Extended Downtime Assessment Report

Approved by Board 6-4-25

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Executive Summary

This report summarizes how healthcare organizations across East Central Florida (RDSTF Region 5, including Brevard, Indian River, Lake, Martin, Orange, Osceola, Seminole, St. Lucie and Volusia Counties), are preparing for and managing extended downtime impacts. This assessment evaluates the region's ability to maintain clinical operations, support vulnerable populations, and coordinate with regional and state partners during prolonged events that impact healthcare. The findings highlight the operational functions most affected, current mitigation strategies in place, and common challenges related to communication, continuity, and escalation protocols. Special attention is given to practices that promote resilience and ensure continuity of care when local capabilities are strained.

Background

Extended downtime events can lead to significant impact on healthcare delivery. Healthcare facilities may be affected by infrastructure/utility outages (e.g., water, electricity, gas, telephones/internet) besides being targeted by ransomware and disruption of service attacks. Healthcare facilities have increasingly faced infrastructure failures that threaten safe provision of care. In conjunction with implementing routine system mitigation efforts and periodic exercises and drills, it is critical for downtime preparedness activities to consider the effects of either infrastructure/utility outages or cyber events. Careful planning for downtime will save time during any event where resources are maxed.

Regional planning efforts support ensuring all healthcare coalition (HCC) members better protect against, mitigate, respond to, and recover from extended downtime, ensuring patient safety and operational continuity. To that end, CFDMC conducted an assessment aligned with the 2024–2029 Hospital Preparedness Program (HPP) Notice of Funding Opportunity (NOFO) priorities. The assessment focused on how these events affect clinical and operational functions, disproportionately impact vulnerable populations, and require both localized and escalated responses. A follow-up survey was conducted to identify resiliency measures currently in place at healthcare facilities and how CFDMC could support additional resiliency strategies.

Assessment Methodology

Healthcare partners from across the region, including hospitals, EMS, public health, long-term care facilities, and other healthcare providers, were asked to complete a self-assessment covering patient care, communication systems, infrastructure dependencies, mitigation strategies, and escalation procedures. The survey tool used open-ended response formats to gather detailed operational insights. The survey was sent to all healthcare members on April 25, 2025, with a reminder on May 2, 2025. In addition, a special request to complete the survey was made to all hospitals within the region. A follow-up resiliency survey was sent to all members on May 9, 2025.

Key Findings

Twenty (20) members responded to the extended downtime assessment survey:

- Hospitals (45%)
- EMS (5%)
- Long-Term Care (15%)
- Public Health (5%)
- Outpatient/Ambulatory Care (15%)
- Other Medical Providers (15%)

Below is a summary of the assessment findings. See Appendix A for detailed results.

Impact on Patient Care, Communications, Infrastructure/Operational Functions

Organizations consistently identified patient registration, medication administration, and access to electronic medical records as the areas most at risk during an extended downtime event. Infrastructure failures such as loss of water/power/sewer were the most common noted. Manual and back-up procedures are in place at most facilities, but the standardization and effectiveness of these vary.

Impact on Communities Most Impacted by Disasters

Respondents acknowledged that vulnerable populations, including low-income individuals, seniors, and people with disabilities—would be disproportionately affected. The most common concerns were transportation barriers and communication difficulties.

Mitigation Strategies and Integration with ESF8

Most organizations reported having some form of mitigation strategies in place, such as MOUs, written downtime protocols, manual processes for registration, medication administration, patient tracking, and redundant communication mechanisms. The implementation and frequency of testing of these processes may vary significantly across facilities.

CFDMC has processes to integrate with ESF8 lead agencies across the region. This includes participation in county and regional EM/ESF8 meetings and including EM/ESF8 in Coalition meetings such as the monthly hospital calls, monitoring ESF8 requests to the State ESF8 and providing resources when available. CFDMC recognizes that these partnerships are stronger in some counties than in others and is working diligently to strengthen relationships across the region.

