NORTH CAROLINA
OFFICE OF EMERGENCY MEDICAL SERVICES
HEALTHCARE PREPAREDNESS PROGRAM (HPP)

EMERGENCY OPERATIONS PLAN

June 2021

Version 3.00

Record of Changes

Date	Change	Section/Page	Updated By
06/14/2021	Complete update and rework of EOP	Whole document	Preparedness Unit
11/3/2021	Updated annexes and appendices	Whole document	

Table of Contents

TABLE OF CONTENTS

AUTHORITIES

The North Carolina Division of Emergency Management (NCEM) is delegated the responsibility and authority to respond to emergencies and disasters by the Governor via The North Carolina Emergency Management Act found in **Chapter 166A** of the North Carolina General Statutes

In accordance with this statute, the North Carolina Emergency Operations Plan (NCEOP) and Executive Order No. 15, Promulgation and Implementation of the North Carolina Emergency Operations Plan, the North Carolina Office of Emergency Medical Services (NCOEMS) is recognized as the lead agency in North Carolina representing Emergency Support Function 8 (ESF-8) Health and Medical Services. As such, NCOEMS is responsible for the overall statewide coordination of health and medical services.

MISSION

In the State of North Carolina health and medical services have been further organized under NCESF-8A (Disaster Medical Services) and NCESF-8B (Public Health). Under this organization, NCOEMS acts as the NCESF-8A Lead and has primary responsibility for coordinating statewide support for emergency medical services while the North Carolina Division of Public Health (NCDPH) act as NCESF-8B Lead with primary responsibility over public health services. NCOEMS responsibilities under Disaster Medical Services include the:

- Assessment and treatment of medical needs
- Provision of medical care personnel and supplies
- Transportation of medical personnel and supplies
- Evacuation of patients
- Provision of emergency responder health and safety
- Provision of medical command and control

NCOEMS strives to manage these responsibilities through its Healthcare Preparedness Program (HPP) and provide the capabilities to meet them through State Medical Response System (SMRS) organizations.

PURPOSE & SCOPE

This NCOEMS Emergency Operations Plan (NCOEMS-EOP) has been developed as one means for NCOEMS, through its Healthcare Preparedness Program (HPP), to direct and coordinate various State Medical Response System (SMRS) organizations. These organizations can be activated in response to and/or recovery from a disaster or other emergency as part of the State Emergency Response Team (SERT) and enhance its ability to respond to medical emergencies due to all hazards.

This plan details the activation, organization, operation, and demobilization, of the NCOEMS, including the ESF8 Desk and its interactions with the SERT, SMRS organizations, and other ESF8 Health and Medical partners during emergent events and disasters. Although, it may not cover all possible situations that may occur after activation, it is meant to provide NCOEMS staff who may be assigned to these areas with information essential for the successful set-up and operation of the positions described. This plan is a component of the NCEOP.

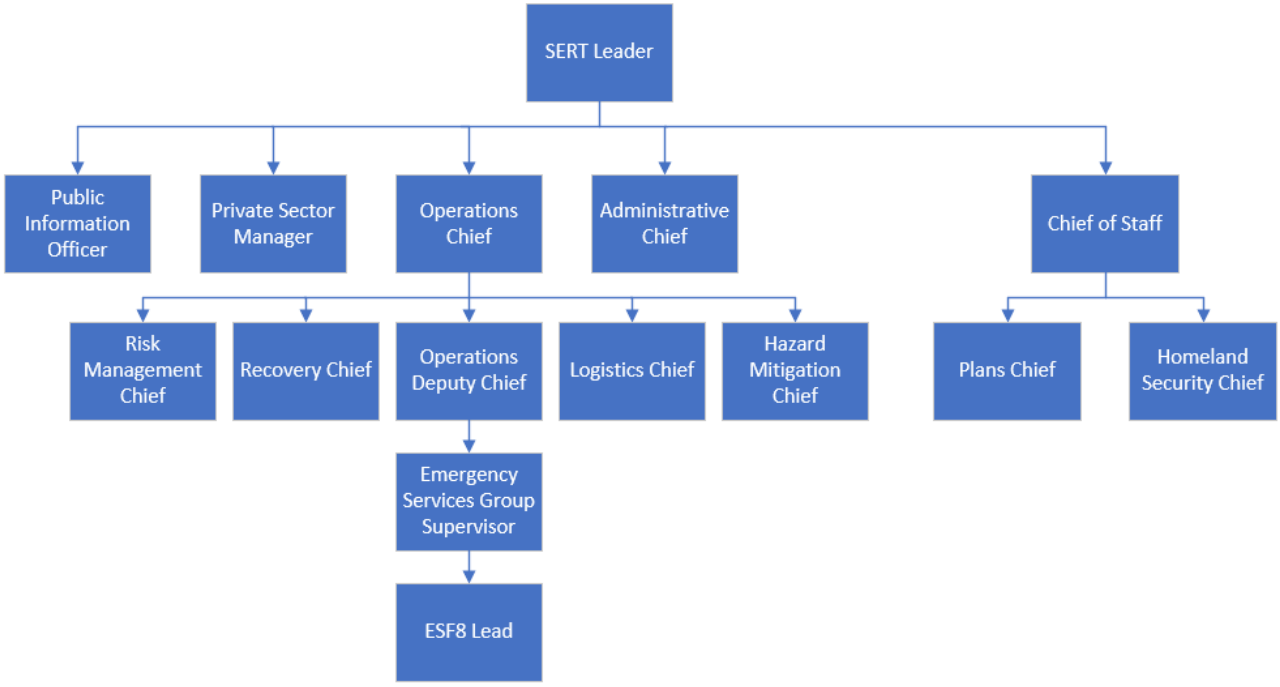
ESF8 ORGANIZATION

NORTH CAROLINA OFFICE OF EMERGENCY MEDICAL SERVICES: The North Carolina Office of Emergency Medical Services (NCOEMS) sits within the Department of Health and Human Service's Division of Health Service Regulation and has the mission to foster emergency medical systems, trauma systems and credentialed EMS personnel to improve in providing responses to emergencies and disasters which will result in higher quality emergency medical care being delivered to the residents and visitors of North Carolina. According to the North Carolina Emergency Operations Plan, NCOEMS is responsible for Disaster Medical Services as part of the State Emergency Response Team (SERT).

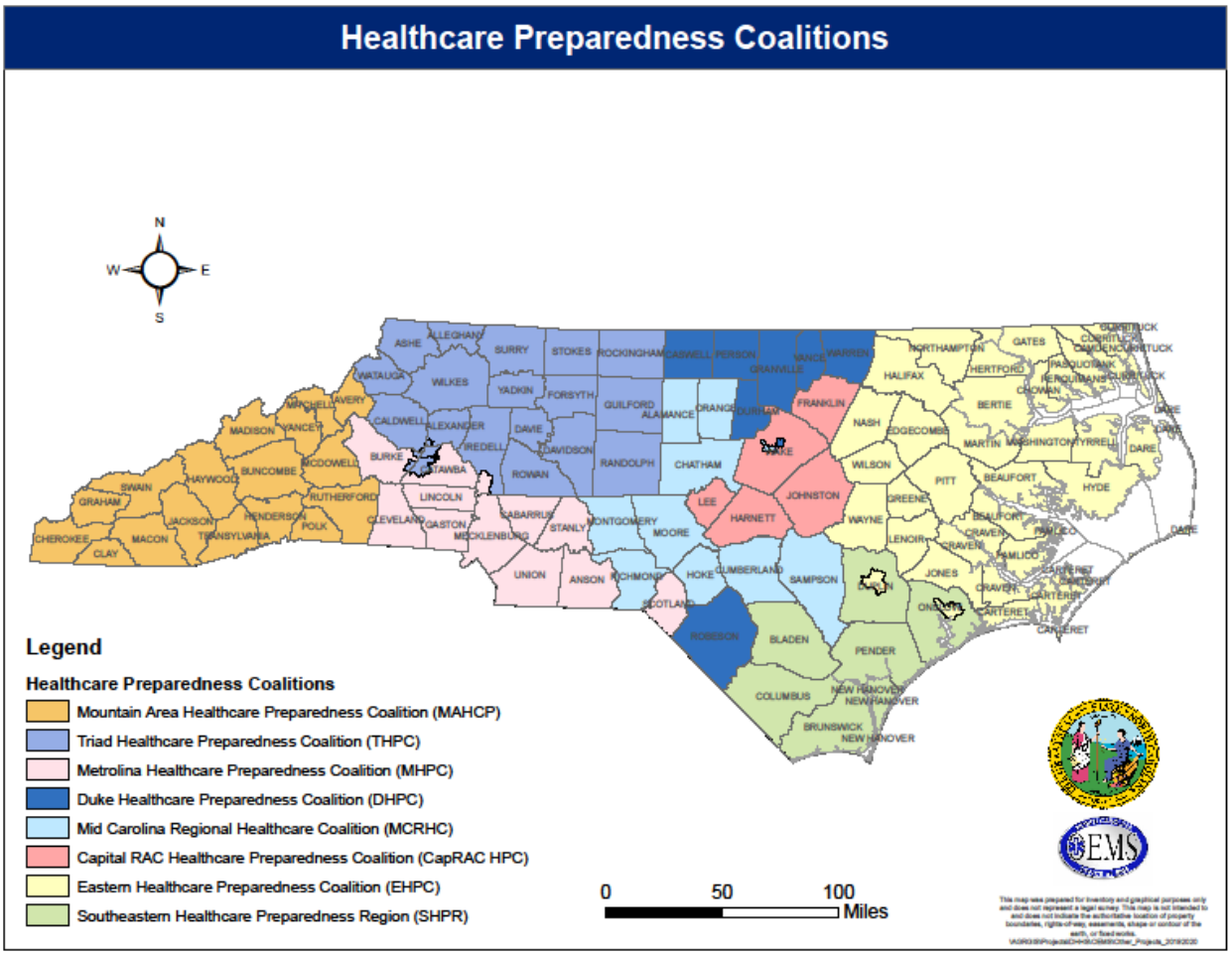
HEALTHCARE PREPAREDNESS PROGRAM: The North Carolina Healthcare Preparedness Program (HPP) sits within the Division of Health Service Regulation's North Carolina Office of Emergency Medical Services. HPP's mission is to partner with healthcare and emergency response organizations working to prepare for, mitigate, respond to, and recover from emergencies and disasters. During emergencies and disasters, the HPP is responsible for managing NCOEMS responsibilities under the NCEOP including providing situational awareness, supporting continuity of operations, augmenting medical surge, coordinating healthcare resource allocation, coordinating statewide patient movement, and providing technical assistance. To fulfill these responsibilities, HPP staff may be deployed to the ESF8 Desk at the State Emergency Operations Center (SEOC), the ESF8 Support Cell, to a state coordinated field operation, to provide support as part of a State Medical Response System (SMRS) organization, or working remotely to support operations. As part of the Healthcare Preparedness Program, there are eight regional Healthcare Coalitions (HCCs) across North Carolina that have similar responsibilities during emergencies and disasters.

STATE MEDICAL RESPONSE SYSTEM: NCOEMS, as a member of the SERT and Lead Agency for ESF8, has facilitated the collaboration of local, regional, and state emergency response agencies in North Carolina to form the State Medical Response System (SMRS). The SMRS is composed of clinical and non-clinical professionals that are trained and equipped to ensure access to and continuity of medical care during an emergency or disaster. The SMRS is organized into several different operational teams with complementary capabilities with the shared primary mission of maintaining health and medical services while strengthening the continuity of healthcare in communities affected by disasters. SMRS organizations/teams are deployable and scalable to the situation. Examples include: Ambulance Strike Teams (ASTs), Mobile Disaster Hospital (MDH), and State Medical Support Shelters (SMSSs).

STATE EMERGENCY RESPONSE TEAM (SERT): The SERT is comprised of senior representatives of state agencies, volunteer and nonprofit organizations, and corporate associates who have knowledge of their organizations' resources. SERT members provide technical expertise and have the authority to commit their organization's resources to support local, regional, and statewide emergency responses. During a response, these representatives may join the SERT Leader at the State EOC or remotely to coordinate relief efforts and provide support. As the situation develops or if additional assistance is required, SERT agency representatives may be deployed as All-Hazard Incident Management Teams (IMT) to affected counties to provide on-scene coordination and assistance.



JURISDICTIONS



REGIONAL: Within North Carolina there are eight (8) defined Healthcare Coalition regions which are all lead by a sponsor hospital. Healthcare Coalitions (HCCs) provide information sharing, healthcare system situational awareness, response coordination, logistical support, and augment medical operations to jurisdictions and healthcare facilities. They are comprised of members from healthcare organizations (e.g. hospitals, EMS agencies, public health, long-term care facilities, dialysis centers etc.) and their public and private sector response partners (e.g. emergency management agencies, volunteer organizations active in disaster etc.). Coalition members are activated through region-specific preparedness and response plans developed and maintained in coordination with their Healthcare Preparedness Coordinator (HPC). During the activation of this EOP, NCOEMS has the ultimate authority and oversight of the HCC response as part of the State Medical Response System.

STATE: When activated for emergency response, NCOEMS provides statewide oversight, coordination, and support to county and regional entities, including the HCCs and their partners, for the sustained delivery of health and medical services in accordance with its obligations under the NCEOP. As the need for health and medical resources exceed the capacity or capability of the resources in any one region, NCOEMS plans, coordinates and executes the delivery of needed support to those areas from other identified regional, state, or federal resources. Working as part of the SERT, NCOEMS coordinates statewide support through the Emergency Services Group of the State Emergency Response Team (SERT-ESG) at the State Emergency Operations Center (SEOC).

