clients
- Other government associations and affiliations:
  - [Association of State and Territorial Health Officials (ASTHO)](#)
  - [National Coalition of STD Directors (NCSD)](#)
  - [National Governors Association (NGA)](#)
  - [National Association of County and City Health Officials (NACCHO)](#)
  - [American Medical Association (AMA)](#)
  - [American Pharmacists Association (APhA)](#)

Identifying Key Partnerships Recap

1. Ensure that pharmacy system components are included in planning
2. Engage all HIV service providers in planning
3. Communicate with bordering state programs for possible collaboration/memoranda of agreement
4. Engage non-traditional partners for emergency assistance for program clients

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[1] Landesman, L Y. Public Health Management of Disasters--the Practice Guide. 2nd ed. Washington, DC: American Public Health Association, 2005.

3. Evacuation versus Shelter-In-Place

Evacuation

In the event that an emergency prompts evacuation, the ADAP program administration needs to access an updated registry of clients with accurate medication history that can be shared with other states. This data sharing process can be accomplished through membership and participation in the Emergency Management Assistance Compact (EMACs). EMAC is governed by the National Emergency Management Association (NEMA) and all states are eligible to participate. EMAC can provide model legislation and state specific examples of mutual aid across states. ADAPs are encouraged to determine if their state currently has intrastate agreements through EMAC or another mechanism that would make sharing resources and reimbursement simpler and more secure.

ADAPs should also build into their plan how the program will manage disaster evacuees from other states related to ADAP services. Client tracking, eligibility determination, medication lists, reimbursement, and monitoring can present significant challenges for both clients and programs. Communication plans targeting clients who have been evacuated should be considered via appropriate media outlets (e.g., press, radio, TV) and flyers and posters in shelters, and coordination with American Red Cross representatives. Communication flyers can be distributed through local social service organizations, AIDS service organizations, or possibly [FEMA Disaster Assist Centers](#).

Both state and federal emergency plans incorporate "special needs" or "medically fragile" shelters into their evacuation safety plans. It is important to provide HIV education and materials to these designated shelters in advance of an emergency. Information about how HIV is and is not transmitted, confidentiality laws, and general HIV treatment information can alleviate the stigma ADAP clients may face in shelters. This planning can markedly improve client access to the shelters and adherence to necessary medications. Conversely, in the client education component of an ADAP plan, ADAPs can inform clients about "special needs" shelters and their various locations.

Sheltering in Place

Sheltering in place is an emergency preparedness response that requires vulnerable populations to remain safely secluded in their homes for an extended period of time. In the event that an emergency occurs that requires ADAP clients to shelter-in-place, ADAP program administrators should consider mechanisms to provide home access to medications for a prolonged time frame. Potential solutions include providing a surge supply of medications (30 days or greater) prior to the emergency, continued monitoring and tracking through hotlines, and planning for medication distribution through pre-determined Point of Distribution (POD) sites that may be activated to dispense medications.

Evacuation vs. Shelter-In-Place Recap

- Include emergency policies that allow for early refills when possible emergencies are anticipated.
- Ensure client data on medications prescribed can be accessed.
- Consider establishing an Emergency Management Assistance Compact (EMAC) with neighboring states.
- Include a plan to deliver medications to client homes in the event of shelter-in-place requirement.

Resources

- EMAC
- American Red Cross Shelter In Place Guide
- CDC Shelter In Recommendations

4. Staff Emergency Planning

Before ADAP program staff and other government agency employees can effectively address and assist continuity of operations of their respective programs, employees need to address their personal/family emergency needs. The following is a summary of preparedness planning that staff members and their families should be encouraged to complete in preparation for a possible disaster/emergency.

Components of an individual family or emergency plan	- Discuss what types of disasters might happen in your area - Determine how emergency alert/warning systems and signals (e.g., local radio or TV broadcasts) can be monitored - Plan how family members will communicate/contact each other in different situations such as during an evacuation or shelter-in-place if you are not together when the event occurs - Discuss what escape routes will be used and if separated, where to meet. For example, a nearby grocery store/parking lot - Assign family members to be responsible for utility shut off (water, electricity, natural gas, etc.) in the home - Make sure that important documents, such as insurance and vital records are stored in a safety deposit box away from your home - Create an inventory of your home possessions for insurance and replacement purposes - If your family has pets, identify animal shelters or pet friendly hotels on your evacuation route; and keep veterinary records and a surplus of pet supplies for the care of your animal(s) - Learn and practice safety skills such as first aid, CPR, and use of a fire extinguisher
Collect and assemble a disaster supply kit	- Prepare three kits: one for home, work, and vehicle. Items should be kept in airtight plastic bags. The kits should include: - Three-day supply of non-perishable food and water (replace food and water supplies every six months) - Portable, battery powered radio, and/or TV - Matches in waterproof packaging and flashlight with extra batteries - First aid kit and manual, sanitation and personal hygiene items (toilet paper, etc.) - Cash and coins

- Extra clothing, sturdy shoes, and sleeping bags/blankets
- Photocopies of credit and identification cards
- Special needs items such as prescription medications
- Items for infants such as formula and diapers, if applicable
- Paper/pencil, books, games, and puzzles for children
- Pet food and extra water for the pet(s)

Family Emergency Planning Recap

- Consider most likely disaster risks
- Complete a comprehensive emergency plan for evacuation
- Collect and assemble three disaster supply kits: home, work, and vehicle

Resources

- FEMA Preparedness Presentation
- Are You Ready: A In-Depth Guide to Citizen Preparedness
- The American Red Cross
- PandemicFlu.gov

5. Client-Specific Emergency Planning

ADAPs should encourage and assist clients in planning for their specific needs during an emergency, in addition to those outlined above under section 4. This assistance can be provided in a variety of ways depending on the way ADAP services are provided: case managers can disseminate a simple one-page emergency planning guide; the program can send emergency planning information with prescriptions; and/or staff can present emergency preparedness plans at planning meetings or client groups. Individuals who are HIV positive should follow standard individual planning guidelines but also consider their specific health and medication needs that may require additional preparation.