Coalition-Level Support and Continuity Resources

As the coordinating body for health care system preparedness in the region, the healthcare coalition is seen as playing a vital role in ensuring continuity of care across systems. This includes linking members with needed support, facilitating rapid situational awareness, and coordinating resources, including providing regional assets such as evacuation equipment, portable morgues, alternate care and MCI caches, etc. CFDMC recognizes that many

members are unaware of the services and resources provided by the Coalition. Ensuring that all members understand and can activate support resources will strengthen the region's ability to sustain patient care, especially in critical service areas during a widespread downtime event affecting multiple partners.

County or State-Level Escalation Protocols

Most facilities noted that escalation to the county or state level would be triggered by an inability to provide patient care, resource exhaustion, or widespread infrastructure failures. Definitions of escalation thresholds varied, highlighting the need for more consistent triggers and communication pathways.

Opportunities for Improvement

- Continue to strengthen relationships with ESF8 across the region.
- Standardize escalation procedures to state and regional authorities.
- Expand regional awareness of resources and support options.
- Increase focused planning to protect vulnerable populations during extended downtime events.

Next Steps

To build on these findings, over the coming year, CFDMC will develop an extended downtime plan. This will include:

- Continue to engage healthcare members in identifying resiliency strategies.
- Establish an extended downtime planning team, including IT experts and front-line clinical and operations staff.
- Develop templates for facilities for extended downtime disruptions to healthcare operations and patient care.
- Establish a "knowledge center" or web-based system to store cyber or extended downtime event-related information and ensure members know how to access this resource.
- Participate in the regional Cyber response plan project.
- Establish a schedule to exercise and update the extended downtime plan.

Appendix A – Extended Downtime Survey Data

Respondents:

ORGANIZATION TYPE	RESPONSE PERCENTAGE	# RESPONSES
Hospital	45.00%	9
EMS	5.00%	1
Long-Term Care	15.00%	3
Public Health	5.00%	1
Outpatient/Ambulatory care	15.00%	3
Other medical care (hospice, home health, etc.)	15.00%	3
TOTAL		20

Patient Care (e.g., patient registration/admission, medication administration, critical patient monitoring, patient transfer/discharge):

What critical patient care clinical and operational functions would suffer most from an extended downtime event?

- Adequate levels of Staffing, communications between interdisciplinary T teams.
- Patient Monitoring
- Outpatient Surgery
- None. Non-emergent procedures would be rescheduled and emergent procedures would be fully capable of being performed with generator backup through critical outlets
- Staff require use of internet for access to patient care plans, medication profiles, eMars, view patient schedules and to document care provided and are required to use mobile cell service to clock in and out to verify each shift. Widespread power outages would impact patients on ventilators or feeding pumps. Patients with no power or clean water at home for extended time may need to evacuate to alternate location.
- Life support equipment - We have Facility Wide Generator Back up Power

- EMR, telemetry, dialysis, procedures (surgery, cath lab, etc), medication distribution, supply delivery, linen and food delivery, staffing
- Medication management, Vaccines
- Behavioral health services
- Getting referral/patient information from hospitals, medical offices, and rehab centers. Insurance authorization, supply ordering, billing, accessing patient care plans and lab results.
- Any lab results, imaging results, communication between staff
- Medication administration (transcribe, Rx pads), labs, bed placement (census, patient tracking)
- Critical Care, ED
- Everything
- Medication management initially as well as order transfers
- Scheduling, Admissions, Supplies, and delivery of patient care in the home.
- Most if not all extended care facilities are mandated to have and upkeep a generator for the building. If that equipment would happen to fail or break, most of all operations would be shutdown. The staff would have to use paper forms and manpower to complete tasks. The " paper documentation " would then be documented in the proper applications when power and internet is restored.
- Dispatch unavailable thru normal means
- Patient records, billing, images, etc.

What patient care extended downtime mitigation strategies are in place (manual, redundancies, etc.)?