HHS REGION IV UPC: The Region IV ESF8 Unified Planning Coalition (UPC) provides support during declared disasters where there is a need to provide or receive health and medical resources across state lines. The organization is comprised of ESF8 leadership from each of the FEMA Region IV states (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) and federal ESF8 representatives. The UPC supports member states by assisting with the coordination of ESF8 planning and logistical/resource support. Prior to and during disaster response, the UPC assists impacted or potentially impacted member states with situational awareness, resource identification and acquisition via the Emergency Management Assistance Compact (EMAC), and coordination between member state and public health and medical (ESF8) systems.

FEDERAL: The Robert T. Stafford Disaster Relief and Emergency Assistance Act provides the authority for the Federal government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. The U.S. DHHS-Assistant Secretary for Preparedness and Response (ASPR) acts as the lead agency for federal ESF-8 Health and Medical assistance however other federal agencies such as the Centers for Disease Control and Prevention (CDC) may also provide support. In the event that state health and medical resources are insufficient to maintain ESF-8 response or recovery operations and a State of Emergency has been declared by the governor of North Carolina, federal health and medical resources can be considered. This coordination will be done in conjunction with the ESF8 lead, NCEM ESG and ASPR Regional Emergency Coordinators (RECs) which are available to support the response physically or remotely. All federal response assistance will be based on State-identified priorities and must be approved by the SERT leader.

CONCEPT OF OPERATIONS

ACTIVATION: In general, ESF8 may be activated whenever an event (planned) or incident (unplanned) occurs, or is expected to occur, in which local or regional healthcare resources have become exhausted or are anticipated to become exhausted. Activation may be initiated in conjunction with a general activation of the SERT and SEOC or to provide direct support to SMRS organizations that may already be deployed. Depending on the situation, activation requests will usually be initiated by:

- The Emergency Services Group Supervisor of the North Carolina Division of Emergency Management (NCEM)
- The appropriate Healthcare Preparedness Coordinator (HPC) or their designee

The individuals holding the following positions within NCOEMS have the authority to activate this EOP:

1. HPP Program Manager
2. HPP Operations Manager
3. OEMS Chief
4. OEMS Assistant Chief
5. OEMS Regional Manager (East, Central, West)

Once activated, the ESF8 Lead, or their designee, will coordinate internally with appropriate senior staff, the SMRS Medical Advisor, and, if necessary, externally with NCEM, the NC Division of Public Health (NCDPH), and other NC Department of Health and Human Services (NCDHHS) organizations to inform decisions to activate and the appropriate level of activation. See Activation Levels below. **Refer to Appendix 1: ESF8 SEOC/Support Cell Staffing and Sustainment SOG for additional information covering staffing plans, battle rhythm, and the notification of personnel.**

ACTIVATION LEVELS: Levels of activation will depend on the situation and may be independent of the activation level of the SEOC. Over the course of an activation, the coordination of resources and support for NCOEMS coordinated field operations will begin at the ESF8 Desk, may expand to include the ESF8 Support Cell and/or other locations before contracting back to the ESF8 Desk. During this time, a portion of the duties and responsibilities held by the ESF8 Desk may be shifted to these other locations. Activation levels along with planned staffing, responsibilities, and battle rhythm are summarized in the table below.

Activation Levels, Staffing, and Battle Rhythm				
Activation Level	**Description**	**Staffing**	**Responsibilities**	**Battle Rhythm** Specific timelines in which staff perform their basic responsibilities will be fluid and will be set per situation.
Blue	Information sharing. No coordination of SMRS assets is necessary.	1 - Shift Duty Officer (SDO)	Refer to **Appendix 2: Shift Duty Officer SOG**	24 hours a day, 7 days a week, 365 days a year.
Green	Coordination of SMRS assets is necessary but can be accomplished remotely.	Minimum of **1** person: 1 – ESF8 Lead or designee	• Conduct basic information sharing calls • Produce and distribute situation report of actions taken	Intermittent, as required by situation.
Yellow	Coordination of SMRS assets is necessary and/or requires deployment to specific physical location (e.g. SEOC, Support Cell, etc.)	Minimum of **2** persons: 1 – ESF8 Lead or designee, and 1 – SEOC ESF8 Desk or ESF8 Operations Manager	• Conduct basic information sharing calls • Conduct other coordinating calls with HPCs/small groups, weekly or as necessary • Produce and distribute situation report of actions taken	Schedule dependent on deployed location. SEOC usually daytime only 0700-1900 hours but times will vary depending on situation.
Orange	Coordination of SMRS assets is necessary, requires deployment to specific physical location and the establishment of up to two (2) field operations.	Minimum of **7** persons: 1 – ESF8 Lead or designee, and 1 – ESF8 Operations Manager 2 – SEOC ESF8 Desk Lead and other staff (1 day/1 night) 1 – ESF8 Support Cell Lead and OEMS staff (day only) 2 – OEMS staff at each field site (1 day/1 night)	• Conduct basic information sharing calls • Conduct coordinating calls with: ○ HPCs/small groups, as necessary ○ OEMS staff ○ ESF8 partners • Produce and distribute situation report of actions taken	Standard schedule for ESF8 duty in the SEOC is listed below but is subject to change depending on the situation: • Day shift: 0600-1600 hours • Swing shift: 1200-2200 hours • Night shift: 2100-0700 hours
Red	Coordination of SMRS assets is necessary, requires deployment to specific physical location and the establishment of three (3) or more field operations.	Minimum of **13** persons: 1 – ESF8 Lead or designee, and 1 – ESF8 Operations Manager 3 – SEOC ESF8 Desk Lead and staff (2 day/1 night) 2 – ESF8 Support Cell Lead and OEMS staff (day only) 6 – OEMS staff at Field sites (1 day/1 night per site)	• Conduct basic information sharing calls • Conduct coordinating calls with: ○ HPCs/small groups, as necessary ○ OEMS staff ○ ESF8 partners ○ Healthcare association partners • Produce and distribute situation report of actions taken	Standard schedule for ESF8 duty in the SEOC is listed below but is subject to change depending on the situation: • Day shift: 0600-1600 hours • Swing shift: 1200-2200 hours • Night shift: 2100-0700 hours

SUSTAINMENT OF SEOC OPERATIONS: In the event that NCOEMS involvement with disaster response and recovery operations extend to a 24-hour schedule, operations at the Support Cell and the ESF8 Desk at the SEOC must be sustained. The sustainability of these operations is dependent on having adequate personnel, equipment (including communication equipment), facilities, meals, and lodging available as well as adequate support for these factors. **Refer to Appendix 1: ESF8 SEOC/Support Cell Staffing and Sustainment SOG for additional information addressing these issues.**

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

GENERAL: Once notified, activated staff will support/coordinate ESF8 operations, handle associated requests for health and medical (ESF8) information and resources, represent ESF8 to local, state, and federal partner organizations, and provide reports to the SERT as requested. Key responsibilities and roles are detailed below.

ESF8 RESPONSIBILITIES:

SEOC ESF8 Desk: The ESF8 Desk at the SEOC is typically the initial and primary center for ESF8 coordination of State Medical Response System (SMRS) information and resources, and the authoritative source for response and recovery decisions as they pertain to disaster medical services in North Carolina. The functions of the ESF8 Desk may be conducted remotely depending on the operational situation or particular nature of the event. Once activated, personnel assigned to the ESF8 Desk are responsible for coordinating medical resource management and supporting NCOEMS field operations**.** (**Refer to Appendix 3: Medical Resource Management SOG**) The desk should coordinate directly with the NCEM Emergency Services Group Supervisor (ESG Supervisor) regarding potential and assigned ESF8 missions. As the response to a disaster expands, the ESF8 Lead may activate the ESF8 Support Cell and shift selected ESF8 Desk responsibilities to the support cell.

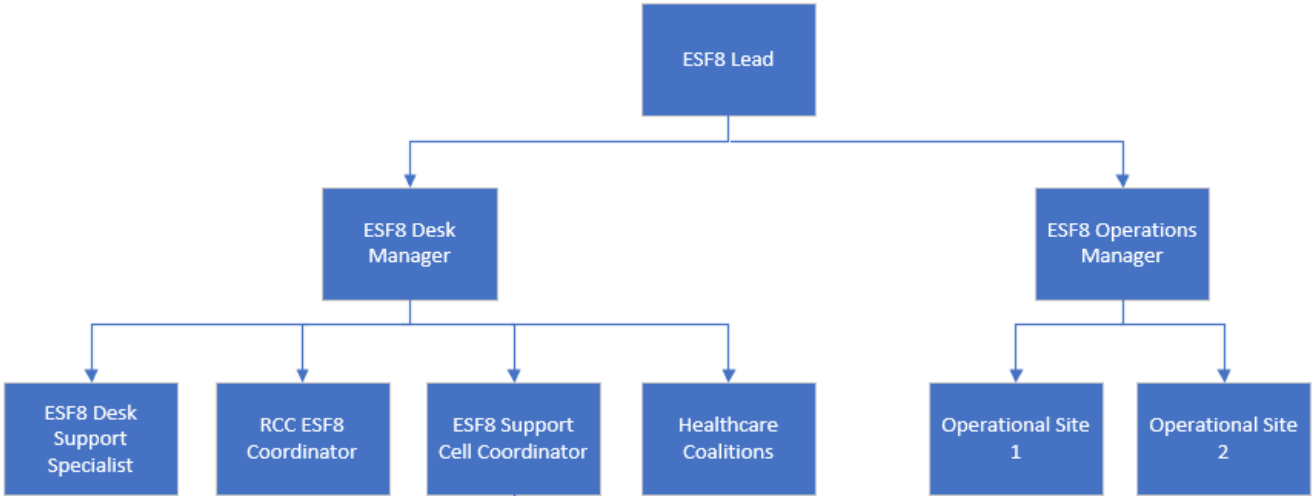
ESF8 Support Cell: The ESF8 Support Cell typically serves as a secondary center for the coordination of SMRS information and resources, primarily in support of the ESF8 Desk when it is necessary for operations to expand. However, these functions may also be conducted remotely depending on the operational situation or particular nature of the event. Once activated, the personnel assigned to these roles are responsible for the duties assigned to them as directed by the ESF8 Desk Manager.

HCC Operations Centers/Support Cells: Each HCC maintains an Operations Center/Support Cell as their initial and primary location for the coordination and support of healthcare facilities or ESF8 operations both within their regions and throughout the state. Once activated, HCC staff assigned to these areas, work as part of ESF8 and assist with the coordination of SMRS information and resources in support of local Emergency Management, their regional response partners, other HCCs, and the ESF8 Desk or ESF8 Support Cell. Similar to the ESF8 Desk and ESF8 Support Cell, these functions may also be conducted remotely depending on the operational situation or particular nature of the event.

Regional Coordination Centers (RCCs): RCCs operate under the direction of the NCEM Operations Chief and are directly managed by NCEM Regional Managers. They are activated as staging areas for personnel and equipment (from all Emergency Support Functions) necessary to support disaster response and recovery operations on the local and regional level when necessary. Once an RCC is activated the ESF8 Lead may be tasked with providing representatives to staff the RCC ESF8 Desk. If tasked, the ESF8 Lead, or their designee, will select staff from the NCOEMS Regional Offices (Eastern, Central, Western) to act as ESF8 representatives to the RCCs. NCOEMS Regional Managers and regional staff assigned to the RCCs operate under the ESF8 Desk Manager and are responsible for

coordinating disaster information, facilitating ESF8 mission support and medical resource tracking, informing medical resource allocation decisions, and for coordinating and resolving operational issues between ESF8 agencies and government jurisdictions.

ESF8 ROLES:



ESF8 Lead: Advises, sets priorities, and provides overall direction for ESF8 response and recovery activities. Represents ESF8 goals, objectives, and activities to local, state, and federal partners as part of the North Carolina SERT and authorizes the activation of state ESF8 resources. Coordinates with DHHS/NCOEMS Leadership, State Medical Response System Advisor, and NC SERT partners on the development and implementation of policies necessary to support ESF8 response activities and the release of health and medical information to the public.

SEOC ESF8 Desk Manager: Monitors available communication and information technology systems to maintain situational awareness of ESF8 response and recovery activities (**Refer to Appendix 4: Communications and Information Systems)**. Develops situation reports and leads coordination calls for the purpose of sharing ESF8 situation and mission status information across ESF8 organizations and with local, state, and federal partners, as appropriate. Manages requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, and HPCs. The SEOC ESF8 Desk Manager works directly with the ESF8 Lead and is activated when assistance is necessary for developing situational awareness, managing resource requests, or coordinating the provision of ESF8 resource support with the Healthcare Coalitions (HCCs) and Regional Coordination Centers (RCCs). This position is usually at the SEOC to coordinate resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions. The position coordinates in a similar way with RCC ESF8 Manager and also works to identify ESF8 resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs.

ESF8 Operations Manager: Ensures pre-deployment readiness and planning for potential ESF8 operational mission requests. Conducts assessments of need with requesting jurisdictions/organizations and advises ESF8 Lead on approval of operational mission requests. Oversees operational site(s) coordination (site assessment, site plans) with response partners. Ensures necessary mission support is coordinated with the ESF8 Desk Manager. Oversees site demobilization when indicated. The ESF8 Operations Manager is activated when there is the potential for the activation and deployment of SMRS

operational units (e.g. SMSS, MDH, Patient Transfer Centers, etc.) to meet health and medical resource needs both within and outside of North Carolina. Once activated, this position coordinates all aspects of the deployment of SMRS operational units into the field. The position coordinates directly with the ESF8 Lead and SEOC ESF8 Desk Manager to identify necessary IMT personnel, staffing, and logistics resources. Once SMRS operations have been established, this position provides direct support and leadership to the deployed IMTs and coordinates further support through the ESF8 Lead and SEOC ESF8 Desk Manager.

ESF8 Desk Support Specialist: Assist the ESF8 Desk Manager in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT.