In the event of evacuation:	- Ensure that all HIV medication prescriptions are current - Keep at least an extra three-day supply of medications on hand - Ensure that prescriptions for other medications, such as Hepatitis C, diabetes, high blood pressure, are also filled - Ensure that all ID cards (e.g., health insurance cards, ADAP enrollment card) are easily accessible - Keep a list of all medications - Keep a list of all emergency contacts - If the client has a caretaker, alternative support in the event the caretaker is injured or displaced during an emergency should be secured in advance - If the client receives palliative care or home based care, find out if there are any alternative relocation options and review these options (e.g., family or friends) - Keep a supply of non-perishable food items that meet the energy, protein, fat, and micronutrient requirements for medication and health needs - Store a supply of clean water
In the event that clients must remain in their home for safety (i.e., shelter-in-place), they should have the following additional supplies:	- Alternative telephone service other than the land line; cordless or wireless phone if possible - Plastic sheeting, duct tape, and scissors to cover doors, windows, vents and inset cabinets, mirrors, electrical outlets and switches, etc. - A radio with extra batteries - Toilet tissue, trash bags, and a bucket - the bucket can be used as a toilet; trash bags for any contaminated clothing, etc.

Client Specific Emergency Planning Resources

- Santa Clara County Medically Fragile Guidelines
- ASTHO Public Health Preparedness
- An ADA Guide for Local Governments

6. Creating a Continuity of Operations Plan (COOP)

With the information gathered from the risk assessment, evacuation vs. shelter-in-place planning, and family and client specific emergency planning, the ADAP should be ready to prepare the Continuity of Operations Plan (COOP). The COOP should operationalize the steps necessary to restore the ADAP functions that provide clients access to medications during an emergency or disaster. The COOP should be based on the specific risks and hazards identified for ADAP. The COOP should be written and shared with all stakeholders. All parties should know the role they have in implementing the COOP, and it should be tested and reviewed on a regular basis to determine which elements work and which do not. As time passes, risks and hazards change and evolve; as a result, all parties should expect to make needed changes to the COOP and should note these changes carefully.

An ADAP COOP should be created with the following objectives in mind:
- Be capable of implementation within 12 hours of a state-declared disaster and can be maintained for a minimum of 12 weeks
- Be integrated with the state disaster plan
- Ensure the continuous performance of ADAP's essential functions/operations during a disaster or public health emergency
- Protect essential facilities, equipment, vital records, and other assets
- Facilitate decision-making during an emergency by establishing an identified chain of command of appropriate staff with pre-assigned duties and authority
- Achieve a timely and orderly recovery from an emergency and resumption of full services to clients

Suggested Eight Week Timeline for Creating an ADAP COOP
The following is a proposed eight (8) week timeline that can be used to create an ADAP COOP. Beginning with activities in the Week Two, there are accompanying appendices at the end of the document to assist with completing the weekly tasks.

Week One	Identify a core ADAP Disaster Preparedness Committee, comprised of four critical personnel with significant knowledge of ADAP administrative operations and at least one member with an in-depth knowledge of the state health disaster preparedness plan. Examples of key ADAP COOP staff members include, but are not limited to, the following:
	- Program Manager - Program Point of Contact - ADAP COOP Planning Coordinator - Plan Maintenance Coordinator - Legal Compliance Counsel - Public Relations/Media Officer - ADAP COOP Administration/Logistics Support Officer - ADAP COOP Financial Operations Officer

	The group ideally meets weekly for one hour or as necessary to complete the ADAP Disaster Preparedness Planning Guide. It is important to notify the State Health Department's emergency planning division that ADAP is developing a COOP which will need to be integrated with the overall state plan. It is also important to note that many planning objectives (for example, hazard-vulnerability analysis) may have already been accomplished by the State Health Department or other state agency.
Week Two	Obtain and review the state health disaster response plan for its structure and chain of command and review where ADAP will likely report and to whom. Begin discussions to develop an ADAP-specific chain of command incident management reporting structure (e.g., ADAP chief disaster coordinator, incident commander, operations chief officer, logistics chief officer, finance chief officer). **See Appendix A.**
Week Three	Define the essential functions that are necessary for ADAP to continue providing antiretroviral medications and all ADAP services to ADAP clients (e.g., the need to have an up-to-date database list of ADAP clients). **See Appendix B**.
Week Four	Create a personnel roster and identify key individuals whose day-to-day duties are associated with completing the ADAP essential functions as well as backup personnel who could complete those tasks (e.g., who are the key personnel that would be required to ensure up-to-date data management for clients?) Create a key personnel emergency call list. **See Appendix C.**
Week Five	Create an equipment and resource list that would be required for the essential personnel to function (e.g., for database management you may need laptop computers). **See Appendix D.**
Week Six	If not already completed, conduct, obtain, and review a hazard-vulnerability analysis of your state specific ADAP and distribution locations, and prioritize the most likely threats (hurricanes, flooding, blizzards, pandemic influenza, etc.) and most vulnerable locales necessary to ADAP functions. Begin considering how to back-up essential equipment (generators, satellite phones, etc.). Create a disaster preparedness equipment "to go" bag that would have the critically necessary equipment should the ADAP central office be required to move to an alternate location due to the disaster (database list with

	clients, laptops, key phone numbers, satellite phones, etc.) **See Appendix D.**
Week Seven	Identify and draft policies regarding medication distribution strategies for the most vulnerable ADAP distribution points and clients in the event of a large scale disaster (e.g., hurricane) that may cause evacuation to areas within the state, to areas out of state, or for a disaster that would require a prolonged shelter in place (e.g., pandemic influenza). These may include using established point of distribution sites. Consider risk communication strategies (1-800-hotline) to notify clients and clinics in the event of a disaster. **See Appendix E.**
Week Eight	Review the disaster planning guide with the state health department's emergency planning division. Consider drills and exercises in conjunction with the overall state health department to test the given plan and look for ways of improvement.

