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<tr>
<td>January 2018</td>
<td>New Plan</td>
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| October 2021 | Updated formatting  
Added *At-Risk Individuals* section  
Added *Procedures* section  
Added *Emergency Procurement* sub-section  
Added * Expedited Hiring of Contract Staff* sub-section  
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Purpose

This Alternate Care Site (ACS) Plan is intended to support statewide operations during an emergency or disaster that necessitates the activation of one or more ACS(s) within the state. The goal of ACS activation and operation is to maximize appropriate healthcare for the largest number of patients during a pandemic or other disaster causing a major surge in patient volume. In most cases, the operational, logistical, and administrative challenges of operating these sites will require partnership and collaboration between public and private sector entities.

This Plan is an annex to the Arizona Department of Health Services (ADHS) Emergency Response Plan (ERP) and can be used in conjunction with other annexes to guide the statewide public health and medical response to any type of emergency or disaster.

Scope

This Plan supports responses to all levels of public health emergencies requiring ACS activation and operation, from local responses with state involvement, to statewide and even national responses. In keeping with the Incident Command System (ICS) concepts of flexibility and scalability, all or part of the procedures contained in this Plan may be used to support ACS operations depending on the scope and reach of the disaster.

This Plan applies to all types of natural and human-caused disasters including chemical, biological, radiological, nuclear, and explosive (CBRNE); weather and natural disasters; terrorism; pandemics; and technological failures. It defines the various types of ACS(s) and supports the activation and operation of these sites at the local, state, or federal level.

The scope of this Plan encompasses coordination and support for at-risk populations, including limited English proficiency (LEP) populations, geographically isolated individuals, access and functional needs (AFN) groups, people with serious mental illness (SMI), and others requiring behavioral healthcare. Response strategies will take into account the medical and public health needs of groups such as people with disabilities, pregnant women, children, senior citizens, and other sub-groups as dictated by the response. The needs and challenges facing at-risk populations will be central to any ACS response and will be included in ADHS incident action planning to be addressed during interagency coordination.

Situation Overview

Health emergencies have the potential to overwhelm local healthcare systems. During a catastrophic public health emergency, communities may need to expand their healthcare delivery system to one that includes the role of an alternate care system. Depending upon the severity of the incident and availability of resources in the community, activation of one or more ACS(s) may be considered by community partners to address insufficient ambulatory care or hospital capacity.
Activation Types
Activation may be in response to:

1) Surge: large number of people seeking emergency and/or acute medical assistance at healthcare facilities (e.g., epidemic, mass casualty incident [MCI]).
2) Damaged medical infrastructure: Healthcare facility inoperability due to damage or resource shortages (e.g., explosion, flooding, etc.).
3) Combination of 1 and 2.

ACS activation and operation will require collaboration and coordination from a wide variety of public health and medical partners. These organizations may include:

- Arizona Burn Care Network
- Arizona Department of Economic Security
- Arizona Emergency System for Advance Registration of Health Professionals (ESAR-VHP)
- Arizona Healthcare Acquired Infection (HAI) Multidisciplinary Advisory Group
- Arizona Healthcare Cost Containment System (AHCCCS)
- Arizona Local Health Officers Association (ALHOA)
- Arizona Department of Health Services (ADHS)
- Arizona Pediatric Disaster Coalition
- Arizona State Board of Pharmacy
- Arizona State Emergency Council
- Arizona Tribal Executive Committee (AzTEC)
- Indian Health Services (IHS)
- Poison Control Centers (Phoenix and Tucson)
- Radiological Injury Treatment Network (RITN)
- State-designated healthcare coalitions (HCCs)

During ACS activation, ADHS Health Emergency Operations Center (HEOC) staff will work with these partner organizations and systems to support the response. ADHS may send a liaison to serve as the Health and Medical Services Coordinator at the State Emergency Operation Center (SEOC), which is coordinated by the Arizona Department of Emergency and Military Affairs (DEMA). The Health and Medical Services Coordinator should be staffed by an ADHS representative with substantial experience managing public health responses. This liaison role is crucial to maintaining operational control and situational awareness during an ACS response.