RCC ESF8 Coordinator: Responsible for coordinating disaster information pertaining to affected health and medical facilities and services and facilitating ESF8 mission support at the RCC level. Provides direction and support to ESF8 resources assigned to the RCC. Conducts medical resource tracking, advises medical resource allocation decisions, and assist with the coordination and resolution of operational issues between ESF8 agencies and government jurisdictions. RCC ESF8 Coordinator may be activated when it is anticipated that an area or areas within an NCEM Region (East, Central, West) may be affected by an emergency or disaster with the potential to overwhelm ESF8 resources there. The positions may be requested by an NCEM Regional Manager and assigned by the ESF8 Lead. Once activated, RCC ESF8 Leads work closely with the SEOC ESF8 Desk Manager and, in some cases, the ESF8 Support Cell Coordinator to coordinate ESF8 resources in support of health and medical facilities or local ESF8 operations within the RCC.

ESF8 Support Cell Coordinator: Coordinates directly with the ESF8 Desk Manager and ensures all assigned tasks to the support cell are completed. Potential tasks include, maintaining situational awareness, managing resource requests, supporting field operations, coordination of patient transfer operations and the vetting of medical supply requests during medical logistics operations. The ESF8 Support Cell Coordinator is activated when the ESF8 Lead or SEOC ESF8 Desk Manager need assistance with the support and/or coordination functions that cannot be easily conducted from within the SEOC (e.g. SMSS patient movement coordination, etc.). Once activated, this position works directly with the ESF8 Desk Manager to define the staff and schedule necessary to support the situation. Once established, this position coordinates all aspects of the roles/functions assigned to the ESF8 Support Cell and works directly with the SEOC ESF8 Desk Manager to ensure that the needed support is provided.

Coordination: Personnel filling the roles listed above provide the leadership framework for ESF8 response and recovery actions in North Carolina. Although, the situation will dictate the extent in which these positions are activated, the ability of the personnel in these positions to work together in an efficient manner is essential to the success of the ESF8 response. In the initial phases of a response, the ESF8 Lead may fulfill all the roles listed above but, as health and medical needs become better defined, the ESF8 Lead will activate one or more of the other leadership positions until, if necessary, all are active parts of the ESF8 response. These positions may be physically located at the SEOC, the Support Cell, Operational Sites and/or filled in a remote capacity depending on the situation.

Support for NCOEMS Coordinated Operational Sites: All established ESF8 field operations require support to help manage or provide direction for meeting operational and logistical needs that arise during deployment.

- Operational needs may include areas such as staffing, patient care, and the integration of ESF8 field operations with existing local health and medical operations.
- Logistical needs may include areas such as the resupply of medical equipment and supplies, establishment of IT and security support from partner organizations, and the

integration of local services such as waste management, material handling, transportation, and janitorial services.

When ESF8 field operations have been established, support for all needs should be entered into WEBEOC by onsite staff and routed to the ESF8 desk for review and assignment. The assigned Incident Management Teams (IMTs) are expected to communicate their operational and logistical needs to the ESF8 Operations Manager.

CHAIN OF COMMAND: A clearly defined chain of command is necessary to ensure continuity of health and medical operations in response and recovery from emergency events and disasters. During these times, it is important that the line of succession be based on the knowledge, skills, and abilities of individuals and the established disaster response structure. For these reasons, once activated the following chain of command will be established:

1. ESF8 Lead
2. ESF8 Operations Lead
3. SEOC ESF8 Desk Manager
4. ESF8 Support Cell Coordinator

As needed ESF8 field operations are stood up, NCOEMS staff may be assigned many different roles within them to meet ESF8 mission requirements as part of the SERT. Each role includes a range of responsibilities necessary to ensure that the organization fulfills its operational or support mission successfully. **Refer to Appendix 5: Organization and Assignment of Responsibilities which provides additional information covering ESF8 organization by activation level, and responsibilities of staff assigned to the State EOC and Support Cell roles.**

CAPABILITIES

ADMINISTRATIVE PREPAREDNESS: Addresses the ability to conduct and maintain administrative functions necessary for the execution and proper documentation of ESF8 emergency response and recovery operations. Provides guidelines and information including, the recording of responder time and activities, emergency purchase processes, and FEMA reimbursement. **Refer to ANNEX A: ADMINISTRATIVE PREPAREDNESS for specific plans and information utilized to meet this capability.**

HEALTHCARE CONTINUITY: Addresses the ability to support and maintain healthcare service delivery, workforce, infrastructure, supply chain, transportation systems, and information systems. Covers plans and guidelines for state maintained or organized healthcare continuity assets such as the Mobile Disaster Hospital. **Refer to ANNEX B: HEALTHCARE CONTINUITY for specific plans and information utilized to meet this capability.**

MEDICAL SURGE: Addresses the ability to provide adequate medical evaluation and care in events that severely challenge or exceed the normal medical infrastructure of an affected community (through numbers *or* types of patients). Covers plans and guidelines for support of the healthcare system during events resulting in medical surge conditions including Alternate Care Sites and Ambulance Strike Teams. **Refer to ANNEX C: MEDICAL SURGE for specific plans and information utilized to meet this capability.**

PATIENT MOVEMENT: Addresses the ability to triage and place patients in appropriate receiving facilities and develops a structure for the coordination of transportation for patients. Covers plans and

processes for state-coordinated patient movement when local jurisdictions require regional, state, or federal assistance to manage patient movement including evacuation of existing healthcare facilities. **Refer to ANNEX D: PATIENT MOVEMENT for specific plans and information utilized to meet this capability.**

SCARCE RESOURCES: Addresses the ability to provide and maintain medical resource support (personnel, equipment, supplies) and ethical standards over extended periods due to long-term impacts from disasters such as pandemics and tornadoes. Includes the transition from the use of existing ESF8 personnel, facilities, and short-term processes to contracted personnel, facilities, and longer-term processes as required. **Refer to ANNEX E: SCARCE RESOURCES for specific plans and information utilized to meet this capability.**

SITUATIONAL AWARENESS & INFORMATION SHARING: Addresses the ability to provide and maintain situational awareness and share information regarding ESF8 response/recovery operations during an emergency or disaster. Covers guidelines for the collection and dissemination of information, use of briefings and conference calls, and use of messaging systems. **Refer to ANNEX F: SITUATIONAL AWARENESS & INFORMATION SHARING for specific plans and information utilized to meet this capability.**

STATE COORDINATED SHELTERS: Addresses the ability to maintain continuity of healthcare through the establishment, operation, and/or support of medical and general population sheltering operations. Covers plans and guidelines for State Medical Support Shelters (medical) and State Coordinated Shelters (general). **Refer to ANNEX G: STATE COORDINATED SHELTERS for specific plans and information utilized to meet this capability.**

MORGUE SURGE CAPACITY: Addresses the ability to support morgue operations during periods of surge due to emergency events or disasters. Includes the provision of personal protective equipment (PPE), rehabilitation services, and supplies and equipment to support the handling of remains (decontamination systems, body bags, x-ray, trailers, etc.). **Refer to ANNEX H: MORGUE SURGE CAPACITY for specific plans and information utilized to meet this capability.**

DEMOBILIZATION

GENERAL: As response objectives are achieved and the emergency event or incident comes under control, Incident Command/emergency management leadership, in coordination with ESF8 leadership and representatives, will direct the demobilization of personnel and assets on-scene, at Regional Coordination Centers and the SEOC. **Refer to Appendix 6: Demobilization SOG for additional information covering the processes and procedures for the demobilization ESF8/SMRS operational and operations support organizations and teams.**

NORTH CAROLINA
EBOLA VIRUS DISEASE &
HIGH CONSEQUENCE PATHOGENS
CONCEPT OF OPERATIONS

September 2019

This page intentionally left blank.

Table of Contents

Introduction

High Consequence Pathogens are infectious diseases that may occur infrequently but are associated with high rates of death.[1] Ebola Virus Disease (EVD), considered an infectious disease of high consequence[2], is a rare and deadly disease caused by infection with one of the Ebola virus strains. Ebola can cause disease in humans and nonhuman primates (monkeys, gorillas, and chimpanzees). One of the primary roles of government is to provide for the public health and medical welfare of its residents and visitors. Per the National Response Framework[3], federal and state governments depend on local agencies, such as local public health and healthcare organizations, to engage in mitigation, preparedness, response, and recovery actions to safeguard citizens during disaster and public health incidents.

This plan provides a concept of operations (ConOps) for the safe and timely identification, isolation, information sharing and transportation of suspected and/or confirmed cases of infection caused by EVD. This ConOps is considered an incident specific plan, although many of the concepts may be applicable to other high consequence pathogens. The coordination between Local, State, Federal, and private organizations and resources is key to being able to prepare for, respond to and recover from potential outbreaks of high consequence pathogens. In an effort to keep up with shifting priorities, emerging threats and new guidance, this plan is intended to be a dynamic document that can be modified as new information becomes available.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3901478/
[2] https://www.cdc.gov/ncezid/dhcpp/pdfs/DHCPP-factsheet.pdf
[3] https://www.fema.gov/media-library-data/1466014682982-9bcf8245ba4c60c120aa915abe74e15d/National_Response_Framework3rd.pdf

Approval and Implementation

The management authority for actions during a response to EVD and high consequence pathogens is done through the execution of this Concept of Operations (CONOPS). The implementation of this CONOPS is executed by the State's authorized agencies: North Carolina Division of Emergency Management (NCEM), North Carolina Office of Emergency Medical Services (OEMS): Healthcare Preparedness Program (HPP), and the North Carolina Division of Public Health (DPH): Epidemiology Section: Public Health Preparedness and Response Branch (PHP&R); Communicable Disease Branch (CDB) and State Laboratory of Public Health (SLPH). This plan is separated into two phases: The Assessment Phase and The Response Phase. During the Assessment Phase the responsibility to implement this plan falls to PHP&R and/or HPP. During the Response Phase it is expected that PHP&R and/or HPP will request assistance with the coordination and control of the response from the NCEM Director for activation of the State Emergency Response Team (SERT).

The following agencies were involved in the planning of this ConOps and their signatures indicate the willingness of their agencies to carry out the roles and responsibilities outline in this plan.

Name: Dr. Zack Moore Position: Section Chief, Epidemiology Section Office: 919.546.1725	Signature:
Name: Brian Combs Position: Branch Head, Public Health Preparedness and Response Branch Office: 919.546.1821	Signature:
Name: Evelyn Foust Position: Branch Head, Communicable Disease Branch Office: 919.733.9490	Signature:
Name: Susie Orton Position: Manager, Bioterrorism and Emerging Pathogens Unit, State Laboratory of Public Health Office: 919-807-8576	Signature:
Name: Kimberly D. Clement Position: Program Manager, Healthcare Preparedness Program Office: 919.855.3936	Signature:
Name: Michael A. Sprayberry Position: Director, North Carolina Division of Emergency Management Office: 919.825.2500	Signature:

Ebola Virus Disease / High Consequence Pathogens Concept of Operations Record of Changes

This ConOps was revised in January 2019, again in July/August 2019, and is now the 2019 EVD/HCP ConOps dated October 2019

Change Type	Number	Change Date	Date Distributed	Authorized By

Key: Change = Ch Update = Up Revision = Rev

Change – a change constitutes the least invasive of the three plan management processes and is conducted annually. A change includes but is not limited to variations in phone numbers, office symbols, locations, etc. A change, despite the level of magnitude, requires a record of changes sheet within the plan to be completed. A change can be requested in writing by any agency represented as part of the core entities outlined in the introduction and no formal signatures are required.

Update – After annual plan review, if less than 25% of the content within the plan requires a change, an update is constituted. An update could be minor organizational, procedural, and/or situational changes. An update, despite the level of magnitude, requires a record of changes sheet within the plan to be completed. Also, an update requires a formal signature from the requesting agencies planning lead.

Revision – After annual plan review, if greater than 25% of the content within the plan requires a change, a revision occurs. A revision constitutes the most invasive level of change to organization, procedure, situation, overall format, and governing policy. A revision requires a formal signature by all core agencies represented in this plan.

Background

The 2014-2015 EVD epidemic was the largest and longest lasting in history, primarily affecting three countries in West Africa (Liberia, Sierra Leone and Guinea), with more than 28,000 cases and more than 11,000 deaths reported. A small number of cases were also reported in other countries; however, these cases were contained, with no known further spread. These cases either were transported to other countries for treatment or arrived during incubation (after exposure and prior to onset of symptoms) and became ill after arriving in countries outside of the outbreaks area. These resulted in a limited number of secondary cases. A major international effort monitored travelers from the affected area in an effort to control the spread of disease.

Globalization increased the likelihood for international spread of emerging pathogens. Concentrated efforts will need to be implemented in order to identify, treat and control the spread of these pathogens and avoid, where possible, pandemic events.

Authorities

The North Carolina Division of Emergency Management (NCEM) is delegated the responsibility and authority to respond to emergencies and disasters by the Governor via The North Carolina Emergency Management Act found in **Chapter 166A** of the North Carolina General Statutes [4].

NC General Statute 166A
https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_166A.html

The North Carolina Department of Health and Human Services (DHHS) is the lead agency for disease prevention, treatment, and control. Per the State Emergency Operations Plan (EOP) developed and coordinated by the North Carolina Division of Emergency Management (NCEM), the North Carolina Division of Public Health (DPH) and North Carolina Office of Emergency Medical Services (OEMS) are delegated specific roles and responsibilities during a health and medical event such as this. If an event occurs that presents an imminent threat to the public, or exceeds OEMS and DPH day-to-day capacity, NCEM may request coordination through the State Emergency Response Team to coordinate the state-level emergency management activities and the engagement with other emergency management stakeholders, including local, state, and tribal governments, nongovernmental organizations (NGOs), other states, the federal government, and the private sector.