- Emergency Plan: Our Team A & B Downtime Forms and Drills
- Manual Monitoring capable
- Policies
- We have everything printed so we would have information. We have a hybrid chart therefore everything is not in the computer.
- Paper charting backup, physical record storage on site.
- Printed Care Plans in every client home. Printed Medication Profile available in each home. Paper forms available for documentation in the event online services are out. All our home care patients have family caregivers who are skill validated and able to provide care in the absence of home health agency staff. Patients unable to receive care at home or experiencing medical emergency depend on local hospitals. Emergency shelter registrations are done in advance for all clients and annually updated at the start of hurricane season. All client families educated on emergency planning and have a written plan in place to evacuate to family home, hotel or emergency shelter if needed.
- Facility Wide Generator Back up Power
- Some redundancies, manual processes, paper documentation
- Use of Paper Charts and redirecting to another office
- Critical incident stress response team support in person response.
- We can hand write careplans and orders and deliver them to the MD to sign and approve
- Have BCA (backup computers) that are not tied into the network. Downtime manuals

- Downtime computers, unit clipboard for management
- Training on DT Procedures are ongoing.
- Manual entries and downtime computers that would have to upload when the downtime is over. Limited computers available. Blood Bank issues, etc.
- Paper and downtime computers and access within Epic
- Paper back -up for current patient care with frequency. Supply room is always stocked.
- Paper documentation, hard copy of online applications as redundancies.
- Secondary site for dispatch if primary is lost, generator backup at both sites.
- Downtime computers, downtime printers, downtime forms, smartphone apps, etc.

What regional resources support patient care downtime response?

- EmResources and our CodeReady System
- Unknown
- We have both solar and generator backup that is supported by regional resources. County-wide emergency planning and EMS would be able to assist if needed.
- Patient care supplemented by local hospital and emergency shelters, special needs shelters, emergency and non-emergency medical transportation providers.
- Sister Facility on Compound, ALF and Apartments with their own Generator systems
- Orlando Health relationships, Brevard EOC, healthcare coalition
- HRSA
- See above
- MUA with other local home health agencies
- not sure there are
- Pulsara?
- Coalition? EOC
- Down time computers
- Blood bank operations
- MOU with 2 other Home Care agencies to work together during an event to help with staffing and supplies. corporate office will also provide support.
- We are owned and overseen by a corporate entity. They would be a resource.
- Other dispatch centers can assist if they are on same radio system. For example, Orange County or Orlando can assist since they are on Motorola radios, Volusia could not.
- Not sure to be honest.

What triggers state-level escalation in an extended downtime event impacting patient care?

- When the demand of care exceeds the resources.
- Unknown. Will find out.
- We have oxygen concentrators and cylinders- building has over 96 hours of generator available and everything has been topped off for an emergency.
- Nothing in our facility would necessitate a state-level escalation due to extended downtime.
- Governor declaring state of emergency
- If we see a possibility of not being able to provide all necessary care to our residents

- County activation
- Hurricanes
- The Department of Health has licensed behavioral health professionals on a list of those willing to activate for a state-level disaster.
- Unknown
- If multiple hospitals are affected and delay in patient throughput
- Widespread resource allocation (human resources and materials/supplies)
- Length of time
- Only if there were issues that required reporting such as a serious negative outcome directly connected to the down time.
- Surge beyond regional capacity. Assistance with lengthy transport or ambulance strike teams. State access to help with any medical supply chain disruptions
- Inability to provide patient care in the home.
- Natural disaster, Pandemic, epidemic, mass casualties. The event of biological event and other.
- Any time we are unable to handle normal dispatch procedures
- When numerous hospitals are impacted which will impact patient care in a county and region.

Communications in an extended downtime event (e.g., internal staff communication, external agency communication, patient/family communication).

What critical clinical and operational communication functions would suffer most from an extended downtime event?