At-Risk Individuals
Planning for at-risk individuals occurs on several levels within Arizona. The U.S. Department of Health and Human Services (HHS) and ADHS use the Communication, Maintaining Health, Independence, Support and Safety, and Transportation (CMIST) framework to identify and understand at-risk individuals with AFN when planning for, responding to, and recovering from a disaster. The CMIST Framework provides a useful and flexible framework for emergency planning and response that emphasizes a person's needs without having to define a specific diagnosis, status, or label.
During a disaster, it has been observed that certain at-risk individuals, specifically those with AFN, have required additional response assistance before, during and after an incident. These additional considerations for at-risk individuals with AFN are vital towards inclusive planning for the whole community, and have been mandated for inclusion in federal, state, territorial, tribal, and local public health emergency plans by the Public Health Service (PHS) Act. In addition, the Arizona Health Care Coalition may be called upon during an emergency event to share information throughout their members to ensure that the needs of at-risk individuals are addressed.

Planning Assumptions

ACS activation, operation, and demobilization will be guided by this plan and applicable public health support and hazard-specific annexes. This plan was developed to support any type of disaster including the hazards identified in the 2019 Arizona Threat and Hazard Identification and Risk Assessment (THIRA). The following assumptions apply to the activation of this Plan:

- Local, state, and/or federal disaster declarations will be in place during a response requiring ACS.
- Many Arizona hospitals are routinely near or at capacity and may not be able to handle the surge in patients associated with a major disaster or public health emergency.
- Local emergency medical services (EMS) will likely be the first entity to deal with mass casualty victims.
- During MCIs, hospitals can expect to receive self-transported casualties directly from the scene, even if triage, treatment, and transport services are in place at the scene of the MCI.
- Patients may seek emergency healthcare services at other types of medical facilities (i.e., locations other than hospitals).
- Many patients and their families will view the ACS as short-term and will expect care in a hospital setting as soon as possible.
- A high level of cooperation and coordination among agencies (local health departments, hospitals, emergency management, etc.) will be necessary to establish and operate an ACS.
- Steps will need to be taken not only to assist and protect victims of the disaster but also to protect healthcare staff so they can continue to participate in the response.
- Coordination with medical licensing is needed to ensure status as an outpatient facility is established.
- The scope of the incident may be such that state or even federal resources will be required to establish an ACS.
- A major challenge in ACS operations will be the extra staff needed to operate the facility.
- An Incident Command (IC) structure will be needed to efficiently and effectively operate an ACS.
- ACS(s) may rely on local public health assistance for logistical and other operational support.
Roles and Responsibilities

An ACS is a collaborative effort between community partners. A single facility or agency should not attempt to open an ACS in the absence of support from state and local public health, emergency management, EMS, and other medical partners. The table below outlines some of the functions the healthcare sector and the public health sector may address when activating and operating an ACS. The table is grouped into four main functions 1) overall, 2) electronic care, 3) ambulatory ACS(s), and 4) non-ambulatory ACS(s).

General Concepts for Healthcare and Public Health Sector Functions in ACS

<table>
<thead>
<tr>
<th>Function</th>
<th>Healthcare Sector</th>
<th>Public Health Sector</th>
</tr>
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<tbody>
<tr>
<td>Overall</td>
<td>● Providers</td>
<td>● Organizational support</td>
</tr>
<tr>
<td></td>
<td>● Private infrastructure</td>
<td>● Situational awareness</td>
</tr>
<tr>
<td></td>
<td>● Medical materiel support</td>
<td>● Liaison to emergency management and state/local government (including legal authorities and regulatory, policy, and logistical support [e.g., sites for care])</td>
</tr>
<tr>
<td></td>
<td>● Medical care and decision making</td>
<td></td>
</tr>
<tr>
<td></td>
<td>● Clinical policy development/technical expertise</td>
<td></td>
</tr>
<tr>
<td>Electronic care: telephone triage, expanded hotlines, web-based assessment and prescribing, tele-medicine</td>
<td>● Augment and unify telephone advice and prescribing systems</td>
<td>● Set up public lines/resources when demand exceeds available augmented resources</td>
</tr>
<tr>
<td></td>
<td>● Update and modify consistent advice</td>
<td>● Provide mechanisms for backup to other call centers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Facilitate phone script coordination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Address prescribing and practice regulatory issues</td>
</tr>
<tr>
<td>Ambulatory alternate care sites (e.g., flu centers or minor trauma care sites)</td>
<td>● Augment existing clinics, and open new clinics in other spaces</td>
<td>● Set up clinics in high incidence/impact areas where healthcare resources are inadequate</td>
</tr>
<tr>
<td></td>
<td>● Assist in staffing public health clinics</td>
<td>● Provide site and logistics support (and potential</td>
</tr>
</tbody>
</table>
In addition to the functions identified for the healthcare and public health sectors in the table above, there are a variety of partners involved in an ACS response with their unique roles and responsibilities.