Local Health Directors (LHDs) and/or the State Health Director (DHHS) or designee have the authority to activate their isolation and/or quarantine plan and issue orders as necessary under; 130A-145, the main isolation and quarantine statute, provides specific procedures for a person to obtain judicial review of an isolation or quarantine order.

[4] https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_166A.html

NC General Statute 130A-145
https://www.ncleg.net/EnactedLegislation/Statutes/PDF/BySection/Chapter_130A/GS_130A-145.pdf

NC General Statute 130A-25
https://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_130A/GS_130A-25.html

Purpose

The purpose of this concept of operations is to provide local, state, and federal partners, relevant healthcare agencies and organizations, and other stakeholders the strategic high-level overview based on our tiered healthcare system's approach to safely and effectively prepare for, manage and respond to persons/patients with suspected or confirmed Ebola Virus Disease (EVD) in North Carolina.

This CONOPS is based upon current guidance from the Assistant Secretary for Preparedness and Response (ASPR) and U.S. Centers for Disease Control and Prevention (CDC) and is subject to change as the risks and threats evolve or change.

Scope

While many local, state, and federal partners may have roles and responsibilities outlined in this ConOps the following are considered the core agencies of this plan: North Carolina Division of Emergency Management; North Carolina Division of Public Health: Epidemiology Section: Public Health Preparedness & Response Branch, Communicable Disease Branch; the North Carolina Division of Public Health: State Laboratory of Public Health; and the Division of Health Service Regulation: Office of Emergency Medical Services: Healthcare Preparedness Program.

This plan provides guidance for all public health agencies, healthcare systems, healthcare facilities, healthcare coalitions, and EMS agencies within North Carolina on the framework that will be used to prepare for, respond to, and recover from a confirmed or potential Ebola Virus Disease outbreak.

Note: This EVD ConOps primarily addresses specific activities related to the response of an EVD event. The many agencies and facilities involved in this type of response each have their own emergency operations plans to facilitate the response and coordination of all types of emergencies and will be used concurrently with this plan.

Situation Overview

Hazard and Threat Analysis Summary

- North Carolina has a population of approximately 10 million people dispersed over a land area of 54,000 square miles. In November 2017, according to an analysis performed by ASPR, North Carolina was considered a high-risk jurisdiction during the 2014-2015 EVD Outbreak based on the percentage of returning travelers from affected countries and because of its globalized workforce as well as populations of international origin[5].

- Ongoing and future epidemics of EVD or illnesses caused by other High Consequence pathogens pose a risk to the population and may adversely affect the ability of the public health organizations, hospitals, and other healthcare infrastructure within North Carolina to resolve them.

- Outbreaks of EVD are occurring or have occurred outside North Carolina and will probably continue in the future.

Clinical Characteristics of EVD

Ebola is only contagious after the onset of symptoms. The incubation period before symptoms may appear is 2-21 days, with 8-10 days being the most common. Ebola is spread through unprotected contact with blood or body fluids from someone who is infected. Anyone who becomes ill within 21 days after traveling to an affected area in West Africa should contact a healthcare provider right away and limit their contact with others until they have been evaluated.

Ebola is spread through direct contact (through broken skin or through your eyes, nose, or mouth) with:

- Blood and body fluids (like urine, feces, saliva, vomit, sweat, and semen) of a person who is sick with Ebola.
- Objects (like needles) that have been contaminated with the blood or body fluids of a person sick with Ebola.

Ebola is not spread through the air, water, or food. In 2019 at the time of this plan writing there is no FDA-approved vaccine available for Ebola. Experimental vaccines and treatments for Ebola are under development, but they have not yet been fully tested for safety or effectiveness.

Symptoms of Ebola include: Fever, Severe headache, Muscle pain, Weakness, Diarrhea, Vomiting, Abdominal Plan, Unexplained bleeding or bruising[6].

[5] https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/RETN-Ebola-Report-508.pdf
[6] https://www.ncdhhs.gov/divisions/public-health/ebola-information

Additional information regarding the clinical presentation of Ebola Virus Disease can be located here: *https://www.ncdhhs.gov/divisions/public-health/ebola-information* or here: *https://www.cdc.gov/vhf/ebola/index.html*

Jurisdiction and Capabilities

Public Health Agencies

In North Carolina, state and local resources work in concert to protect the public health. On a day to day basis the Division of Public Health's (DPH) Epidemiology Section and the State Laboratory of Public Health (SLPH) work to reduce health risks across North Carolina and responds to outbreaks of disease[7]. Within the Epidemiology Section of DPH are two Branches that have shared roles and responsibilities for EVD and high consequence pathogens response: Public Health Preparedness & Response (PHP&R), Communicable Disease Branch (CDB). Investigation and control of communicable diseases are coordinated by the State Epidemiologist and the CDB. A key component is the EPI On-Call line which is a 24/7 monitored phone line that is used by the public health and healthcare systems to report potential and/or confirmed communicable diseases and to receive communicable disease response technical assistance. The staff for this EPI On-Call line comes from the Communicable Disease Branch. Overall planning and coordination of response to public health emergencies is performed through PHP&R. The SLPH is responsible for the initial Diagnostic Specimen Testing for Ebola Virus and lab consultation and support to healthcare systems. The 84 Local Health Departments are responsible (and have legal authority) to investigate cases and outbreaks, and to identify and require control measures.

Emergency Medical Services System

The Emergency Medical Services (EMS) systems across all local jurisdictions should be prepared and capable of transporting a patient with EVD or infection with other high consequence pathogens. EMS systems should have access to an initial cache of personal protective equipment that staff can utilize once a potential EVD patient has been identified. Transportation of an emergent event in the community will be the responsibility of the local EMS agency, according to applicable local jurisdictional plans. For individuals that are under monitoring and are not emergent (i.e. the 911 system has not been activated), the hospital-based critical care services will be responsible for transport to an in-state or out of state assessment hospital and/or treatment center.

Transportation to an out of state healthcare facility should be coordinated in accordance with the Region IV Ebola Patient Transportation Plan and include NC DPH, NC OEMS and the receiving State's Department of Health. In some circumstances it may be safer and more practical to transport to an Ebola Assessment or Treatment Hospital that is out of state (i.e. Virginia, South

Carolina, Georgia, Tennessee etc.) Patient assessment and treatment decisions will be made on a case-by-case basis to include a specific transportation location, method, and airport if needed. OEMS is responsible for activation of transportation assets and for coordination with the DPH and Department of Public Safety (DPS), Division of Emergency Management (NCEM).

Healthcare Preparedness Program

The North Carolina Healthcare Preparedness Program (HPP) sits within the Division of Health Service Regulation's Office of Emergency Medical Services. HPP's mission is to partner with healthcare and emergency response organizations working to prepare for, mitigate, respond to, and recover from emergencies and disasters. HPP has the following responsibilities during a potential Ebola Virus Disease response: provide situational awareness, support continuity of operations, augment medical surge, coordinate healthcare resource allocation, EVD patient transportation coordination and technical assistance.

There are eight Healthcare Coalitions (HCCs) across North Carolina that include representation from all jurisdictions or emergency response organizations, to include Hospitals, Emergency Medical Services, Emergency Management, Public Health, Dialysis Centers, Skilled Nursing Facilities, Home Health & Hospice Agencies, Durable Medical Equipment Agencies, Pharmacies, ancillary healthcare organizations, Volunteer Organizations Active in Disasters (VOADs), and other relevant members. Each of these HCCs are part of the Healthcare Preparedness Program and have similar responsibilities during an EVD response to include: provide situational awareness to the healthcare system, support continuity of operations, augment medical surge and coordinate healthcare resource allocation.

North Carolina will utilize the tiered healthcare system outlined below with the eight Healthcare Coalition lead hospitals serving as Assessment Hospitals. These facilities are geographically distributed across the state to effectively meet the needs of potential EVD patients or potential at-risk populations. This tiered system was established to effectively triage and treat high acuity medical issues related to trauma and other specialty care through the regional advisory committee system and the healthcare preparedness program.

These healthcare organizations will provide the capability of assessment hospital for their specific referral areas. The eight Healthcare Coalition lead hospitals are a group of academic medical centers and regional healthcare systems affiliated with the regional Healthcare Preparedness Coalitions: Mission Hospital (Asheville, NC), Wake Forest Baptist Health (Winston-Salem, NC), Atrium Health (Charlotte, NC), Duke University Medical Center (Durham. NC), WakeMed Raleigh Campus (Raleigh, NC), University of North Carolina Hospitals (Chapel Hill, NC), Vidant Medical Center (Greenville, NC), and New Hanover Regional Medical Center (Wilmington, NC).

Appendix A – Healthcare Coalition Regions

Tiered Healthcare System

It is expected that all healthcare workers have awareness of Ebola Virus Disease regardless of the tier of their healthcare facility. Early identification of a potential EVD patient is key to managing the outbreak. Healthcare Facilities in North Carolina will not be formally designated into one of the categories below, however, all hospitals are expected to provide Frontline-level capability. Further, in a medical surge event, where national and regional treatment facilities are unavailable, the eight North Carolina Ebola assessment hospitals will be expected to share their existing resources in order to provide necessary treatment capabilities based on the acuity of patients and geographic needs. It is expected that all hospitals work closely with their Healthcare Coalitions to coordinate resource sharing across the healthcare system. If necessary, additional support may be facilitated by OEMS and NCEM. The algorithm for this process is detailed in **APPENDIX B: North Carolina State Medical Resource System Health and Medical Resource Request Algorithm**

Frontline Healthcare Facilities (FHF) are any healthcare facility (e.g. physician's office, urgent care, outpatient clinic, emergency department, in-patient hospital etc.) to which a patient with symptoms, regardless of monitoring status, may present. Frontline healthcare facilities should be prepared to:

- Identify and triage a potential Ebola Virus Disease (EVD) and/or other High Consequence Pathogen patient within 5 minutes of arrival based on the patient's relevant exposure history and signs or symptoms consistent with EVD and/or other high consequence pathogens. Each Frontline Healthcare Facility should have access to an initial cache of personal protective equipment that staff can utilize once a potential EVD patient has been identified.
- Isolate any patient with relevant exposure history and signs or symptoms consistent with EVD and/or other high consequence pathogens.
- Inform as soon as possible their hospital/facility infection control program, all appropriate facility staff/ management and state and local public health departments of the identified potential EVD patient.
- Participate in a risk-assessment between Local/State Public Health to determine potential risk for EVD
- It is the expectation that a patient be transferred as quickly as possible from a FHF to an assessment or treatment facility, however, in a worst-case scenario, facilities that have in-patient capability (e.g. Hospitals) need to be prepared to care for a potential EVD patient for up to 24 hours.

APPENDIX C: Identify, Isolate and Inform: Ambulatory Care Evaluation of Patients with Possible EVD

Assessment Hospitals (AH) are tertiary care hospitals that have adequate dedicated treatment areas, skilled and trained staff, appropriate equipment and demonstrated proficiency in infection control procedures. Each Assessment Hospital should be prepared to:

- Meet all the requirements of the Frontline healthcare facilities
- Receive and Isolate potential EVD patients in their EVD Containment areas within 8 hours of receiving activation from NC HPP and/or NC DPH
- Care for the potential or confirmed EVD patient for up to 96 hours or until an Ebola diagnosis can be confirmed or ruled out and until discharge or transfer is completed
- Initiate or coordinate Ebola testing and testing for alternative diagnoses
- Coordinate with NC HPP and NC DPH the potential transfer of the individual to an Ebola Treatment Center (if indicated)
- If EVD is ruled out as a potential diagnosis, then the EAH is responsible to continue caring for the patient based on their normal protocols.

It is expected that the transport/transfer of suspected EVD patients from the community or FHF will follow each individual health system's normal referral patterns or established catchment area. Additional screening should be made real-time in concert with guidance from local and state public health entities and the receiving EVD assessment facility. Inter-facility transports will be made by appropriate vehicles with staff trained and equipped specifically for the transport of persons under investigation. If EVD or a high consequence pathogen is confirmed, patients will be considered for transfer to an EVD and high consequence pathogen treatment hospital. This transfer coordination should involve state and federal entities and should not be coordinated directly by the Ebola Assessment Hospital.

Ebola Treatment Centers (ETC) are hospitals that have adequate designated treatment areas, skilled and trained staff, appropriate equipment and infection control procedures matching requirements for Ebola and/or other high consequence pathogens. These facilities have the capability to manage a confirmed EVD or high consequence pathogen patient for duration of necessary medical treatment. These types of facilities also include specialized biocontainment facilities. The HHS Region IV Treatment Center is Emory University Hospital in Atlanta however additional ETCs exist within Region IV and Region III. Placement of a patient into an ETC is coordinated between NC DPH and the receiving state's Public Health Department, NCHPP, the sending and receiving facility and ASPR Regional Emergency Coordinators.

Laboratory Capacity

The North Carolina State Laboratory of Public Health (SLPH) is capable of performing testing for many of the suspect agents identified by the CDC Laboratory Response Network (LRN) as emerging diseases with the appropriate biosafety level. It also has the capacity to expand testing once it is available by the LRN. The SLPH also maintains a laboratory response network within the state comprised of both hospital and private clinical laboratories. This network coordinates testing protocols and processes throughout the state. Within that program is a robust training program for safe packaging and transportation of samples to the SLPH. See **APPENDIX D: Laboratory Specimen Collection, Testing, and Transport**

Planning Assumptions

The following assumptions are made:

- By law (10A NCAC 41A .0201), North Carolina adopts CDC published guidance for infection prevention and control by reference.
- Horizontal and vertical partnerships will be established to include, but are not limited to appropriate federal, state, local, private and non-governmental organizations.
- Healthcare system planning is required to include patient screening, evaluation, isolation, transfer protocols, equipment, training and staffing needs, EMS transport protocols, and coordination with outpatient/ambulatory care facilities.
- Healthcare system (Public Safety Answering Points, Emergency Medical Services, Emergency Departments, Hospitals, Ambulatory Care, and other clinical settings) must be able to identify persons presenting with a travel history or exposure history compatible with communicable diseases of consequence and be prepared to isolate patients, provide basic supportive care and inform/consult with public health officials
- Many high consequence pathogens will not have an active monitoring program. People at risk may not be identified until actually symptomatic.
- Suspected or confirmed EVD and high consequence pathogens patients will access the healthcare system through various points of entry.
- Active monitoring (AM) may be in place when available to identify at risk persons with early symptoms of EVD and high consequence pathogens.
- All healthcare organizations fall into one of the three tiers of this system: frontline healthcare facilities, assessment hospitals and treatment centers.