Appendix A

Identify Chain of Command that Integrates with State Plan

The ADAP program administrator or their designee should become the chief emergency response coordinator for the program and would be responsible for activation and implementation of the ADAP emergency response plan. This emergency response coordinator will be notified by the health department incident commander. The emergency response coordinator will be the lead staff member responsible for responding to questions from ADAP staff, the health department, and the media. A sample COOP plan may include the following staff roles; these roles will remain operations throughout the duration of the emergency, as determined by the ADAP program administrator:

Chief Emergency Response Coordinator: The Emergency Response Coordinator is responsible for the ADAP specific plan to continue care and communication with ADAP clients. This is the staff member responsible for activating and implementing the ADAP emergency response plan in the event of an emergency. This individual will be the lead for responding to questions from staff, the Department and the media.

Operations: This role is responsible for maintaining contact with the PBM, medication distribution center, and/or area pharmacies including sharing data and adding new medications to the formulary that may be particular to the emergency as required by the program's medical consultant or the Department's medical staff.

Logistics: This staff member is responsible for coordinating services between the Health Department and AIDS service organizations/subcontractors throughout the state and for assisting the Emergency Response Coordinator.

Communication: This individual is responsible for ensuring that clients have up-to-date information on accessing medications from pharmacies, confirming eligibility with the PBM, medication distribution center, and/or area pharmacies, while ensuring the confidentiality of client records.

Planning: This staff person will be responsible for maintaining and updating the ADAPs emergency response plan, ensuring that lessons learned are incorporated into the plan in a timely manner.
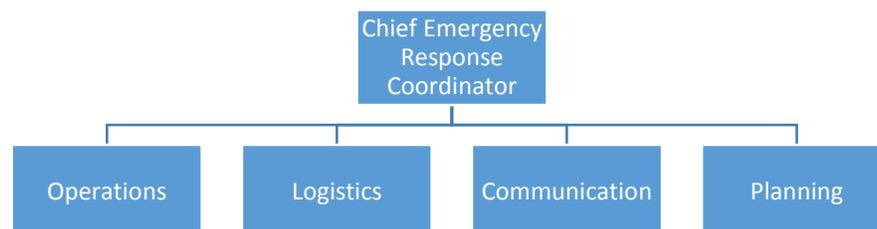
Appendix B

Prioritizing Essential Functions for an ADAP

Prioritizing Essential Functions for an ADAP during a disaster includes:

Drug Acquisition	- Develop a plan to ensure continuity of drug acquisition and payment processes - Maintain communication with the PBM, medication distribution center, and/or pharmacies to discuss ongoing drug acquisition - Implement a short term plan to allow extended supplies or early refills of medications
Drug Distribution	- Review and coordinate with the PBM, medication distribution center, and/or area pharmacies to ensure there is an adequate emergency plan - Locate stored or stock-piled drug distribution systems in the state – determine if ADAP medications are stored - Determine whether ADAP clients can access this medication reserve - Develop alternative distribution methods including local health department and hospital or community-based distribution systems
Client Database	- Complete data back-ups must be conducted on a periodic basis – continuity depends on access to current information - Ensure that back-up data and computer file servers are stored off-site, if possible
Payments to Contractors	- Determine a plan to provide assurance of payment to providers - Establish whether the state's finance department has the capability to continue to make payments during an emergency - How long will providers continue to provide medications and care without prompt payment?
Adding New Clients to the Program	- Determine how and when new clients will be enrolled - Establish who will assume responsibility for client eligibility - Establish alternative venues to process and receive ADAP applications

Appendix B (continued)

Essential Function, Key Personnel, and Equipment Checklist

Essential Function	Number of Personnel	Names of Personnel	Vital Records & Databases	Equipment & Supplies	Vendors
Intake Enrollment					
Support of Database					
Procurement					
Ordering					
Receiving					
Pharmacy Dispenser					
Shipping Function					

Appendix C

Employee Roster (Call Down List)

Name	Title / Position	COOP Role	Work	Cell	Emergency Contact
	ADAP COOP Planning Coordinator				
	Plan Maintenance Coordinator				
	Legal Compliance Counsel				
	Public Relations/Media Officer				
	ADAP COOP Administration /Logistics Support Officer				
	ADAP COOP Financial Operations Officer				

Appendix D

Key Actions to Consider for ADAP Emergency Preparedness Planning

ADAP program administrators need to establish a hierarchy of priorities/mission critical functions. They also need to identify the resources necessary to re-establish these functions. Scenarios that address risk could be as simple as setting up an alternative work location for staff in the event of an emergency at the main location. Other solutions to functional operation establishment may be more complex, making it necessary to redistribute the work load and program functions to multiple units within the division. When identifying necessary resources, the ADAP also should research and negotiate use of those resources and alternatives in the event that original resources are not available.

Analysis of hazard and vulnerability	▪ What are the most likely emergency events to affect your state and ADAP? ▪ Are these risks to your ADAP operations large or small? ▪ Will the steps you take mitigate both large and small events? ▪ Has the ADAP developed a community checklist of hazard vulnerability?
Pre-identify resources	▪ Are ADAP staff members crossed trained in job responsibilities? ▪ Is there an alternate ADAP work location? ▪ Do staff members know what is expected of them in an emergency situation? ▪ Have the systems the ADAP plans to rely on been tested (pharmacy, federal programs, state and local programs, etc.)? ▪ Are there unrestricted dollars and/or an alternative purchasing mechanism available to purchase necessary work items to improve preparedness?
Asset inventory	▪ Has the ADAP conducted an asset inventory? (alternative worksites, laptops, etc.) ▪ Has the ADAP conducted an inventory of current, remote, and alternate work locations that could potentially be used for ADAP purposes in a state of emergency (e.g., mobile clinics, county and local health departments)? ▪ Is the ADAP aware of available resources to secure additional medications during an emergency (e.g., pharmacies, Strategic National Stockpile (SNS))?

Hazard-Vulnerability Assessment

Hazard	Expectations	Essential Functions Affected	Impact on Business	Contingency Planning
Pandemic				
Flooding				
Hurricanes				
Earthquakes				
Wildfires				
Blizzard				
Terrorism				

Identify Alternative Worksites

Primary Backup Site: Until space, telephones, and computer access can be arranged, an alternative work site must be identified. This location will serve as the operations center for the health department or as a stand-alone site for ADAP. The state ADAP will function from this site until full operations can return to the original office/location or until another location is identified.