**Hospitals and Out-of-Hospital Facilities**
- Ensure facility-specific ICS has been activated to prepare for ACS.
- Contact and maintain communication with local emergency management and/or public health emergency preparedness partners to inform them of the need for ACS.
- Ensure that facility-level medical surge plans and hazard specific plans have been activated to address the incident at hand.
- Coordinate with medical licensing (ADHS Division of Licensing) to inform them of the need for ACS. ADHS Licensing will coordinate with the Centers for Medicare and Medicaid Services (CMS) Survey and Certification if a certified facility is involved.

**Regional Healthcare Coalitions**
- Ensure regional healthcare communications are established.
- Share situational awareness information with local and state public health.
- Ensure that coalition-level ERPs have been activated to address the need for ACS(s).
- Provide support including supplies and personnel.

**Emergency Medical Services**
- Ensure that EMS IC protocols have been activated to support ACS operations, including coordination with dispatch.
- Establish and maintain communication with local EOC.
• Coordinate with hospital(s) regarding transportation and dispositions.

Local Public Health Departments
• Ensure that local public health emergency operations and ICS have been activated to support ACS operations.
• Establish and maintain coordination with hospitals and healthcare facilities.
• Coordinate with state public health (ADHS).
• Coordinate local public information messaging in coordination with ACS facility and state public health (ADHS) personnel.

Local Emergency Management
• Activate local EOC to support ACS operations.
• Provide local logistical support for ACS operations.
• Provide incident management oversight and operational support as needed.
• Coordinate local public information messaging in conjunction with ACS facility and state emergency management public information personnel.

State Public Health Department (ADHS)
• Activate the ADHS HEOC and institute a Public Health Incident Management System (PHIMS) to support ACS operations.
• Establish unified command with the SEOC and local public health EOCs involved in the response.
• In conjunction with the SEOC, initiate volunteer health professional alerting and notification via the AZ ESAR-VHP if required to support ACS operations.
• In conjunction with the SEOC, initiate medical materiel requests through the ADHS Strategic National Stockpile Coordinator HEOC as required to support ACS operations.
• Coordinate with DEMA public information staff to establish statewide messaging and a Joint Information System (JIS) if needed to support local public information efforts.
• Maintain awareness with AHCCCS for coordination with CMS regarding waivers.

AHCCCS
• Coordinate out of network waivers with CMS Region IX, ADHS Licensing, AHCCS, and third party payers (private insurance companies).

State Emergency Management (DEMA)
• Activate the SEOC to support ACS operations.
• Provide statewide logistical support for ACS operations.
• Provide incident management oversight and operational support as needed.
• Organize statewide public information messaging in coordination with ACS facility, local emergency management, and ADHS public information personnel.

Concept of Operations
This section outlines the public health and medical response components to an ACS operation. It also addresses the various types of facilities such as out-of-hospital care sites and alternate care facilities that can be activated during a response. Out-of-hospital care sites are existing non-hospital facilities that are routinely used for patient care. On the other hand, alternate care facilities are non-licensed facilities that may be temporarily
activated to meet healthcare demands during a disaster. Both categories of ACS(s) are listed in the table below.