Concept of Operations

Overview

The concept of operations for all healthcare workers in North Carolina is to be prepared to identify potential person(s)/patient(s) with suspected or confirmed EVD (hereafter referred to as Person Under Investigation PUI), rapidly and appropriately isolate the PUI and inform internal team members and external stakeholders of the PUI. The concept of operations for NC DPH, NC HPP, NCEM and other state-level partners is to minimize the potential spread of EVD or other high consequence pathogens in North Carolina through the mobilization of local, state, and federal resources to effectively identify the threat, isolate it, inform responders and transportation the patient to a definitive level of care.

Critical Tasks include:

- Train Healthcare Workers Across North Carolina on Identify, Isolate and Inform

- Identification through ongoing surveillance and early detection methods
- Tracking through case investigation of persons-at-risk
- Monitoring of identified Persons Under Investigation (PUI)
- Transport of PUI for assessment
- Isolation and assessment of PUI
- Transfer of PUI for treatment

Surveillance

Surveillance is a routine activity, encompassing the tasks of identification, tracking, and monitoring of persons-at risk. In most cases of a high consequence pathogen, a population may be suspected of being at risk but individuals within that population in North Carolina may not be known.

Assessment Phase

The assessment phase begins with the receipt of a notification to CDB and/or EPI On-Call of a person within North Carolina with relevant exposure history and signs or symptoms consistent with EVD (Person Under Investigation - PUI) or through the notification of a returning traveler from areas with active EVD transmission (Monitored Person - MP).

Notification of a Person Under Investigation

Public Health & Healthcare facilities across North Carolina who identify a PUI should contact EPI On-Call for consultation and assistance with completing a risk assessment to determine potential risk of EVD and to determine if EVD laboratory testing is indicated.

EPI On-Call is a 24/7 system that is answered M-F from 0800-1700 and a monitored voicemail line that is checked by CDB staff after hours. Every effort is made to return calls quickly, but public health & healthcare facilities should be prepared to wait 15-30 minutes to receive a call back. For emergent concerns, PHP&R can be contacted at 888-820-0520, however the notification still must be made to EPI On-Call to facilitate the risk assessment.

Potential EVD Patient Notification:	
DPH/State CDB Epidemiologist On-Call	919-733-3419

If EVD testing is indicated this will trigger the Response Phase of this ConOps. If no testing is indicated, then public health and healthcare facilities should continue assessment and treatment of the patient to determine a potential diagnosis. If additional support is needed from CDB and/or HPP then the healthcare facility is responsible to request this additional support.

Returning Travelers

Notification of returning travelers are received through a variety of ways (e.g. emails/calls directly from Non-Governmental Organizations (NGOs), emails/calls from the Centers for Disease Control and Prevention (CDC), in addition to emails/calls directly from local health departments). As of August 2019, there is no required reporting for returning travelers from areas with active EVD outbreak and notification to CDB is made on a completely voluntary basis.

The assessment of a returning traveler will trigger an evaluation by CDB to determine if a patient is considered "No Known Exposure," "Low-Risk Exposure," or "High-Risk Exposure." If a patient is considered High-Risk Exposure, then testing for Ebola Virus Disease is considered indicated. If a patient is a Low-Risk or No Known Exposure, then a review of the case with the health department will be completed to determine if testing for Ebola Virus Disease is indicated. **APPENDIX E: Algorithm for Evaluation of the Returned Traveler**

If EVD testing is indicated this will trigger the Response Phase of this ConOps and this individual will be referred to as a PUI. If no EVD testing is indicated, then the returning traveler will receive information from the local health department on monitoring for symptoms of EVD and who to contact should they begin to experience symptoms. These individuals will be considered a Monitored Person (MP) for the remainder of their 21-day monitoring period unless they develop symptoms.

PHP&R is responsible for notifying HPP of these Monitored Persons along with the following information:

1. Risk Assessment Outcome (No Known Exposure, Low-Risk Exposure, or High-Risk Exposure)
2. Port of Entry
3. Final Destination
4. Any pertinent medical concerns

HPP is responsible for notifying the Healthcare Coalitions and Ebola Assessment Hospitals whose catchment areas include the Port of Entry and the Final Destination of this same information.

Risk Assessment Coordination Call

A key component of the assessment phase is a coordination call between the agencies involved in the risk assessment. These agencies include but are not limited to: Notifier/Monitor, EPI On-Call, State Epidemiologist or designee, CDB Representative and PHP&R Representative.

The purpose of this call is to gather information on the situation, confirm if case meets threshold of case definition, and determine further actions (e.g. EVD testing, ongoing

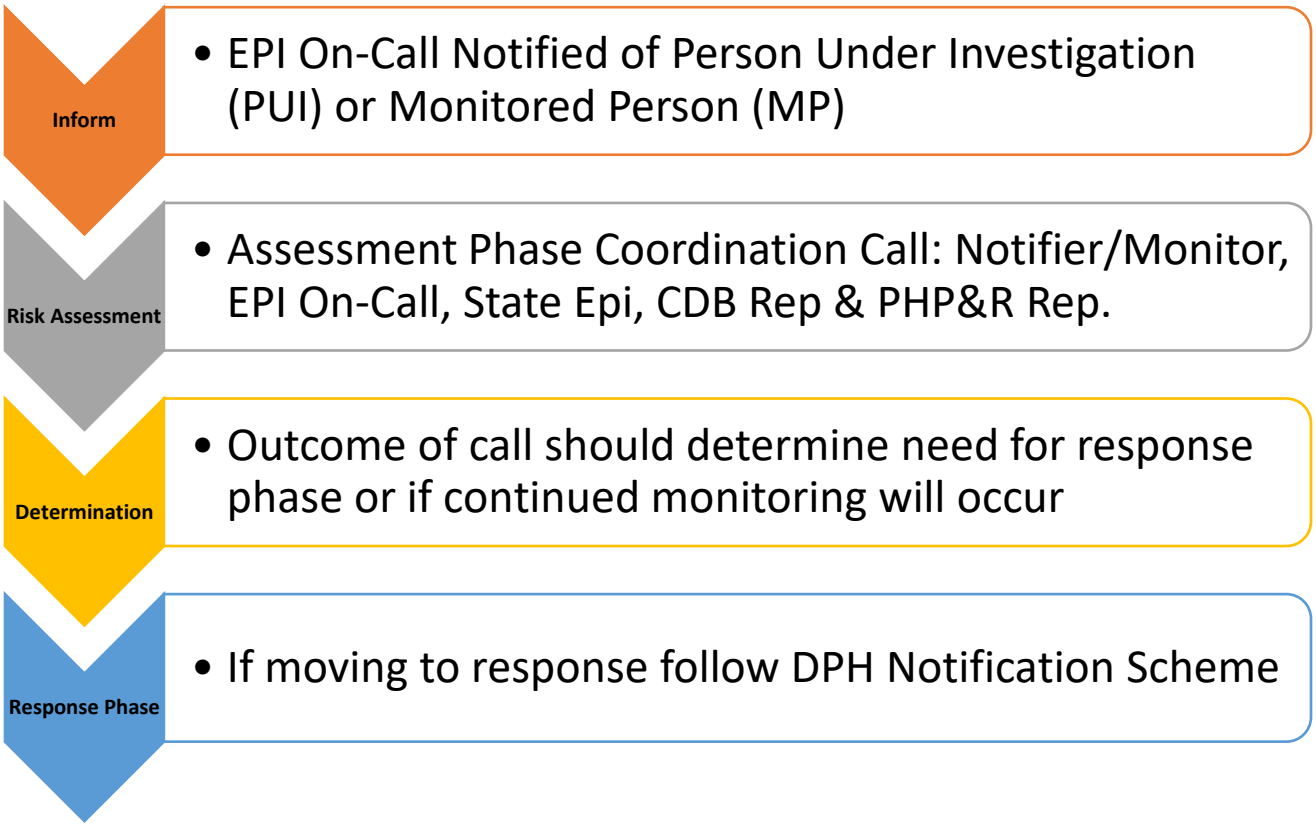
monitoring, other diagnostic tests etc.). A decision must be made whether or not to move to the response phase on this call.

If the decision is made to move into the response phase the following notifications are required:

- State Epidemiologist, or designee is responsible for notifying Case Location LHD and Case Destination LHD
- PHP&R is responsible for notifying HPP Program Manager or HPP Shift Duty Officer and NCEM Emergency Services Lead
- HPP is responsible for notifying Case Location and Destination Healthcare Coalition and Case Destination Ebola Assessment Hospital
- NCEM is responsible for notifying Case Location EM and Case Destination EM

APPENDIX F: DPH Notification Scheme

Assessment Phase Steps:



Response Phase:

The response phase begins when it is determined by NC State Epidemiologist, or designee, that a PUI within North Carolina has met the threshold of the case definition and requires testing for

EVD. The PUI's health and wellbeing along with protecting the public's health and the first responder's and healthcare worker's safety should be top priorities during the response phase.

A PUI may present in a variety of situations and locations when the response phase is first activated including but not limited to the following: Frontline Healthcare Facility, Assessment Hospital, EMS Encounter, Port of Entry, or private residence/hotel. Based on this, the specifics of each step of the response phase may vary however the following outlines the core key steps.

The response phase starts with a coordination call between all designated agencies from the assessment phase. The purpose of this call is for CDB/PHP&R to brief stakeholders on the situation and determine a plan for the medical management of the PUI.

PHIMT

Once the response phase has been activated, PHP&R in consultation with the CDB and the State Epidemiologist should determine when to assemble the Public Health Incident Management Team (PHIMT) to control and coordinate this incident. It is anticipated that a liaison from NCEM and HPP will be requested for the PHIMT. The PHIMT should operate out of the Public Health Coordination Center (PHCC) or alternate designated location until the situation either resolves or expands beyond the capacity of the PHCC. Activation of the State Emergency Operations Center (SEOC) should be requested upon confirmation from the SLPH that there is a confirmed EVD patient in North Carolina or when the coordination of partner agencies expands beyond NC DPH, NC EM and NC HPP.

EVD Assessment

The main goal of this step is to ensure the PUI is able to be medically assessed for EVD and other potential diagnoses. This step may involve the coordination of patient movement to an Ebola Assessment Hospital's containment unit. It is anticipated that the coordination of transportation assets will be a key component of this step. NC HPP has the responsibility for the coordination and communication between the Ebola Assessment Hospitals and the transportation agencies unless the transportation assets are coming from the EAH.

Laboratory Testing

The main goal of this step is to ensure that a specimen from the PUI suitable for state lab testing is obtained in a timely and safe manner. Transportation of the specimen to the State Laboratory of Public Health (SLPH) is the responsibility of the healthcare facility caring for the patient at the time the specimen is taken. Support and guidance for the healthcare facility will be provided by SLPH and PHP&R. SLPH will communicate with the CDC regarding any EVD labs requested of CDC. Notification, information sharing and coordination with ASPR Regional Emergency Coordinators (RECs) and the Georgia Department of Public Health should also be initiated.