Secondary Backup Site: A secondary site for the health departments and ADAPs should be identified in the event the primary work site and primary back-up site city have been affected by a disaster/emergency. The secondary back-up site should be at least four hours' drive away from the primary work and back-up sites.

Logistics Supplies/To-Go Kits

To-Go Kits should be created by each ADAP Program Administrator to ensure the establishment of a mini operations center with relative ease in the event of an emergency. To-Go Kits should be kept off-site and contain at a minimum:
- A copy of the ADAP COOP
- Accident and injury forms, and other vital reporting forms
- Division phone lists and emergency phone trees including hotline numbers for both staff and community (i.e., immediate staff, health department staff, and necessary stakeholders). Phone trees should include optional or alternate contact numbers for key staff and stakeholders. In addition, alternate email addresses may be useful when departmental email is not working or in trying to locate individuals who have been forced to evacuate.
- Office supplies (e.g., pens, pencils, paper, tape, stapler, markers, masking tape, clipboard)
- Backup files and documents needed to continue operations
- Maps, policies, procedures, or instructions
- Telephone, flashlight, battery operated radio
- Extra batteries, extension cords, car jack charger/adaptors for cell phone

Appendix E

Identify Internal/External Communications Strategy

In the likely event that land line phones, cellular phones and email will be unavailable, ADAP staff should determine that specific alternate resources are identified and available until services can be re-established.

Ensure the local or state emergency response system contacts are distributed and included in the planning document; the distribution list would include radio, television, and online transmissions.

In some circumstances facsimile machines work when other phone lines do not. This possibly should be considered when creating an internal communication plan.

Compile a staff 24-hour contact directory and keep a copy off-site. Staff home phones, home computers, personal e-mail addresses, and other outside communication devices may be utilized when access to the ADAP office is limited.

To receive or distribute public health emergency information, satellite radio providers can also be utilized.

Place instructions off-site on how to check voicemail or change voicemail to provide clients and service providers with pertinent information about ADAP activities. Messages on each section's main voice mailbox and on staff direct lines must be updated to inform callers/customers on the status of program operations.

The AIDS Coordinator, or designee, should have the responsibility of sending mass e-mails to update customers on the bureau's status and provide emergency instruction.

Be sure that any specialized software/hardware that runs major systems for the ADAP is loaded onto at least two secure predetermined laptops and used to access vital information and continue operations from a mini-operations center.

Glossary

Disaster Medical Assist Team (DMAT)
Disaster Medical Assist Teams (DMAT) are teams operating within the National Disaster Medical System with the Department of Homeland Security, Federal Emergency Management Agency (FEMA), Response Division, Operations Branch. DMAT are comprised of teams of medical professionals and para-professionals who act as a rapid-response medical team to aid local medical care during a disaster.[2]

Emergency Operations Center (EOC)
Functions as "the brain of the operations" and from which vital data is being analyzed (situational awareness) and community interventions (evacuation, shelter-in-place) are being considered.

Emergency Support Function #8
Supplements State and local resources in response to public health and medical care needs following a major disaster or emergency, or during a developing potential medical situation. Assistance provided under ESF #8 is directed by the Department of Health and Human Services (HHS) through its executive agent, the Assistant Secretary for Public Health Emergency Preparedness (ASPHEP). Resources are provided when state and local resources are overwhelmed and public health and/or medical assistance is requested from the federal government.

Incident Command System (ICS)
As stated previously, disasters cut across all sectors and require a multi-sectoral and multidisciplinary response. A common lexicon and response framework has been established by the federal government to respond to disasters entitled the incident command system (ICS). ICS was developed by firefighters in California in response to the wildfires, to mitigate the chaos and to establish coordination and control. ICS is a framework that establishes a chain of authoritative command, with the Incident Commander as the chief authority. Health systems can use a variation of this structure entitled the Health Incident Command System or (HEICS). The components of each are the same and allow for scalability. At the most basic level the ICS has an Incident Commander, and four additional sectors of management (Planning, Operations, Finance, and Logistics). Public health is integrated into this overall framework for response and is dependent on your state.

Medical Reserve Corps (MRC)
The MRC is a federally sponsored program of the Office of the Surgeon General. The MRC organizes medical and public health volunteers to aid local emergency staff during local emergencies.

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[2] Landesman, L Y. Public Health Management of Disasters--the Practice Guide. 2nd ed. Washington, DC: American Public Health Association, 2005.

Mutual Aid Agreements

Mutual Aid Agreements are used to request resources from surrounding jurisdictions when resources of a local jurisdiction are insufficient to respond to an emergency or disaster. States can receive assistance from state, regional, or federal levels through the process of mutual aid. Intra-state and inter-state mutual aid agreements provide timely and cost-effective support and can be formed and executed prior to a Presidential disaster declaration. Communities should increase mutual aid by broadening geographic and traditional partnerships through cross-jurisdictional/regional collaboration extending to agencies and organizations that previously are not linked. Some communities have multiple mutual aid agreements within the public health and medical community that help the local Office of Emergency Preparedness coordinate mutual aid pacts and the impact on community health during an emergency.

National Response Plan (NRP)

Identifies authoritative roles and responsibilities for all relevant federal agencies. Included in the NRP is ESF #8 which refers to health and medical care and is led by the Department of Health and Human Services. This agency will augment and assist the state health department in the public health response to the disaster if requested by the state. Assets that are included in the federal support include the Strategic National Stockpile (SNS), Disaster Management Assist Teams, and Medical Reserve Corp units. It is important to note that the SNS is a pharmaceutical stockpile which includes antibiotics and medical supplies. The SNS does not include HIV medications or other chronic disease medications.

Strategic National Stockpile (SNS)

Each state manages a SNS with the purpose of preserving a supply of medical supplies, medication and equipment to assist local and state resources during a disaster or emergency.[3]

ADAP program administrators should know what medications are and are not available through the SNS. For more information, click here.

[3] Landesman, L Y. Public Health Management of Disasters--the Practice Guide. 2nd ed. Washington, DC: American Public Health Association, 2005.