- Handoff Reports and communication to patients and families.
- External Emergency Communication
- Urgent Surgeries in my unit
- We have food supplies and medical supplies-for at least 2 weeks
- Patient follow-up and communication post operatively. We have backup in place for most if not all functions, but being able to reach patients post operatively for mandatory follow-up would be most likely to be impacted.
- Widespread internet or phone outages would impact scheduling, emergency communication and providing support to our patients and staff. Billing may be affected, impacting cashflow and ability to continue full operations.
- Our phone systems could be affected
- All electronic systems (email, cell phone, overhead paging), eventually cell phones. maybe use radios and runners
- Communication to patient
- An inability to serve individuals unable to exit their home with no access to electronic care.
- Access to patient records, case conference, reaching MD's for urgent needs, staff schedules
- Communication internally. Red phones (old pots lines, copper lines) have become too costly due to deregulation example one line costs 3,000 per month for our facility. We can't afford to put in multiple lines like that. Radios have become expensive, especially those that are more than what get from target. Runners (staff) becomes expensive too.

- Patient scheduling, patient app, staffing scheduling, knowing who to call (in-house, on call, voalte)
- All
- Order entry
- Internet, EMR, voip, Microsoft all have communication operations that could be impacted
- Ability to provide/schedule visits for patient care. Inability to accept new patients.
- Staffing, Medication pass/documentation, fire and safety systems, electronic door locks.
- If radio systems go down unable to receive calls and call info, unable to give radio report to the hospitals when we are enroute with a patient.
- Patient records, billing, images, pharmacy, labs, surgeries, etc.

What communications downtime mitigation strategies are in place (manual, redundancies, etc.)?

- Handheld radios, satellite phone. cell phones
- We have a manual and back ups
- Email and Texting
- We have radios - satellite phone- we have 70 staff on days, 40 staff on nights and 20 staff on midnights on campus
- We have backup methods of communication including email, backup phone systems, and mobile lines to account for this.
- Office phones forwarded to cell phone in the event of outage at the office for afterhours and on-call emergencies. Backup battery available for phones.
- We have back up Group Text and a system of Walkie Talkies
- Satellite phone, radios, runners, white boards
- Manual calling and Texting
- County EOCs depend upon their human services branch to provide outreach services in prearranged community locations.
- None really
- Staff, some radios looking at items like Starlink to see if would help.
- Working on department-based BC plans; satellite phones?
- Radios, cell phones
- Radios, texting, runners
- Analog phones as emergency back ups across our system, satellite phones and Starlink for command center and IT backup. Portable radios for every department across our system
- Paper back-up for current patients. Reliance on cell phones for e-mail and communication.
- Can receive calls via text message, have computers in the trucks to get call info. In process of setting up Pulsara for reports to hospitals
- Smartphones, amateur radios, runners, MS Teams (smartphone app), Everbridge, Alertus, etc.

What regional resources support communications downtime response?

- Handheld radios and our CodeReady System

- All campuses work together.
- Telephone, satellite radio- ring central telephone, internet, US mail, UPS.
- Communications to personal email and cellular devices is required with county led resources.
- Local governments and private companies are needed to assist with restoring any long term outages or provide quick response with backup generators and mobile cell towers.
- Our Corporate offices
- Unsure
- N/A
- State EOC Incident, incident command infrastructure
- Unknown
- Starlinks
- Ham operators
- If the outage was widespread and long in duration all resources would be stretched thin
- Portable COW (cellular on wheels), MACC for regional coordination of resources and comms
- Corporate office has access to EMR database, e-fax, & portals that generate referrals.
- Not sure.

What triggers state-level escalation of a communications downtime event?

- When the communication between the provider of services and the care of patients is affected. When demand exceeds resources.
- Unknown
- cyber attack- HIPPA violation- unable to use our internet.
- Unknown
- Governor declaring state of emergency
- If we see a possibility of not being able to provide all necessary care to our residents
- Unsure
- N/A
- State EOC activation
- Unknown
- Number of facilities affected and length of time
- Length of time
- Only if ACHA triggers are met
- Beyond capabilities of one county
- Inability to provide patient care in the home.
- When hospitals are not able to talk amongst themselves and/or community partners (EMS).

Infrastructure/Operational Impact (e.g., impact on facility operations due to loss of power, water, HVAC, etc.):

What critical infrastructure and operational functions would suffer most from an extended downtime event?