Laboratory Results

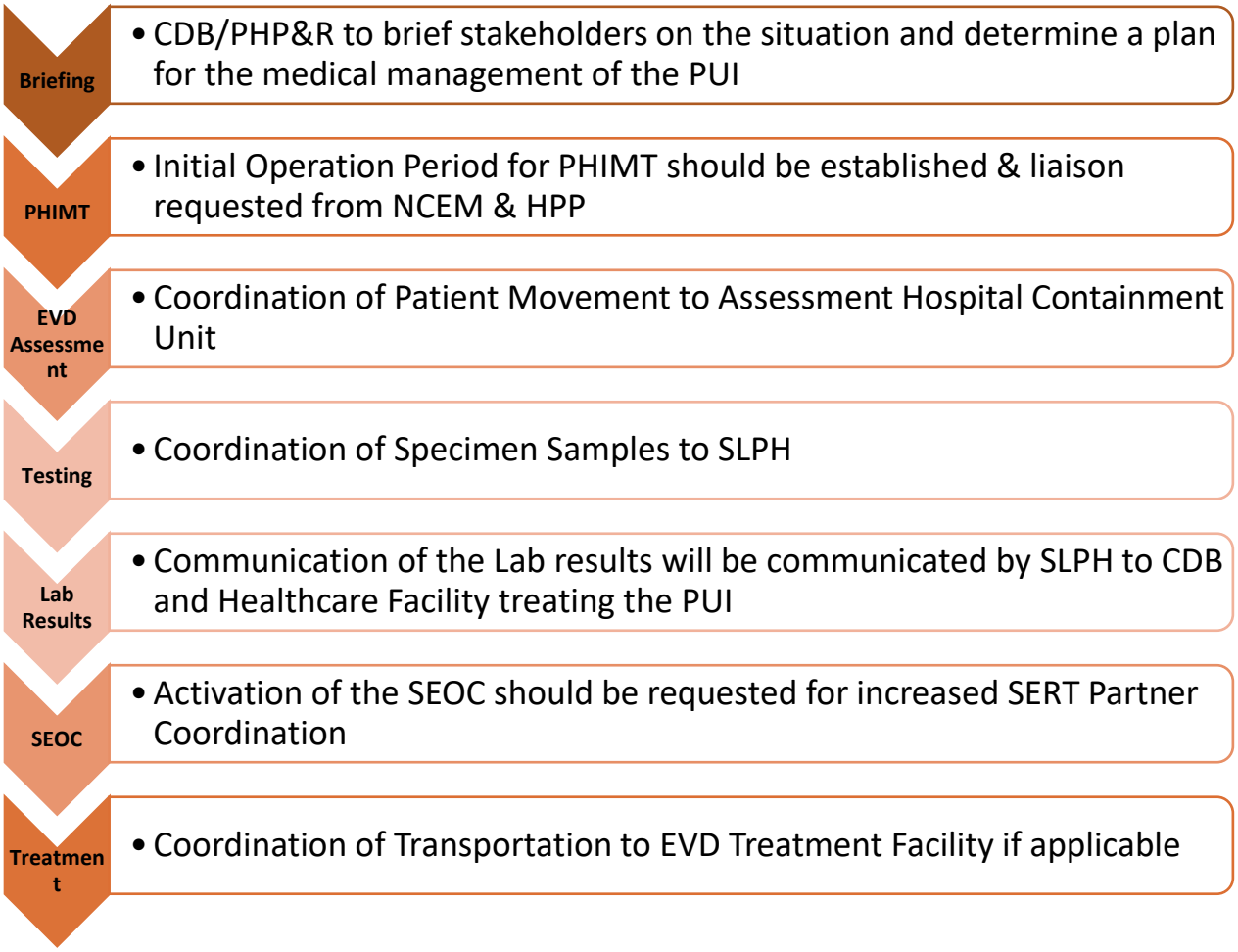
Once EVD tests have been performed at the SLPH then the results will be communicated to the PHIMT and the healthcare facility caring for the patient. Three possible outcomes from the initial results: Confirmed Negative; Retesting Required (a second sample collected 72 hours after onset of symptoms is required to definitively rule out Ebola) and or Presumptive Positive Result (confirmation required by CDC). It is anticipated that a coordination call will occur regardless of results to discuss next steps.

Transportation to EVD Treatment Facility

Once a PUI is confirmed positive for Ebola, the patient is transported to an Ebola Treatment Center (ETC) in accordance with the HHS Region IV Transport Plan. North Carolina does not have any identified ETCs so the coordination for transfer of the patient must follow the checklist outlined for patient transportation to an ETC within the HHS Region IV Transport Plan.

Appendix G: 2019_ASPR Region IV Ebola Transport Checklist

Response Phase Steps:



Appendix H: Response Phase Playbook

Environmental Care & Waste Management

Healthcare Settings

Within the local healthcare organizations, solid waste generated during the identification, assessment, and treatment of a patient in whom EVD or high consequence pathogen is suspected or confirmed is managed through that facility's existing hospital waste management and environmental care procedures. Waste management and environmental care capacity varies regionally but should meet the CDC's minimum standards for waste management and environment care; these standards are noted in **APPENDIX I: Procedures for Safe Handling and Management of Ebola-Associated Waste** and **APPENDIX J: Ambulance Decontamination SOG.** Healthcare organizations should coordinate with local public waste management agencies to assure compliance with local standards.

Non-Healthcare Settings

Contamination of the environment will be assessed on a case-by-case basis based on the patient's status and symptoms. If the patient is determined to have the potential to be contaminating to the environment, then the area will be secured and decontaminated by a previously vetted private vendor with oversight by state public health and emergency management. If the patient is determined not to be contaminating to the environment, then the patient is transported, and the area is released.

Patient Discharge Back to the Community

In the event the PUI does not test positive for EVD or another HCP, the patient will be discharged in accordance with an integrated plan for housing, monitoring, and continued follow-up. Discharge planning for return to the community will be accomplished on a case-by-case basis through coordination with state and local public health and emergency management agencies. Plans will consider continuity of medical care, communicable disease control measures and public messaging.

Fatality Management

Fatality management and the handling of remains will be guided by recommendations from CDC. Facilities for handling of multiple fatalities will be identified early in the event so that preparations can be made for infection control practices and appropriate handling of remains. This will be accomplished through state, local and public-private partnerships. This process will be coordinated through DPH, local, and private entities.
APPENDIX K: Mortuary Guidance Job Aid: Postmortem Preparation in a Hospital Room

Organization and Assignment of Responsibilities

In order to coordinate the complex response to EVD and high consequence pathogen in a system-wide manner, roles and responsibilities have been identified.

Local Agencies

Local Health Departments (LHDs)

- Develop and implement plans for contact tracing, symptom monitoring, local containment measures and public information to provide the general public with appropriate information
- Provide active monitoring (AM) of potentially exposed individuals
- Perform contact tracing

- Coordinate with local response partners and healthcare organizations.

Public Safety Answering Points (PSAP)

- Adopt and utilize statewide protocols for screening and identification of individuals at risk for effective dispatching of local Emergency Medical Services to the community
- Provide initial screening of individuals at risk
- Provide notification to Local Emergency Medical Services and dispatch EMS unit(s) as appropriate to the situation

Local Emergency Medical Services

- Adopt and utilize statewide protocols for Isolate, Identify and Inform when responding to individuals at risk for Ebola Virus Disease (EVD)
- Ensure personal protective equipment is available and ensure all responding providers are properly trained in donning, doffing, and appropriate disposition.
- Provide EMS unit(s) necessary for the transportation of patient from communities to designated Healthcare Organizations
- Ensure capability for proper decontamination of transport ambulance, medical equipment and personnel.
- Comply with State/Local Health Department guidelines on EMS provider observation following the transport.

Healthcare Organizations

- Provide initial patient triage at points of entry, while ensuring protection of other patients.
- Provide minimal screening per facility based on local ability for EVD or other high consequence pathogen.
- Utilize established plans for the:
    - Isolation and quarantine of patients under investigation (PUI)
    - Care and protection of PUI and caregivers
    - Transportation of PUI between FHF and AH
    - Sharing of resources necessary for the isolation, care, and transport of PUI between healthcare organizations

North Carolina Airports

- Participate in planning of air transportation of PUI to designated Treatment Facilities
- Provide support for the transfer of PUI between Healthcare Organizations and federally-contracted air medical services on airport property

State Agencies

DPH

- Provide technical assistance and guidance on the surveillance, investigation, and

screening of individuals, performance of contact tracing, environmental safety, infection control measures, and community outreach. **APPENDIX L: Ebola Guidance for Non-Hospital Healthcare Facilities**

- Provide laboratory capacity for testing clinical samples of potentially exposed individuals who have symptoms consistent with communicable diseases of consequence where testing is available.
- Support the coordination of healthcare organization identification for transport.
- Facilitate information sharing among agencies.
- Implement CDC recommendations for response and control including:
    - Coordination of the outbreak investigation
    - Patient medical consultation, treatment, and movement, when necessary

OEMS

- Provide technical assistance and guidance to local EMS agencies and healthcare organizations involved in the CONOPS. **APPENDIX M: SC-1 Suspected Ebola EMS Protocol**
- Assist with the coordination and identification of assessment and treatment facilities.
- Facilitate information sharing between OEMS, healthcare coalitions, healthcare organizations, NCEM, DPH, and ASPR.
- Facilitate resource sharing and other medical surge support to affected Healthcare Organizations through regional Healthcare Coalitions as necessary.
- Coordinate with DPH, Healthcare Organizations, and EMS systems concerning appropriate transportation method and healthcare organization location based on presented case(s).

DHHS Communications Office

- Develop public information messages and oversee public health information efforts.
- Coordinate with print, radio and electronic media outlets for public information messaging and announcements

NCEM

- Coordinate incident management of the State Emergency Response Team and/or relevant agencies.
- Coordinate law enforcement, emergency management and other first responder agency planning.
- Provide incident management and logistical support as needed.

North Carolina Department of Environmental Quality (DEQ)

Division of Solid Waste

- Provide technical assistance regarding the management and disposal of medical waste.

Wastewater Branch

- Provide technical assistance regarding waste water systems.

Federal Agencies

Responsibilities at the federal level are divided within the U.S. Department of Health and Human Services (HHS), to include CDC and the ASPR. The CDC will provide consultation and expertise for clinical care and subject matter experts for patient management. The ASPR and the HHS Secretary's Operation Center will be responsible for coordination and logistical considerations of any transport and treatment outside of North Carolina.

CDC

- Maintains an emergency operations center (EOC, 770-488-7100) 24 hours a day, 7 days a week for direction and control, communications, and information collection, analysis, and dissemination.
- Provides epidemiologic consultation for the determination of risk factors for illness and development of prevention and control strategies.
- Provides on-site assistance (e.g., Epidemiologic Assistance or "Epi-Aid upon request for urgent public health responses and investigations.
- Provides reference diagnostic support to state public health laboratories, direct laboratory testing, and confirmatory capability beyond state laboratory capacity.

ASPR

- Acts as a liaison and manages federal agencies engaged in interstate transport.
- Requests air transport services from the U.S. Department of State (DOS).
- Provides interstate and interagency communications about the need for transfer of potential EVD or high consequence pathogen patient.
- Assists with air and ground transportation logistics.
- Facilitates communication among all agencies and individuals about incoming patients.
- Facilitates logistics when appropriate; ensure secondary logistics are considered (e.g., law enforcement escort).
- Facilitates conference call with all parties involved when arrangements are complete and prior to arrival.
- Assists with patient return to home state as necessary.
- Provides education and training opportunities through the National Ebola Training and Education Center (NETEC).

Joint Information Center

Public Information Dissemination

The Joint Information Center (JIC) can be either a physical or virtual operation setup to ensure that the information released to the public is coordinated through local, state, and hospital authorities/public information officers (PIO). The JIC should have representation from all agencies and organizations involved in the assessment and response phases of this ConOps. If a physical JIC is determined to be necessary, it should be coordinated through the PHIMT at the PHCC or through the SERT at the SEOC.

The main responsibility of the JIC is to:

a. Coordinate with PIOs from all agencies and organizations involved in the response
b. Disseminate public information when necessary
c. Coordinate between all agencies and organizations involved to ensure accurate and current information is provided

Glossary of Acronyms

ABHR – Alcohol-based hand rub
AH – Assessment Hospital
AM – Active Monitoring
ASPR – Assistant Secretary for Preparedness and Response
CDB - Communicable Disease Branch
CDC – Center for Disease Control
CONOPS – Concept of Operations
DEQ – Department of Environmental Quality
DHSR – Division of Health Service Regulation
DM – Direct Monitoring
DOS - U.S. Department of State
DPH – North Carolina Division of Public Health
DPS – Department of Public Safety
EIS - Epidemic Intelligence Service
EOC – Emergency Operations Center
EOP – State Emergency Operations Plan
EPA – Environmental Protection Agency
ESF-8 – Emergency Support Function 8 (Health and Medical)
ESG – Emergency Services Group
ETC – Ebola Treatment Center
EVD – Ebola Virus Disease
FHF – Frontline Healthcare Facility
HCP – High Consequence Pathogen
HHS - U.S. Department of Health and Human Services
HPC – Healthcare Preparedness Coordinator or Healthcare Preparedness Coalition
LHD – Local Health Department
LRN - Laboratory Response Network
MCI – Mass Casualty Incident
MMA - Mutual Aid Agreement
NCEM – North Carolina Emergency Management
NETEC - National Ebola Training and Education Center
NGO - Nongovernmental organizations
OCME - Office of Chief Medical Examiner
OEMS – Office of Emergency Medical Services
OSHA – Occupational Safety and Health Administration
PIO – Public Information Officer
PHP&R - Public Health Preparedness & Response
PPE – Personal Protective Equipment
PSAP – Public Safety Answering Points
PUI - Patient Under Investigation
RCC – Regional Coordination Center
REC - Regional Emergency Coordinator

REP - Rapid Ebola Preparedness
RETF – Region IV EVD Treatment Facility
SEOC – State Emergency Operations Center
SERT – State Emergency Response Team
SLPH - State Laboratory of Public
SMRS – State Medical Response System
SOG - standard operating guide
TC – Treatment Center
U. S. DOT HMR – United States Department of Transportation Hazardous Materials Regulations
VOAD – Volunteer Organization Active in Disasters

EVD ConOps Appendices:

APPENDIX A: HCC Regions

APPENDIX B: State Medical Response System Resource Request Process

APPENDIX C: Identify, Isolate and Inform: Ambulatory Care Evaluation of Patients with Possible EVD

APPENDIX D: Laboratory Specimen Collection, Testing, and Transport

APPENDIX E: Algorithm for Evaluation of the Returned Traveler

APPENDIX F: DPH Notification Scheme

APPENDIX G: 2019_ASPR Region IV Ebola Transport Checklist

APPENDIX H: Response Playbook

APPENDIX I: Procedures for Safe Handling and Management of Ebola-Associated Waste