Emergency Preparedness Websites and Services

Whether you are looking for specific information about what to do in your city, county or state, or something broader such as what should be in a "To Go" kit, these sites are good places to start:

[An ADA Guide for Local Governments](#)

[American Medical Association (AMA)](#)

[American Red Cross Disaster Services](#)

[American Red Cross Readiness Quotient Test](#)

[Are You Ready: A In-Depth Guide to Citizen Preparedness](#)

[ASTHO](#)

[Centers for Disease Control and Prevention Emergency Preparedness and Response](#)

[FEMA Disaster Center Locator](#)

[Emergency Email and Wireless Network Notification System](#)

[Emergency Management Assist Compact](#)

[FEMA Risk Assessment Form](#)

[FEMA State Offices and Agencies of Emergency Management](#)

[HAZUS Risk Assessment Software](#)

[HRSA Emergency Planning](#)

[NACCHO](#)

[Pandemic Flu](#)

[Ready America: Prepare, Plan and Stay Informed](#)

ADAP Emergency Preparedness Examples

District of Columbia
AIDS Drug Assistance Program (ADAP)
Continuity of Operations Plan (COOP)

	First 72 Hours	Following 7 Days
Critical Medical Services	N/A	N/A
Essential DOH Operations **ADAP** **Essential DOH Operations** **ADAP**	Supervisor/Alternate should first report to the work site to assess emergency situation, if possible, if not possible Contact Administration management by cell phone – if no response Alternative location – The District of Columbia Department of Health (DOH) (Communications Division) – 825 North Capital NE/ or other alternative location A request should be made by program supervisor/alternate that ADAP program correspondence be sent out to all HIV Service Providers; correspondence should inform providers that the Administration for HIV Policy and Programs (AHPP), emergency Continuity of Operations Plan (COOP) is now in effect. Providers should be notified of ADAP's temporary location, and instructed not to submit ADAP applications until further notice-ADAP staff will contact providers with program updates. All individuals recertifying for the ADAP program will be granted fifteen (15) day extensions as needed. Follow steps below:	Inform providers of any new program updates; in addition make available to providers a phone number to contact ADAP staff and a confidential fax number where ADAP applications can be faxed.

	*Contact Pharmacy Benefit Manager - Emdeon (1-877-633-3722, ex 108), explain the situation and request 15 day extension as needed.	
	*Inform participating pharmacies of the Emergency measures implemented. Their contact information (phone, fax, email) is attached.	
	*Inform providers of the Emergency measures implemented. Their contact information (phone, fax, email) is attached.	
	The continuity of care plan allows us to extend ADAP eligibility in crisis situations. In this manner clients can continue to fill their ADAP prescriptions without interruption.	
	The ADAP laptop is loaded with essential software to process ADAP applications.	
	However, if an individual has an immediate need for HIV/AIDS prescriptions and is not currently enrolled in ADAP, they should contact our Emergency Drug Assistance Program (EDAP) providers. These providers are:	
	Whitman Walker Pharmacy (202) 745-6135, Fax # 202-387-5913	
	Unity Health (Phoenix Health Center) (202) 548-6500, Fax # 202-548-6534	
Essential DOH Operations **ADAP** **Essential DOH Operations**	ADAP Staff Preparedness: Communication Keep update staff phone list *Contact Pharmacy Benefit Manager - Emdeon (1-877-633-3722, ex 108), Account Manager, <ccampbell@emdeon.com> *CARE Pharmacies 703-414-5437	

*HRSA Quarterly Reports contacts: **301 443-2889; Fax: 301 594-2511**
*HRSA Quarterly Report Contact:1-877-Go4-HRSA/877-464-4772;301-998-7373 or CallCenter@HRSA.GOV

*HRSA Program Contact, Phone 301-443-2838
*HADAC contact list attached
*Clinical Pharmacy Associates, Phone 301-617-0555

*NASTAD, Phone 202- 434-8090

Keep list of other important contacts
*Emergency Health and Medical Services Administration (EHMSA) Call Center: 202-671-0733
*DOH Provider Hotline: (202) 671-5000

Alternative plan of communication
*Staff Cell phones
*Emergency Numbers: EHMSA: 202-671-4222, Red Cross Disaster line: 202-303-4525

Yahoo Group web-site, etc.
Administration/communication can create Emergency Web-Group list, if other forms of communication is not possible.

Conference call capability for dispersed staff
1-800- numbers?

You should also have a contact out of state
*Contact Pharmacy Benefit Manager Emdeon (1-877-633-3722, ex 108)

Protecting ADAP Confidential Data
*Monthly Backup on ADAP laptop
*Monthly Backup on DOH z drive/dgurung
*Emedeon – PBM warehouses ADAP data

New York State

New York State Department of Health
AIDS Institute, Uninsured Care Programs
Business Continuity – Disaster Recovery

The Business Continuity Disaster Recovery Plan assures Uninsured Care Program compliance with the requirements of HIPAA Security Guidelines and provides the Program with a plan for continuing business critical functions.

Processes in Place:
- Appropriately sized uninterruptible power supplies (UPS) are used for all crucial system components
- Natural gas powered generator
- Air-conditioning system to maintain appropriate environmental conditions
- Off-site storage of back-up media; on-going real-time back-ups of critical files. (See 1 below)
- An alternative critical function "warm-site." A "warm site" is defined as equipped office space that contains some or all of the system hardware, software, telecommunications and power sources necessary to bring business critical functions up in the event of a primary site loss.
- Connection to allow timely back-ups and conversely reestablish system functions in the event of a disaster
- ISDN communication to pharmacy - switch company to redirect and receive transactions at alternate site
- Business Continuity for ADAP pharmacy transactions in near real time (2-hour delay).
- System Command Center for reestablishment of other business functions in the event of a disaster which affects the entire building. The System Command Center will be staffed by key personnel who will direct the reestablishment of full Uninsured Care Program operations in service priority order. (See 2 below)

Warm Site Specifications
The warm site is located a distance of 7 miles away from the Primary office site.
The physical attributes of the warm site are environmentally monitored and controlled environment, secured room accessible only by HIV Uninsured Care Program personnel and AIDS Institute personnel, virtual closed network and firewalls to prevent outside access, ISDN back-up to Pharmacy switch company to insure continuity of pharmacy claim processing.