- HVAC Systems

- Hospital Surgical Bays in my Unit
- The residents
- Likely water would be the biggest impacted, as that is not handled in-house. HVAC and power are accounted for by both solar and generator backup, and med gas storage is not dependent on these resources. Water, being managed by the county, would likely be the resource most in-concern in this event.
- With widespread loss of power or water across the community, staff would likely evacuate or not be able to provide patient care. Office staff unable to perform regular operations
- Life Support Equipment, Temperature Control
- Generators can support whole hospital functions as long as we could re-fuel
- Care of Patients
- Hospital operations
- Would need to bring in water for staff and possible generator for fans
- Temperature monitoring of OR suites
- Municipal water
- Water, power, sewer
- Labs and patient monitoring and surgical services
- Power, water, steam, HVAC could all be impacted depending on fuel supply, etc.
- Access to EMR
- Really none for EMS except for crews to be able to get rest in between calls.
- Patient records, billing, images, pharmacy, labs, surgeries, etc.

What infrastructure/operational downtime mitigation strategies are in place (manual, redundancies, etc.)?

- We have backup in case of lost of power, water and fuel.
- Policies and Downtime Binders
- We are able to function with fire, police and EMS
- Unknown
- Critical office staff would be given option to work remotely in the event of loss of power, water, HVAC at the corporate offices, and may even work from an evacuated location outside of the affected area. Staff unable to make it to see patients - patients would depend on family caregivers to provide care. Clients encouraged to have backup batteries and additional supplies on-hand in a go-bag. Some extra supplies available on-hand at the corporate office.
- Facility wide Generator coverage, Moving to other building on property
- Paper Charts, Generators
- Triage outside of the hospital and selective admission to the hospital
- We have 5 gallon jugs of water and a generator
- Not sure
- Well, developing MOUs; generators
- Generator checks
- Manual paperwork and down time computers

- Multiple generators. Split half of our large generators on natural gas the other half diesel fuel, self contained capability on chillers for HVAC so no water supply needed all the time. Just top off water periodically
- Paper notes to be done with every visit. Back-up paper Plan of Cares.
- Backup generators on all stations
- Downtime computers, downtime printers, downtime forms, smartphone apps, etc.

What regional resources support an infrastructure/operational downtime response?

- Communication. fuel and water
- Unknown
- All of the utility companies. busses, airports, health department supplies and resources - American red cross-homeless shelters etc.
- Unknown
- Our clients depend on local pharmacies, DME companies and hospitals to provide supplemental care.
- Corporate Office and Mutual aid agreements with other facilities
- N/A
- Critical Incident command structure.
- Unknown
- Not sure
- ?
- Transfer Center
- MOU with 2 other Home Care agencies. Corporate office will also provide support.
- Not sure.

What triggers state-level escalation of an infrastructure/operational downtime event?

- We? resources are out/blocked for a long period of time.
- Unknown
- We have been through Covid and we do have 3 full commercial kitchens and parking garages and 18 floor building, a 7 floor building and a 4 story building. One (1) building has a basement and the other has an underground garage.
- Unknown
- Governor declaring state of emergency
- If we see a possibility of not being able to provide all necessary care to our residents
- Community Event
- Declaration of a state emergency by the Governor
- Unknown
- Not sure
- Length of time
- If it’s widespread we feel the state would already know about it. If it's a system (local) issue it would depend on its impacts.
- Be
- Inability to provide patient care in the home.
- When numerous hospitals are impacted which will impact patient care in a county and region.

How would a potential extended downtime event disproportionately impact communities most vulnerable to disasters? (e.g., low-income, elderly, disabled, geographically isolated)?