<table>
<thead>
<tr>
<th>Category</th>
<th>Facility Type</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Out-of-hospital care sites | ● Outpatient providers and facilities  
● Clinics  
● Surgical and procedure centers  
● Long-term care facilities | ● Medical skills can be used in their regular practice environment or at an alternate care facility  
● Infrastructure can be expanded (i.e., longer hours of operation) if staff and resources are available  
● Infrastructure can be repurposed (e.g., a subspecialty clinic adjusts hours or closes to enable the space to be used for acute care). |
| Alternate care facilities | ● Electronic alternate care systems  
● Ambulatory care facilities  
● Shelter-based care  
● Non-ambulatory care/hospital overflow  
● Federal medical stations (FMS) | ● Can be activated (made operational) during a disaster response  
● Can be established by government response entities and private healthcare institutions to address community needs |

Procedures
The following section outlines broad recommended steps to establish an ACS. These steps are intended to provide guidance to the ADHS HEOC during an ACS event. For more information, refer to the HHS Assistant Secretary for Preparedness and Response's (ASPR's) Federal Healthcare Resilience Task Force Alternate Care Site Toolkit.

1. Potential Site Selection
2. Conduct Site Assessment
3. Secure Funding
4. Secure Property
5. Convert Site for Health Care Use
6. Secure Wraparound Services
   a. Perimeter demarcation
   b. Onsite security
   c. Fire-compliant access
   d. Separate patient and EMS staging, ingress, and egress
   e. Separate staff ingress and egress
   f. Evacuation routes
   g. Command Post/Administrative area
   h. Signage
   i. PPE donning and doffing areas
7. Staff, Equip, and Supply Site(s)
8. Operate Site
   a. Personnel
      i. Roles and Responsibilities
      ii. Site Manager
      iii. Chief Medical Officer (CMO)
      iv. ADHS Representative
      v. Security
      vi. EMS
      vii. Public Information Officer (PIO)
      viii. Case Management Team
   b. Site Flow Plan
   c. Site Security Plan
   d. Site Communications Plan
   e. Plan for Caregivers, Family Members, and Services Animals
   f. Civil Rights and Federal Disability Requirements
9. Retain ACS as a Warm Site
10. Restore Site
    a. Decontamination
    b. Demobilization

Activation

Activation of an ACS or multiple sites is a potential action that could be taken as a part of a disaster response. Activation of an ACS should be considered during initial meetings of the primary and cooperating agencies participating in the State Disaster Medical Advisory Committee (SDMAC) or other inter-agency policy group. See the Arizona Crisis Standards of Care Plan for more information on the SDMAC and its activation and composition.

Prior to activation, regional attempts should be made to augment the healthcare system through regional and surrounding hospitals. If patients can receive adequate care in an existing medical facility within a reasonable time period, patients should be transferred appropriately.

Level of operations should also be considered at each operational period by the SDMAC. Before activation of an ACS, the SDMAC should consider the actual need versus the perceived need within the community and ensure that all alternative solutions have been exhausted. Solutions should be considered in the following order:

1. Hospital activating medical surge plan to accommodate more patients (e.g., canceling elective surgeries, discharging stable patients, relocating patients to other facilities),
2. Non-acute medical facility taking on acute care, or higher level responsibilities,
3. Non-medical facility used to provide medical care (e.g., ACS in existing structure), and
4. Temporary facilities being used to provide medical care (e.g., mobile ACS from Metropolitan Medical Response System [MMRS] or federal assets).
There are different activation processes and requirements for community-based ACS(s) and federal ACS support. These differences are outlined in the tables on the next page:

**Community Support for ACS Operations**

- Incident occurs causing crisis-level surge in community.
- Municipal, county, tribal, state EOCs are activated accordingly; healthcare coalition response plans are activated; and ICS Unified Command established.
- Local public health and emergency management confer with healthcare partners and establish need for ACS.
- State or local emergency declaration in place.
- State public health and emergency management are notified of need for ACS.
- ACS resource requests flow from healthcare coalition partners to local EOCs to state EOCs.
- State medical licensing is engaged and appropriate waivers are requested for ACS operation through CMS Survey and Certification.
- Community-level ACS is established through private and public sector cooperation.