Data Back-up Specifications:
Key eligibility files, and pharmacy transaction files are backed-up hourly on the ½ hour to the warm-site remote server through an automated file transfer protocol. Additional non-critical files are backed up on less frequent basis depending on an annual analysis of data access requirements.

Reestablishment of Uninsured Care Program operations in order of service priority:

Acceptance and adjudication of Pharmacy Claims for existing Participants
- Projected Recovery Time – 2 hours

New Participant Eligibility Application processing
- Projected Recovery Time – 2 Days

Insurance Continuation Payments
- Projected Recovery Time – 2 Days

Full Hotline recovery – limited redirect in the interim
- Projected Recovery Time – 3 Days

Home Care Certification approvals
- Projected Recovery Time – 4-10 Days

Primary Care Claim Processing
- Projected Recovery Time – 10-30 Days

Insurance Recovery Billing
- Projected Recovery Time – 15-30 Days

Home Care Payments
- Projected Recovery Time – 15-45 Days

Rebate Billings
- Projected Recovery Time – 30-60 Days

Provider Enrollment
- Projected Recovery Time – 5-20 Days

Florida

Following is an excerpt from the Florida Department of Health's Disaster Plan for the Bureau of HIV/AIDS:

Each section of the bureau has identified its plans for handling critical activities. These plans, listed below, include the order of delegation, the emergency contact list, a proposed method of communication, and critical functions of the bureau.

Operations & Management Section

Most day-to-day functions will be managed in the most basic form from the Bureau Emergency Operations Center and the Bureau's plan for continuity of government will be followed.

If an emergency occurs during a critical phase of the contract execution process and contracts can't be executed in a timely manner, services can continue and efforts will be undertaken to have the contracts signed within 30 days from the start of work. In an emergency, contract in the development/execution process are on the shared directory and can be accessed from another location. Copies of existing contracts can be obtained from another source if necessary, such as Disbursements, the Comptroller, the Provider, or the Contract Manager.

The Chain of Command in the Operations and Management Section is as follows:
1. Program Administrator
2. Budget Manager (Operations & Management Consultant Manager)
3. Contracts Manager (Operations & Management Consultant II)

Patient Care Section and the Medical Staff

The most critical area of the Patient Care Section is the AIDS Drug Assistance Program. This program must be continued in the event of an emergency. Technical assistance to the field is critical to ensure that patient care services remain in effect without interruption. The Program Administrator for the Patient Care Section and the Medical Director of the bureau, both members of the Senior Management Team, will communicate from the Bond Clinic, or other designated site, with staff from the medical unit, the ADAP unit, and staff from the community programs unit, to ensure the continuation of critical services.

ADAP staff can temporarily operate the program from home, as needed, with cellular phones and landlines, laptops, and direction from the Senior Management Team. This operation must be set-up within 24 hours or less of a disaster. Staff can function from their homes as long as necessary until another off-site facility is designated.

The Chain of Command for the Patient Care Section is as follows:
1. Program Administrator
2. Medical Director
3. ADAP Unit Supervisor
4. Community Programs Unit Supervisor

Washington State

Title	HIV Client Services Emergency Response
References	Department of Health Comprehensive Emergency Management Plan (CEMP)
Management	Washington State Comprehensive Emergency Plan
Contact	Divisional Emergency Response Planner
Effective Date	February, 2006
Supersedes	N/A New Policy
Reviewed	February 1, 2006
Approved Health	Patty Hayes, Assistant Secretary, Community & Family

Purpose

To assist people living with HIV (PLWH) access vital health care services during a Washington State emergency such as an earthquake, terrorism, pandemic flu. These procedures will provide guidance for continuation or timely resumption of functions and services of the Early Intervention Program (EIP) in the event of a critical dependency failure, such as computer system failure, Pharmacy Benefits Manager (PBM) services failure, or office facility becomes non-functional. In addition, the program will provide educational and up-to-date information to clients on an annual basis at time of client renewal to assist them in preparing for any emergency situation.

Policy

The CFH HIV Client Services Program works to ensure that clients are prepared for potential emergencies and have access to EIP services as possible during an emergency. This will be accomplished by:

- Providing emergency preparedness resource information to all Early Intervention Program (EIP) clients annually and as needed to community partners
- Maintaining access to EIP services for EIP clients
- Training staff in emergency response and risk communication management

Program Overview and Limitations

The EIP provides access to HIV-related drugs and medical services to eligible individuals who reside in Washington State. EIP contracts with a pharmacy benefits manager (PBM) to ensure clients have access to medications in their local community. The PBM contracts with community pharmacies to dispense medications and coordinates with other payers and then bills DOH for the remaining cost of the prescriptions. Eligibility is determined by EIP and communicated to the PBM daily. Generally, prescription refills are for a 30-day supply. The dispensing pharmacy must seek verification of continued eligibility for services from the PBM prior to filling prescriptions each month. EIP clients with valid prescriptions may receive any of the drugs on the EIP formulary, some of which require prior authorization.

EIP has a toll-free number (877-376-9316) where providers, interested parties, and clients can call for program information and to request applications. Customer Services Representatives (CSR) process all applications and annual re-applications. To verify eligibility, CSR's check both the Medicaid database to assure that the individual is not Medicaid eligible and the EIP database to verify current status. Access to the Medicaid online database (ACES) is allowed through a cooperative agreement with the Department of Social and Health Services. New and renewing client information is sent to the PBM through secure file transfer. EIP staff maintains strict standards of confidentiality.

Services are provided to eligible PLWH who are enrolled in the EIP. Enrollment may cease for new clients during an emergency. For emergencies that result in migration to Washington State from other areas, the program will follow emergency enrollment procedures. PLWH's may be advised against taking HIV medications before seeing a provider if they experienced an interruption in taking HIV medications for more than 72 hours. In the event of a communicable disease outbreak, EIP may advise immuno-compromised PLWH to shelter in place.