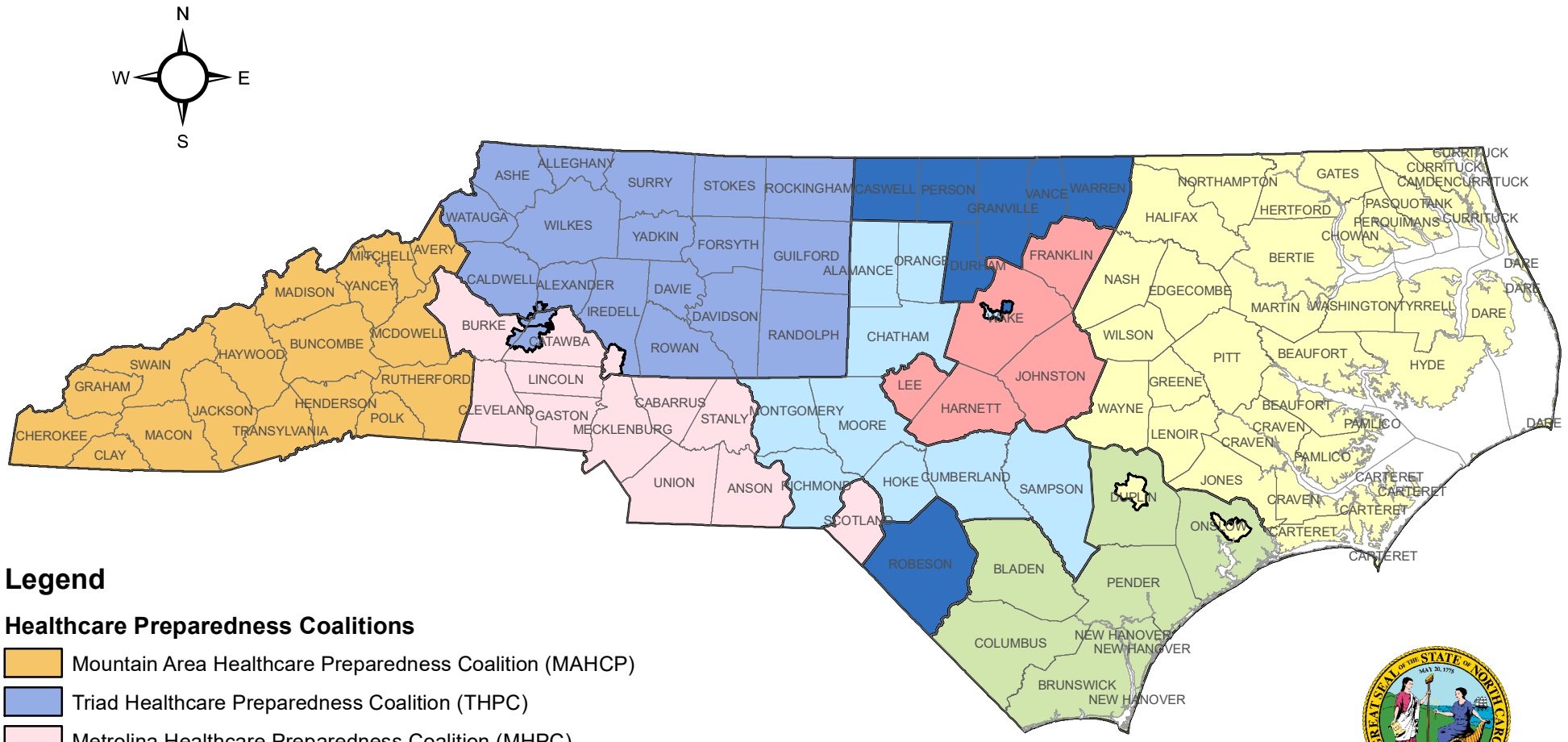
APPENDIX J: Ambulance Decontamination SOG

APPENDIX K: Mortuary Guidance Job Aid: Postmortem Preparation in a Hospital Room

APPENDIX L: Ebola Guidance for Non-Hospital Healthcare Facilities

APPENDIX M: SC 1 Suspected Ebola Protocol for EMS

Healthcare Preparedness Coalitions



Legend

Healthcare Preparedness Coalitions

- Mountain Area Healthcare Preparedness Coalition (MAHCP)
- Triad Healthcare Preparedness Coalition (THPC)
- Metrolina Healthcare Preparedness Coalition (MHPC)
- Duke Healthcare Preparedness Coalition (DHPC)
- Mid Carolina Regional Healthcare Coalition (MCRHC)
- Capital RAC Healthcare Preparedness Coalition (CapRAC HPC)
- Eastern Healthcare Preparedness Coalition (EHPC)
- Southeastern Healthcare Preparedness Region (SHPR)

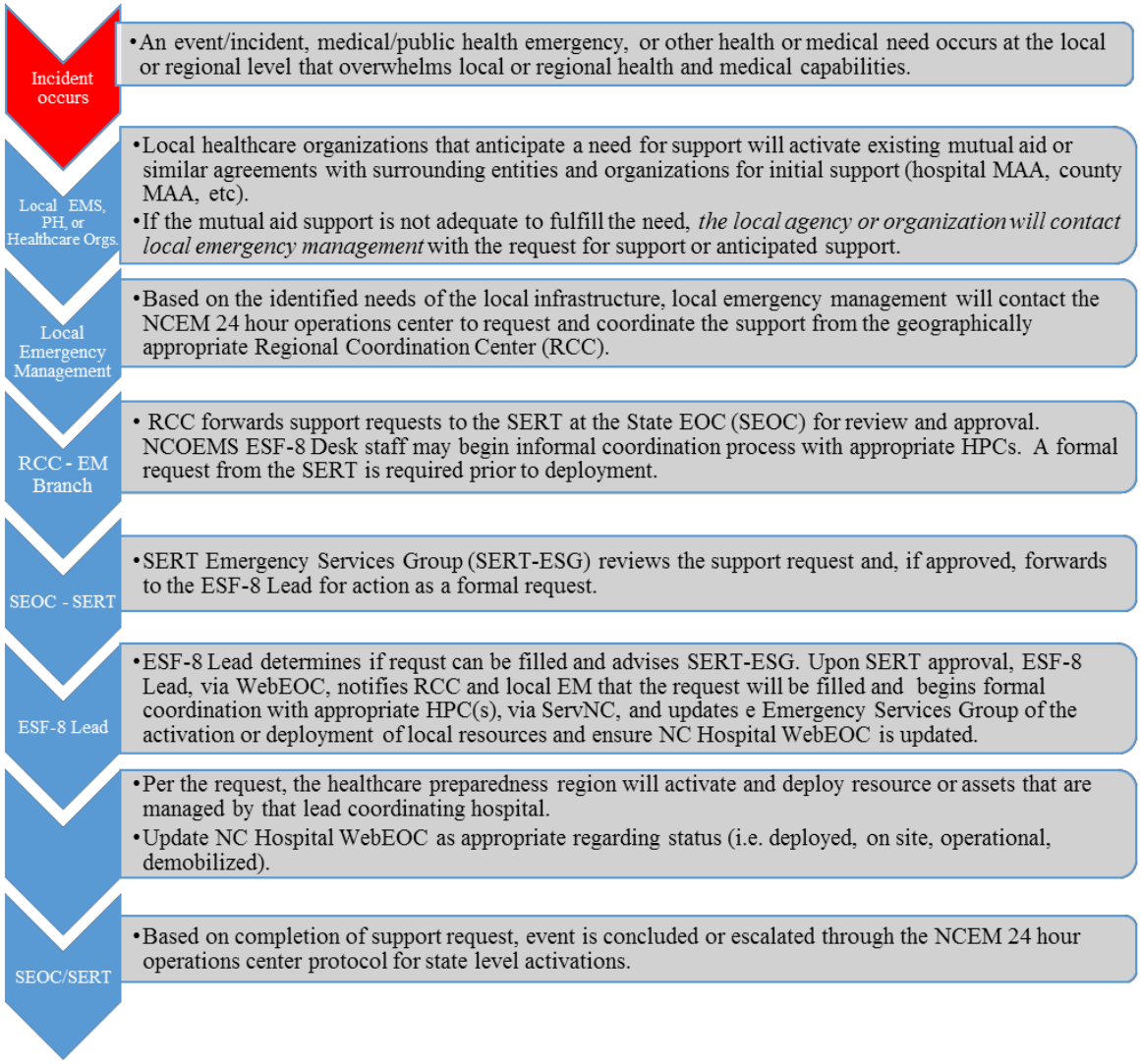
0 50 100 Miles

This map was prepared for inventory and graphical purposes only and does not represent a legal survey. This map is not intended to and does not indicate the authoritative location of property boundaries, rights-of-way, easements, shape or contour of the earth, or fixed works.
\AGRGIS\Projects\DHHS\OEMS\Other_Projects_20192020

APPENDIX B: North Carolina State Medical Resource System Health and Medical Resource Request Algorithm

When an event/incident occurs or is expected to occur, that affects or is anticipated to stress or overwhelm local health and medical capacity/capability of a jurisdiction, decisions to initiate requests for SMRS health and medical resource support will be made by local authorities and organizations in coordination with the local emergency management agency. The process for obtaining SMRS health and medical assets and resources statewide is detailed below.

Events requiring support may be: physical plant/facility failure, local MCI, surge or other health or medical event; incident causing evacuation or facility damage, etc. For incidents or events that overwhelm the local healthcare infrastructure, mutual aid resources should be initially utilized. For events that exceed the capability of local and regional mutual aid assets and resources, escalation of the support request should be submitted via established North Carolina Emergency Management processes.



Identify, Isolate, Inform: Ambulatory Care Evaluation of Patients with Possible Ebola Virus Disease (Ebola)

North Carolina Public Health

For 24/7 consultation, contact the NC DPH Communicable Disease Branch at:
(919) 733-3419

The majority of returning travelers with fever in ambulatory settings do not have Ebola Virus Disease (Ebola), and the risk posed by Ebola patients with early, limited symptoms is lower than that from a patient hospitalized with severe disease. Nevertheless, because early Ebola symptoms are similar to those seen with other febrile illnesses, triage and evaluation processes should consider and systematically assess patients for the possibility of Ebola.

1 Identify travel and direct exposure history:
Has patient lived in or traveled to a country or geographic area within a country with an ongoing Ebola outbreak† or had contact with an individual with confirmed Ebola Virus Disease within the previous 21 days?

NO → Continue with usual triage, assessment, and care

YES

2 Identify signs and symptoms:
Fever (subjective or 100.4°F or 38.0°C) or any Ebola-compatible symptoms: fatigue, severe headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage

NO →
A. Continue with triage, assessment and care
B. Contact NC DPH CDB about asymptomatic persons with travel AND exposure histories unless known to be under monitoring by another entity (e.g., NGO).

YES - Patient may meet criteria for Person Under Investigation for Ebola*

3 Isolate patient immediately: Avoid unnecessary direct contact

- Place patient in private room or area, preferably enclosed with private bathroom or covered commode.
- Avoid unnecessary direct contact.
- If direct contact is necessary, personal protective equipment (PPE) and dedicated equipment must be used to minimize transmission risk.
- Only essential personnel with designated roles should evaluate patient.
- If patient is exhibiting obvious bleeding, vomiting or copious diarrhea, then do not re-enter room until personnel trained to transport Person Under Investigation for Ebola arrive.
- Do not perform phlebotomy or any other procedures unless urgently required for patient care or stabilization.
- Consult with the NC DPH CDB before cleaning up blood or body fluids. Any reusable equipment should not be reused until it has been appropriately cleaned and disinfected.*

AND

4 Inform NC DPH CDB and prepare for safe transport.

- Prepare for transfer to a hospital identified by the health department for evaluation of possible Ebola.
- Coordinate with NC DPH CDB regarding:
  - Who will notify the receiving emergency department or hospital about the transfer, and
  - Arrangements for safe transport to accepting facility designated by public health officials.

Do not transfer without first notifying the NC DPH CDB.

PPE in the ambulatory care setting:**

- No one should have direct contact with a Person Under Investigation for Ebola without wearing appropriate personal protective equipment (PPE).
- If PPE is available and direct patient contact necessary, a single staff member (trained in proper donning and removal of PPE) should be designated to interact with the Person Under Investigation.
- At a minimum, health care workers should use the following PPE before direct patient contact:
  A. Face shield & surgical face mask,
  B. Impermeable gown, and
  C. Two pairs of gloves.
- The designated staff member should refrain from direct interaction with other staff and patients in the office until PPE has been safely removed in a designated, confined area. Donning and particularly doffing of PPE should occur with a monitor. Examples of safe donning and removal of PPE should be reviewed: **www.cdc.gov/vhf/ebola/healthcare-us/ppe/training.html**

NOTE: Patients with exposure history and Ebola-compatible symptoms seeking care by phone should be advised to remain in place, minimize exposure of body fluids to household members or others near them, and given the phone number to notify the local health department. The ambulatory care facility must also inform the local health department and NC DPH CDB. If the clinical situation is an emergency, the ambulatory care facility or patient should call 911 and tell transport personnel the patient's Ebola risk factors so they can arrive at the location with the correct PPE.

* Refer to **www.cdc.gov/vhf/ebola/** for the most up-to-date guidance on the **Case Definition for Ebola, Environmental Infection Control** and **Ebola-Associated Waste Management**.

** Refer to **www.cdc.gov/hai/settings/outpatient/outpatient-care-guidelines.html** for a summary guide of infection prevention recommendations for outpatient settings.

† Refer to **www.cdc.gov/vhf/ebola/** for updates to countries or geographic locations within countries with an ongoing Ebola outbreak.

U.S. Centers for Disease Control and Prevention: 2014 October 31 9:42PM, CS_252427 | Adapted by NC DPH (8/20/2019)

NC Department of Health and Human Services • Division of Public Health • Communicable Disease Branch
epi.publichealth.nc.gov/cd • NCDHHS is an equal opportunity employer and provider. 8/19

APPENDIX D: Laboratory Specimen Collection, Testing, and Transport

Ebola Virus Testing

- **Testing Employed at the North Carolina State Laboratory of Public Health (NCSLPH):** Specimens **will not** be accepted without prior consultation. The NCSLPH utilizes two CDC Ebola virus rRT-PCR assays (EBOV VP40 and EBOV NP) that have been granted FDA Emergency Use Authorization for the in vitro qualitative detection of Ebola virus RNA. Acceptable specimens for Ebola testing are listed in the table below. If the PUI's symptoms have been present for <3 days, a second sample collected 72 hours after onset of symptoms is required to definitively rule out Ebola. The estimated turn-round-time for NCSLPH results is 6 hours for a single specimen and up to 24 hours for multiple specimens. CDC testing can include: rRT-PCR with multiple primer probe sets for Ebola, tests for other hemorrhagic fever viruses, virus isolation, and serology when indicated by the clinical or epidemiological presentation.