- It would be very devastating to the community.
- Suffer Urgent medical care
- We are downtown with many businesses and we have 500 beds among the 3 building campus on the same real estate therefore we do have resources and can be self sufficient for a while.
- One large area of concern is transportation. A large number of individuals in these communities are elderly and require either non-emergent or higher level medical transportation to even attend standard doctor.
- 100% of our clients served are low-income and disabled. Many do not have their own adequate transportation and depend on emergency services or NEMT for transport. They may not have financial resources to evacuate to a hotel in the event of power outages and would depend on local special needs shelters.
- Temperature control, Food Sources, Transportation
- Low income, elderly, disabled, persons on critical functions at home (ventilators)
- Patients not receiving medications
- Financially which would hinder their resilience in recovery efforts.
- Patients would not be able to get the care they needed resulting in increased hospital and ER visits or even death.
- Geographically isolated would be affected due to not as many affected
- Peds, vent dependent, lack of specialty shelters
- Lack of local services
- From the hospital perspective, internally, no different.
- We will attempt to provide services anywhere as long as there is no danger to our clinicians
- If power is down for extended periods during the summer will cause heat related emergencies in those people that do not have access to a generator
- Heavily, it would make it harder for everyone to be able to manage around this.

What other concerns/comments do you have regarding extended downtime events?

- Infection and disease
- The need to act quickly if this happens
- Lights - power- oxygen- water- fire-depends how long we are talking about.
- The largest concern I have is other county or state entities needing to take over our facility for the OR's due to downtime at their facilities, as we do not have all resources available for all procedures.
- Staff who agree to continue working during such an event may face burnout and need to have support in properly emergency planning to care for their own family while they continue to work. In the absence of home health staff, overwhelmed family caregivers may face burnout and exhaustion.
- None

- Lack of resources and too many new residents in the state that have never experienced a large scale disaster and are unprepared and apathetic.
- Extended cyber downtime on a large scale is something that I believe most of us are woefully unprepared for.
- Network downtime would have huge impact; need alignment for requested information for multiple agencies
- Communication impact
- None
- None
- Moving food and other supplies into the area.
- Extended downtimes beyond 30 days into months.

Appendix B – Healthcare Resiliency Survey Data

There were 12 respondents, including seven hospitals, one EMS agency, two behavioral health providers, and two other healthcare providers.

What are some things you are currently doing to make your healthcare organization more resilient towards the disasters of tomorrow (please be specific)?

- Hurricane preparation - building a plan for the center. We added a tornado drill for our staff this spring.
- Pre- planning hurricane response, stretch plans for high census, downtime process for internet or network loss, drills, don/doff training
- Making sure that we have contingency plans, vendor contracts, training, available supplies and have exercised to be prepared for any disaster that may happen in the future
- Taking a good look at business continuity beyond technology. Ensuring our vendors do not intertwine and we can get the supplies needed to keep running during an emergency.
- I created an Emergency Management Department Newsletter to be sent out quarterly. Refining and creating instructional trainings for our procedures and processes. Updating outdated policies.
- Adding more emergency power by adding generators which will energize critical areas that are now "dark" during power outages. Adding a deep well to be used as a backup water source for our cooling towers and steam boilers independent of local government supplied water.
- Generator Redundancy (Bringing in fixed normal power generators to completely power the building during an outage.) Radios (Working on extra HICS team Radios) HICS Conference Room (Additional AV equipment and earmarked location for HICS). HICS Training for all users. Decon training for all ED Employees and a decon team. New Decon Equipment
- MCI Drills, Capacity Management, Hazmat training, Cyber security initiatives.
- Our Head of Safety & Security stays current on disaster matters and has a strong relationship with Seminole County's Emergency Manager.
- Discussing ways to mitigate any assistance we used to get from counties and FEMA. We are then making plans that address these identified areas.
- We have mandatory debriefings built into our models, this includes a team meeting at the end of every response day, and another debrief two weeks after participation in an event to check where everyone is physically and emotionally as they process what they experienced. Team Leaders also check in continually with team members to make sure that they are doing ok and if there are signs of physical or emotional distress they are removed from the site and debriefed again within 24 hours to determine if they can continue to participate or should be returned home. They are

encouraged to seek ongoing support as needed through work EAP or private therapy.
- Our HCC provides trainings and exercises for our partners.
- Looking to mitigate the flooding in the front parking lot. Attended HERTS training so that I could train staff at our facility and sister facilities and build our Decontamination team.
- Emergency Medical Responder Training Wilderness First Aid Training
- Listen, promote conversation

What are some things that you would like to do to make your healthcare organization be more resilient if you had the support (please be specific)?