Activation and Deactivation of an HIV Client Emergency Response
The Secretary of Health, the Deputy Secretary, or their designee will order the activation of the DOH Comprehensive Emergency Management Plan (CEMP) and/or the Communicable Disease Emergency Response Plan (CDERP). This decision will normally be made after consultation with the Assessment Response Team (ART). Upon the decision to activate the CEMP or CDERP, the Secretary of Health or designee will order activation of the DOH Emergency Operations Center (EOC). Once the CEMP or CDERP has been activated, the DOH EOC will be implemented. Activation of the DOH CEMP will signal the HIV program to implement the emergency response procedure. Although the DOH EOC response will use resources and staff from within all DOH divisions, the HIV program will initiate the emergency organizational structure within the section as depicted in Attachment A.

> **HIV Section Call-Up Phone Tree**
> Notification of an emergency requiring HIV staff assistance or subject matter expertise will begin when the HIV Program Manager has been notified by the CFH Assistant Secretary or designee that the DOH Comprehensive Emergency Management Plan (CEMP) has been activated.
> **Reporting for Emergencies**
> Designated emergency response staff in an emergent public health event will be notified via a phone tree (Attachment A). The HIV Program Manager will begin the phone tree, first notifying the Secretary Administrative. The HIV Program Manager and the Secretary Administrative will then call the Communications, Operations, Planning, and Logistics Chiefs to report for duty at Town Center 2, Room 153 on the 1st floor. Each lead will be responsible for calling the staff under their supervision. The HIV Secretary Administrative will ensure that all designated HIV Section emergency staff have been

notified and have reported for duty as soon as required. This
information will be shared with the HIV Program Manager.

HIV Client Services Emergency Duties and Responsibilities
All staff members will be trained in emergency response and
designated staff crossed trained in office procedures to assist the
Department and PLWH. Specific staff members will be assigned
responsibilities in emergencies. In the event of a severe emergency
that shuts down DOH or requires that staff must remain at home, the
department's Pharmacy Benefits Manager will assist program clients to
access their medication.

Emergency Response Coordinator (ERC)
The HIV Client Services Program Manager is responsible for activation and implementation of
the HIV Client Services Emergency Response Plan in the event of an emergency. The
Coordinator will be notified by the CFH emergency response coordinator that the DOH CEMP
has been activated. If the HIV ERC decides to activate the CS Emergency Response, he will
contact the Secretary Administrative. They will immediately notify the Operations, Logistics,
Communication and Planning section chiefs that the plan has been activated. They will remain
with the section until the plan has been completed. If unavailable or unable to stay, the
Logistics Section Chief will take over. The Coordinator will be the lead for responding to
questions from staff, the Department and the Media. The Coordinator will contact CFH if
additional staff is needed. The Coordinator will be notified by staff or the department of any
changes to the program's plan or emergency situation. The Secretary Administrative is
responsible for coverage for the main phone line including the toll free number.

Operations Section
The Operations Section Chief is responsible for maintaining contact with the PBM including
sharing data, adding new medications to the formulary that may be particular to the
emergency as required by the program's medical consultant or the Department's medical
staff. Once notified by the Emergency Response Coordinator for HIV Client Services that the
emergency plan is activated, the Operations Section Chief will notify all staff assigned to
Operations of activation and if they are needed to respond. If designated staff is unable to
come in, the operations section chief will determine if more staff are needed and notify the
Emergency Response Coordinator.

Logistics Section
The Logistics Section Chief is responsible for coordinating services between DOH and AIDS
Service Organizations throughout Washington State and for assisting the Emergency
Response Coordinator. Once notified by the Emergency Response Coordinator for HIV Client
Services that the emergency plan is activated, the Logistics Section Chief will notify all staff
assigned to Logistics of activation and if they are needed to respond. If designated staff is
unable to come in, the logistics section chief will determine if more staff are needed and
notify the Emergency Response Coordinator. The Logistics section will assist AIDS service

organizations activate their emergency plans, coordinate services between state agencies as needed and provide the most up-to-date information directly to the agencies.

Communication Section

The Communications Section Chief is responsible for ensuring that clients have up-to-date information on accessing medications from EIP pharmacies, confirming eligibility with the PBM, while ensuring the confidentiality of client records. All media releases should be coordinated with the DOH Communications Office. At least two staff trained in eligibility procedures plus the section chief must be available to maintain proper phone coverage. Once notified by the Emergency Response Coordinator for HIV Client Services that the emergency plan is activated, the Communications Section Chief will notify all staff assigned to Communications of activation and if they are needed to respond. If designated staff is unable to come in, the communications section chief will determine if more staff are needed and notify the Emergency Response Coordinator.

Planning Section

The Planning Section Chief is responsible for maintaining and updating the Emergency Response Plan for HIV Client Services. Once notified by the Emergency Response Coordinator for HIV Client Services that the emergency plan is activated, the Planning Section Chief will notify all staff assigned to Planning of activation and if they are needed to respond. If designated staff is unable to come in, the planning section chief will determine if more staff are needed and notify the Emergency Response Coordinator. The Planning section will collect and report all financial costs associated with the emergency. The Planning section is responsible for maintaining communication between each section.

Scope of Procedures for Continuation or Timely Resumption of Functions and Services

In an event of a critical dependency failure, this procedure outlines and describes three different levels of severity of system failure with appropriate response to re-establish or to continue business operations for EIP. However, if an event occurred where there would be any disruption that may impact a major portion of a metropolitan area or the state, the demand for EIP services would be immediate and concentrated. The demand would result from the client's need to replace medications lost or inaccessible during the event, in addition to normal prescription refills.

Communication System Failure

EIP staff will continue program operations with the PBM to verify eligibility for services by whatever means still functioning such as phone, fax, postal service, cell phone, or courier. If computer systems are down, client eligibility can be verified by the hard copy in the client files. Staff identified in the Emergency Plan will have access to the building even if the power is out.

The PBM maintains information on all the clients approved for EIP medication services. In the event of a communication failure at the Department of Health (DOH) that lasts more than 24 hours, the PBM would be contacted by the ERC and authorized to extend all clients eligibility for a designated period of time.