**Federal Support for ACS Operations**

- Incident occurs causing crisis-level surge in community. Community resources are insufficient or exhausted.
- Municipal, county, tribal, state EOCs are activated accordingly; healthcare coalition response plans are activated; and ICS Unified Command established.
- Local public health and emergency management confer with healthcare partners and establish need for state/federal assistance.
- State emergency declaration in place.
- State public health and emergency management are notified of need for state/federal ACS support.
- ACS resource requests flow from healthcare coalition partners to local EOCs to state EOCs. State assets are insufficient or exhausted.
- State EOCs request federal assets (e.g., Federal Medical Station [FMS]).
- Federal assets are deployed to the state as determined by HHS.
Direction, Control, and Coordination

During an ACS response it is expected that local and state EOCs will be activated to support operations, and that a Unified Command (UC) will be established in accordance with the National Incident Management System (NIMS). Hospitals and healthcare facilities involved in the response will utilize the Hospital Incident Command System (HICS) to coordinate emergency operations at the facility level and to coordinate with local and state EOCs.

During community-based ACS operations, operational management remains at the local level with support from regional and/or state agencies. Healthcare facilities, local public health departments and local emergency management agencies will be responsible for the operations of the ACS. Healthcare coalitions, state public health, and state emergency management will provide support for ACS operations. Support may come in the form of additional staff, supplies, communications, or public information coordination. Additionally state medical licensing (the ADHS Division of Licensing Services) and CMS will support the response by facilitating and issuing healthcare facility waivers for expanded operations or scope of practice after emergency declarations. These relationships are depicted in the figure below:

**Direction, Control and Coordination for Community-Based Alternate Care Site**

During response operations involving the deployment of mobile or temporary federal assets, the operational management of the ACS will reside with the federal entity deploying the assets. In this case, local public health and emergency management, state public health and emergency management, and other federal agencies (e.g., FEMA) will provide support for operations. This process is illustrated in the figure below:
Direction Control and Coordination for Deployment of Federal ACS Assets

Information Collection, Analysis, and Dissemination

During community-based ACS operations, information will be collected at the ACS facility level, distributed to local and regional response entities (public health and emergency management), further distributed to state response entities (public health and emergency management), and then sent on to federal partners. Information will also flow in the opposite direction, from the federal level down to the state, to local/regional partners and finally to the ACS. Information will be analyzed at each step in the process. Information dissemination between response entities will adhere to the process depicted in the figure below:
Communications

Communication infrastructure must be present for adequate and timely notification of critical personnel. This infrastructure directly influences the ability of public health and medical providers to communicate in the event of a catastrophic disaster. ADHS maintains redundant communications networks and backup systems to support command and control at the ACS. The primary agency will notify necessary partners of activation and provide operational updates for the ACS.

Types of communications used will be:

- Telephones
- Cell Phones
- Email
- Fax
ADHS personnel have access to 800 MHz radios that can be used to communicate with hospitals throughout much of the state. The systems and frequencies and just-in-time training material can be found on the ADHS Sharepoint site.

In the absence of radios or cell phones, face-to-face communication, runners and the written communication shall be used. Voice amplification systems (e.g., bullhorn, in-house public address system, etc.) should be used if necessary and available.

**Administration, Finance, and Logistics**

The following table lists some of the logistical considerations for ACS operations. This list does not represent an exhaustive list for ACS operators, but rather provides an overview for public health and emergency management agencies involved in ACS support.

<table>
<thead>
<tr>
<th>Category</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Access/permissions, timeline to operational, availability (e.g., schools not always available), size, function, access for those with functional limitations, safety issues, restrooms, water/showers, loading dock, etc.; may include supplemental water, oxygen, power, and other considerations</td>
</tr>
<tr>
<td>Traffic Control</td>
<td>Parking and vehicle movement for staff, EMS, and families</td>
</tr>
<tr>
<td>Communications</td>
<td>Including radio, web-based, and public access</td>
</tr>
<tr>
<td>Staffing</td>
<td>Medical, administrative, and support (including lab and pharmacy)</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Durable and disposable (pharmaceuticals, intravenous fluids, dressings, diagnostics, protective equipment, etc.)</td>
</tr>
<tr>
<td>Administrative Supplies</td>
<td>Including computers and networks</td>
</tr>
<tr>
<td>Personal Care Supplies</td>
<td>Bedding, cots/beds, and personal hygiene supplies</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Food Services</td>
<td>Staff and patients</td>
</tr>
<tr>
<td>Security Services</td>
<td>External and internal accountability for valuables</td>
</tr>
<tr>
<td>Transportation</td>
<td>Patients (internal and external) and materials</td>
</tr>
<tr>
<td>Check-in, Check-out and Badging</td>
<td>Time keeping and badges</td>
</tr>
<tr>
<td>Credentialing</td>
<td>Verification system</td>
</tr>
<tr>
<td>Registration and Patient Tracking</td>
<td>Patient registration and tracking systems</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Record, filing, and archiving/storage</td>
</tr>
<tr>
<td>Sanitation</td>
<td>Usual and medical waste</td>
</tr>
<tr>
<td>Animal Control/Husbandry</td>
<td>If pets kept on site</td>
</tr>
</tbody>
</table>