- Metal detector at main and ER entrance, air conditioning for out DECON trailer, vulnerability assessment
- More staff and resources. Improving security management and risk mitigation. Designing for hospital resilience.
- Have more collaboration between systems in the local area and state.
- Conduct energy audits and implement efficiency measures. Crosstrain staff for multiple roles. Use predictive analytics to forecast demand and disruptions.
- More critical training on things like decontamination at a level an individual hospital can handle
- See above. All of these are in the works but aren't cheap or fast. But the one thing I would like to see from Indian River county is more community involvement and hospital involvement. I am new to this community and since I have access to Brevard and Indian River County, I was really let down with Indian Rivers involvement compared to Brevard.
- More frequent drills that exceed the ED.
- Although we are not a healthcare organization 1) re-involvement with the CFDMC 2) restart its Disaster Team 3) once again offer training such as CPR, NOVA/CISM, ICS & other offerings to its congregation in order to support healthcare organizations.
- Find ways to get additional supplies and needed items. Hospitals and Freestanding EDs could use the approval and ability to install wells at many sites to help when city/county water is out. Vital resources are needed to keep us running so we can adequately provide care to the communities we serve.
- Giving our hospitals the equipment and supplies necessary to be able to respond to events like biohazard and chemical hazard incidents.
- Education for the staff; monthly "talks" with subject matter experts to educate staff on the importance of exercises; different subjects like fire response, tornado response, hurricane response, flood response.
- Purchase monitors for field use

What are some things that the healthcare coalition could do to support healthcare resiliency across the region (please be specific)?

- Different methods for active shooter training for staff, training for identifying suspicious behavior in a hospital
- Staying engaged with hospitals' needs.
- Bring everyone together more often and look at how we can lean on each other in major disasters
- Promote additional widespread drills and joint trainings in order to enhance procedures. Conduct regular tabletop and full-scale emergency drills. Use digital twins or simulation software to model disruptions. Develop contingency plans for various scenarios (e.g., cyberattack, natural disaster).
- You guys are doing great now! Thank you.
- Better communication between the OEMS and the hospitals. Not only communications but engagement and cross training. I've been in this region since October of last year and still haven't shaken hands with anyone from the OEM for our counties.
- Continued education
- An area we struggle with is continuing to get involvement from our local government leaders.
- Continue to be our voice and advocate for our needs so we can remain a community lifeline.
- Provide team debriefings after events, separate supervisory staff from other participants in a separate group so that venting cannot be used against an individual or used at a later date as part of an annual assessment of their regular daytime position.
- Training and exercising.
- Our Coalition is amazing and provides so many resources. You are a source of expertise and information that I would not have otherwise. Keep doing this!!

What are some other areas healthcare organizations should look at in becoming more resilient (please be specific)?

- Employee retention
- Cybersecurity.
- Supply chain, water, power, med gas, blood.
- Increase security team numbers, communicate with local LE agencies/community and cross-sector partnerships (more and get them involved in training drills), create and refine courses of actions for disasters (flood, tornadoes, active shooter scenarios), test current responses, workforce flexibility and support (staffing is maxed out and leaves very little room for error),
- Partnering with local organizations on a more regular basis.
- Prime example being Bay Front. Water redundancy in the result of an emergency. Contact lists for all key stakeholders distributed for all events.

- Free Standing EDs
- Development of other funding streams.
- Truly supplies, infrastructure and utilities are the biggest items for us. We need to find ways to be able to provide many of these things on our own without leaning on others. We need the support of the state, county and cities that we serve to allow us the permission to do the things that require their approval.
- Preparation, invest in discussions around daily work duties so that individuals know that the support will be there should there be an escalation event. All talk and no action helps no one,
- Develop MOUs/MOAs that will allow for sharing of resources.
- Provide Incident Command training for c suite.