Building Disruption and Alternate Work Site

The database and voicemail system can also be accessed from the Kent office. Voicemail can be accessed by whatever means are available such as alternate land lines, Blackberry service or satellite phones. If both the Tumwater and Kent offices were inaccessible then the PBM would be contacted by the ERC and authorize to extend all clients eligibility for a designated period of time.

Building Disruption with Communication System Failure

The PBM could be authorized by the ERC to approve temporary eligibility for new or returning clients for a designated period of time. Upon resumption of business the PBM will provide records of new, returning and extended clients so that EIP can update its data system.

Overview of the Pharmacy Benefits Manager

The PBM contracts with pharmacies throughout Washington. Pharmacies determine through the PBM if a client is eligible for services and has a cost share at the point of dispense. Once eligibility has been determined, the prescriptions are filled and the PBM is billed for the cost of the medication. The PBM provides payment to the pharmacies. In turn, the PBM bill s DOH on a weekly basis for repayment. Several of the pharmacies have mail order capabilities in the event a client's local pharmacy is affected by the situation. Clients enrolled in the program may access any contracted pharmacy in the state.

The PBM's Business Continuity Plan

A copy of the PBM's Business Continuity Plan is kept with the Operations Section Chief. The chief is responsible for coordinating services between the PBM and DOH.

PBM Communication System Failure

The Operations Section Chief will have a list of the most current contracted pharmacies. Information will be sent out to the pharmacies by whatever method is possible, such as phone, fax, or email to authorize dispensing of medications. Pharmacies will be instructed to contact EIP if possible or dispense the medication based on previous prescription and program eligibility. EIP will insure reimbursement of all medications on the formulary based on the previous experience.

Scope of Plan for Assisting EIN Clients Prepare for Emergencies

EIP staff will provide Emergency Preparedness resource information to all new and renewing clients each year. The material will be maintained and coordinated as needed by the Communications Section Chief. Resource information will include:

1. Specific issues that program clients should consider.
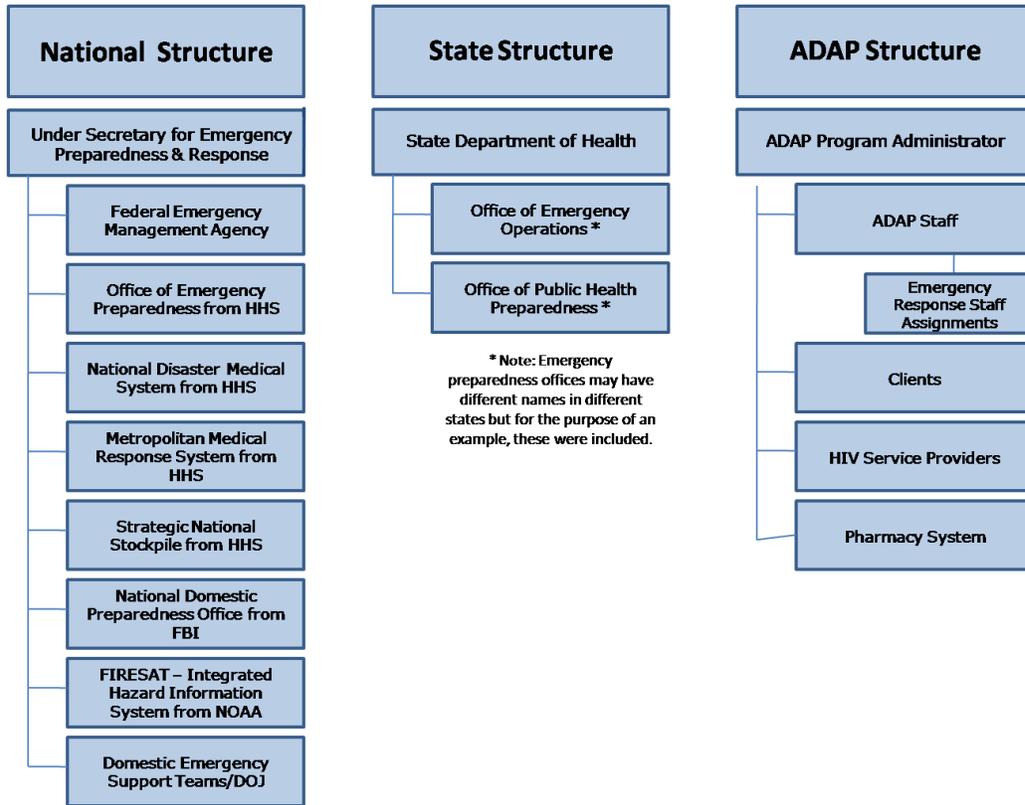2. Contact information and websites for additional information.

Special Mailings

Special mailings will be sent to clients and service providers if new or specific information regarding an emergency is obtained by the program. The program manager is responsible for determining what information is important. The Operations Section Chief will be responsible for organizing the mailings.

Attachments

1. Phone Tree

2. Job Action Sheets

   - HIV Emergency Response Coordinator

   - HIV Communications Section Chief

   - HIV Logistics Section Chief

   - HIV Non-Emergency Response Team (Non-ERT) Section Staff

   - HIV Operations Section Chief

   - HIV Planning Section Chief

Federal and State Emergency Structure Example with a Proposed ADAP Structure

National Structure

- Under Secretary for Emergency Preparedness & Response
  - Federal Emergency Management Agency
  - Office of Emergency Preparedness from HHS
  - National Disaster Medical System from HHS
  - Metropolitan Medical Response System from HHS
  - Strategic National Stockpile from HHS
  - National Domestic Preparedness Office from FBI
  - FIRESAT – Integrated Hazard Information System from NOAA
  - Domestic Emergency Support Teams/DOJ

State Structure

- State Department of Health
  - Office of Emergency Operations *
  - Office of Public Health Preparedness *

*Note: Emergency preparedness offices may have different names in different states but for the purpose of an example, these were included.

ADAP Structure

- ADAP Program Administrator
  - ADAP Staff
    - Emergency Response Staff Assignments
  - Clients
  - HIV Service Providers
  - Pharmacy System

Acknowledgements