**Emergency Procurement**

Resources needed for a response will be handled by the HEOC Logistics Section while working with the Finance Section. The Finance Section will be staffed with personnel from the Agency's Finance office who will be able to conduct emergency purchases for the HEOC.

During any emergency response, there may be a need for the procurement of goods and services to further response efforts. Therefore, ADHS has developed a *Standard Work for Emergency Procurement* and an *Emergency Checklist* to address situations that pose a threat to the public health system and the welfare of the public's safety through the utilization of statewide procurement contracts and state purchasing cards (P-Cards). This procurement process gives ADHS the authority to respond to procurement needs in a fast and flexible way during a declared disaster. Refer to the *Continuity of Operations-Executive Management Plan* (COOP-EMP) for the emergency procurement process (page 14).

**Expedited Hiring of Contract Staff**

In the event of an emergency, the HEOC Manager can authorize the emergency hiring of contract staff to supplement needed operations. The fast-tracking of hiring contract staff is coordinated by the HEOC Logistics Section through the ADHS Procurement Office. Refer to the *COOP-EMP* for the steps involved in accelerating the hiring of contract staff (page 14).
Plan Development and Maintenance

ADHS plan review and revision involves three types of edits—1) Minor Technical Revisions, 2) Major Technical Revisions, and 3) Complete Plan Overhaul. In collaboration with stakeholders, PHEP takes the lead in reviewing and revising the plan to ensure:

1. Plan revision will occur through review by ADHS and stakeholders every year. Revision of the plan can be accomplished by communicating through email, telephone, or in-person meetings. Plan revision will include a new plan date.
2. The plan will be evaluated through exercises or real-world events. ADHS and stakeholder participation will vary and is dependent on the scope of the exercise or event. The associated corrective actions, lessons-learned, and best practices will be integrated as appropriate.
3. All plans will be shared with the leadership for review and approval.
   - Plans not classified as “Confidential” will be posted on the ADHS website to allow for public feedback prior to the finalization of the plan.
   - Plans that are classified as “Confidential” will be shared with the planning team to allow for feedback prior to finalization of the plan.
4. The revised plan will be posted to the ADHS public-facing website and the agency's secure information sharing portal.
5. PHEP will notify ADHS, stakeholders, and other partners through email when significant changes are made to the plan. The plan will be shared with stakeholders to promote alignment between local and state-level emergency response planning.

Authorities

The summary is intended as a basic reference guide. For a comprehensive listing of Arizona Revised Statutes visit the Arizona State Legislature website http://www.azleg.gov/ArizonaRevisedStatutes.asp

Under **ARS § 26-303**, the Governor:

- During a State of Emergency, shall have complete authority over all state agencies and the right to exercise all police power vested in the state by the constitution and the laws of the state; and may direct all state agencies to utilize and employ state personnel, equipment and facilities for the performance of activities designed to prevent or alleviate damage due to the emergency
- During a State of War Emergency, shall have all authorities as with a State of Emergency; may suspend the provisions of any statute prescribing the procedure for the conduct of state business if the governor determines strict compliance with provisions of any statute would hinder mitigation of the effects of the emergency; may commandeer and utilize any property or personnel deemed necessary in carrying out the responsibilities of the governor and thereafter the state shall pay reasonable compensation
- May confer to the Adjutant General the powers of the Governor prescribed under a State of Emergency
References

Federal
6. Hospital Preparedness Program (HPP), U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response.

State