- **CDC GUIDANCE FOR COLLECTION, TRANSPORT and SUBMISSION of SPECIMENS FOR EBOLA VIRUS TESTING** can be found at: https://www.cdc.gov/vhf/ebola/laboratory-personnel/specimens.html

- **USE APPROPRIATE PRECAUTIONS WHEN COLLECTING SPECIMENS FOR EBOLA TESTING**. Staff who collect specimens from PUIs should wear appropriate PPE and should refer to https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

- All specimen submissions must be accompanied by a completed **Bioterrorism and Emerging Pathogens (BTEP) Specimen Submission Form** (https://slph.ncpublichealth.com/Forms/5010-BT-EmergPathogens-20180508.pdf), a **CDC 50.34 DASH Form** (https://slph.ncpublichealth.com/Forms/CDC50-34DASHForm120517.pdf) and a **Viral Special Pathogens Branch Diagnostic Specimen Submission Form** (https://www.cdc.gov/ncezid/dhcpp/vspb/pdf/specimen-submission.pdf) when appropriate.

- Packaging of specimens should follow packing instruction 620, IATA guidelines for Category A, which utilizes a triple packaging system (https://www.cdc.gov/vhf/ebola/laboratory-personnel/shipping-specimens.html). We anticipate active discussion with all entities requesting diagnostic testing for Ebola and we will provide more specific guidance on a case-by-case basis.

Appropriate Specimens for Ebola rRT-PCR Testing at NCSLPH			
Specimen Type	Minimum Quantity	Testing	Transport
Whole blood with EDTA anticoagulant (purple top tube) in non-glass collection tube	➢ Adults 4ml ➢ Pediatric 1ml	rRT-PCR	Refrigerated (4°C), placed on cold packs. Package specimens using Category A guidelines.

Serum	➢ 3ml		
Plasma	➢ 3ml		
Urine*	➢ 3ml		
Appropriate Specimens for Testing Conducted at the CDC			
Uncoagulated whole blood (purple, yellow, or blue top) in non-glass collection tube	➢ 4ml	Culture, PCR	Refrigerated (4°C), placed on cold packs if shipment is to be received within 72 hrs. For delays exceeding 72 hrs. freeze serum at-70°C & ship on dry ice.
Serum (red top, collected in non-glass tube)	➢ 4ml	Culture, PCR, Serology	
Formalin-fixed or paraffin-embedded tissues	As Appropriate	Immuno-histochemistry	Ship at room temperature. Note: An autopsy or surgical report must accompany the specimen.
Fresh frozen tissue	1 cm^3 (except for biopsies)	Culture, PCR	Ship specimen frozen on dry ice in a plastic container.

*Urine will only be tested when it is submitted alongside a blood specimen from the patient.

- **CONTACT THE BTEP UNIT, 24/7 (919-807-8600), PRIOR TO ANY SHIPMENT OR IF YOU HAVE QUESTIONS.**
  Address all specimen shipments as follows:

  Attention: Bioterrorism & Emerging Pathogens Unit
  North Carolina State Laboratory of Public Health
  4312 District Drive
  Raleigh, NC 27607-5490

Routine Laboratory Testing on Suspect EVD Cases

- Clinicians should ensure that laboratory staff are aware if a diagnosis of EVD is being considered so that appropriate precautions can be taken in the laboratory when handling routine or diagnostic specimens.
- The NCSLPH encourages institutions to conduct an internal risk assessment to review all handling and testing procedures that are associated with specimens from a suspect Ebola case. The NCSLPH highly recommends the use of professional judgment to determine the need for enhanced safety precautions.
- The NCSLPH strongly recommends that laboratories consider the following guidelines for handling of routine laboratory specimens from persons under investigation for Ebola: CDC laboratory guidelines: https://www.cdc.gov/vhf/ebola/laboratory-personnel/safe-specimen-management.html.

Ebola Virus Disease (Ebola)

Algorithm for Evaluation of the Returned Traveler

For 24/7 consultation, contact the NC DPH Communicable Disease Branch at: **(919) 733-3419**

FEVER (subjective or >100.4°F or 38.0°C) or compatible Ebola symptoms* in a patient who has resided in or traveled to an area with active Ebola transmission** in the 21 days before illness onset

*headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage

NO → **Report** asymptomatic patients with high- or low- risk exposures (see below) in the past 21 days to the health department

YES

1. Isolate patient in single room with a private bathroom and with the door to hallway closed
2. Implement standard, contact, and droplet precautions (gown, facemask, eye protection, and gloves)
3. Notify other appropriate staff (e.g., hospital Infection Control Program)
4. Evaluate for any risk exposures for Ebola
5. IMMEDIATELY report to your local health department or the NC DPH Communicable Disease Branch (919-733-3419)

HIGH-RISK EXPOSURE

Percutaneous (e.g., needle stick) or mucous membrane contact with blood or body fluids from an Ebola patient

OR

Direct skin contact with, or exposure to blood or body fluids of, an Ebola patient

OR

Processing blood or body fluids from an Ebola patient without appropriate personal protective equipment (PPE) or biosafety precautions

OR

Direct contact with a dead body (including during funeral rites) in an area with active Ebola transmission** without appropriate PPE

LOW-RISK EXPOSURE

Household members of an Ebola patient and others who had brief direct contact (e.g., shaking hands) with an Ebola patient without appropriate PPE

OR

Healthcare personnel in facilities with confirmed or probable Ebola patients who have been in the care area for a prolonged period of time while not wearing recommended PPE

NO KNOWN EXPOSURE

Residence in or travel to an area with active Ebola transmission** without HIGH- or LOW-risk exposure

(Healthcare personnel who have provided care for Ebola patients while wearing appropriate PPE and no reported exposure incident)

Review Case with Health Department Including:

- Severity of illness
- Laboratory findings (e.g., platelet counts)
- Alternative diagnoses

Ebola suspected ↔ **Ebola not suspected**

TESTING IS INDICATED

The health department will arrange specimen transport and testing at a Public Health Laboratory and CDC

The health department, in consultation with CDC, will provide guidance to the hospital on all aspects of patient care and management

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TESTING IS NOT INDICATED

If patient requires in-hospital management:

- Decisions regarding infection control precautions should be based on the patient's clinical situation and in consultation with hospital infection control and the health department
- If patient's symptoms progress or change, re-assess need for testing with the health department

If patient does not require in-hospital management:

- Alert the health department before discharge to arrange appropriate discharge instructions and to determine if the patient should self-monitor for illness
- Self-monitoring includes taking their temperature twice a day for 21 days after their last exposure to an Ebola patient

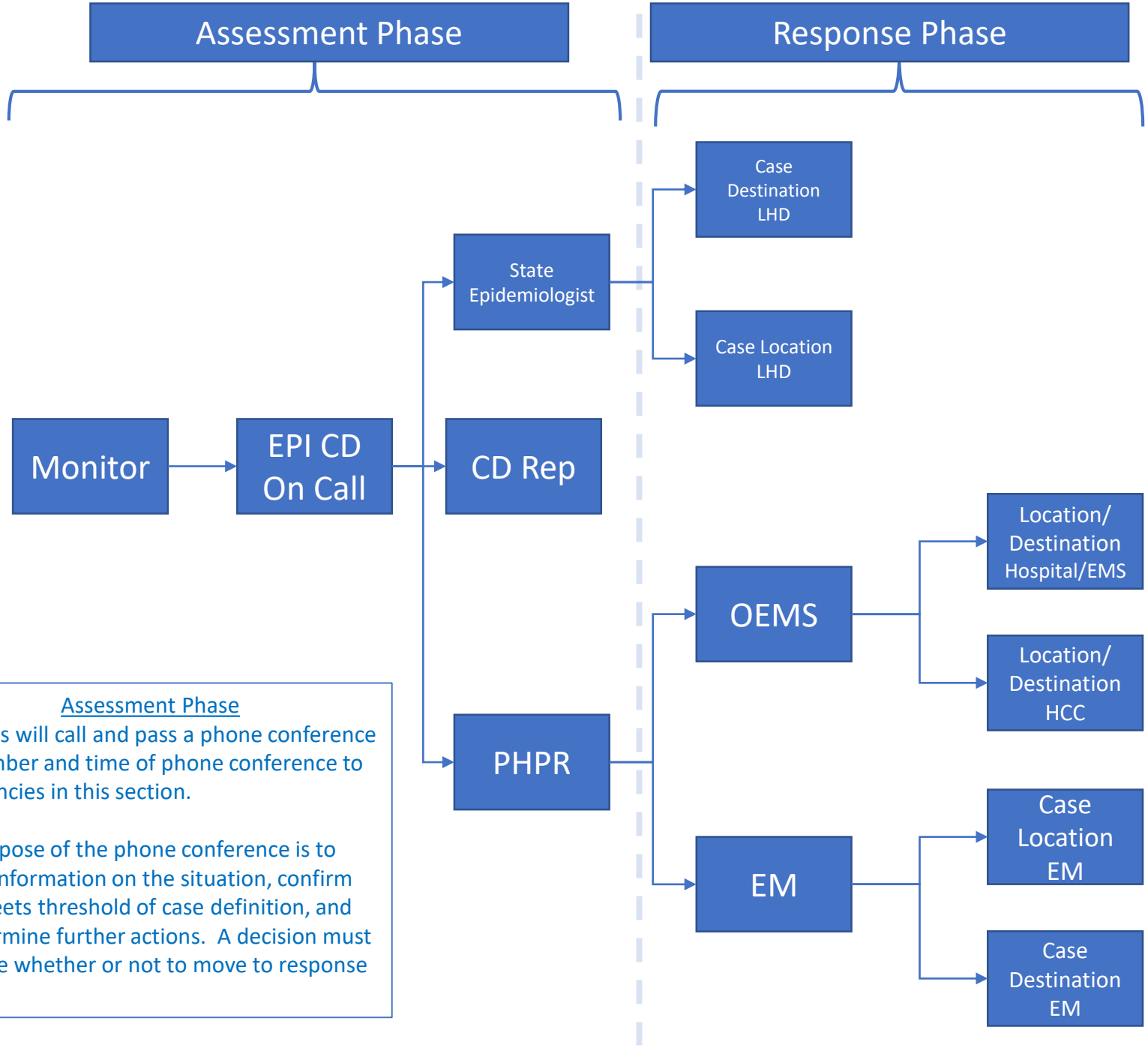
** CDC Website to check areas with active Ebola tranmission: www.cdc.gov/vhf/ebola/

This algorithm is a tool to assist healthcare providers identify and triage patients who may have Ebola. The clinical criteria used in this algorithm (a single symptom consistent with Ebola) differ from the CDC case definition of a Person Under Investigation (PUI) for Ebola, which is more specific. Public health consultation alone does not imply that Ebola testing is necessary. More information on the PUI case definition: www.cdc.gov/vhf/ebola/

U.S. Centers for Disease Control and Prevention CS251958-A
Adapted by NC DPH (11/20/2014) | Revised by NC DPH (1/14/2019)

NC Department of Health and Human Services • Division of Public Health • Communicable Disease Branch
epi.publichealth.nc.gov/cd • NCDHHS is an equal opportunity employer and provider. 01/2019

North Carolina Division of Public Health Ebola Virus Disease Alert and Notification Scheme 25 August 2018



Assessment Phase

Agencies will call and pass a phone conference call number and time of phone conference to the agencies in this section.

The purpose of the phone conference is to gather information on the situation, confirm case meets threshold of case definition, and to determine further actions. A decision must be made whether or not to move to response phase.

Response Phase

Designated agencies from the verification phase will call and pass a phone conference call number and time of phone conference to the agencies in this section.

The purpose of this phase is to conduct a phone conference to brief stakeholders on the situation, and determine a plan for the medical management of the case.

Checklist for Movement of a Patient with Ebola Virus Disease (EVD) or other Highly Infectious Disease (HID)
HHS/ASPR Region IV

Step	Stage of Event	Responsible Party	Precipitating Event		Expected Actions
1	Identify - Isolate - Inform	Originating Local Healthcare Facility (HCF) or clinic	A suspicious patient has arrived to the facility	☐	Identify that a suspicious patient has arrived to the facility Begin appropriate steps to isolate and care for patient(s) ***Identify - Isolate - Inform***
		Originating Local HCF or entity that is caring for patient	Suspicious patient identified as potential person under investigation (PUI)	☐	Activate internal communication procedures
2	Notification	Originating Local HCF or entity that is caring for patient	Suspicious patient identified as potential PUI	☐	Follow state plan for notification of the Regional Epidemiologist (EPI)/Local Health Department (LHD)/State Health Department and provide a situation report with intended plan of care
		Originating Local HCF, Regional (EPI), and/or Local Health Department (LHD)	Regional EPI/Local Health Department (LHD)/State Health Department confirms suspicion of potential PUI	☐	Notify the State Department of Health if not completed in step above **Note** After hours, contact the On-Call EPI or the State Health Duty Officer Telephone numbers will vary by State
		Originating State Health Department	State Department of Health confirms suspicion of potential PUI	☐	Notify Regional Emergency Coordinator (REC) (may vary by state) of PUI and provide as much information as known. Information to provide: • Reason for suspicions: travel history, clinical presentation, lab findings, differential diagnoses • Demographics: Name, age, gender • Symptomology: active symptoms (wet/dry) • Travel history: countries visited OCONUS, and CONUS since returning
		Originating State Health Department	PUI confirmed in Region IV state	☐	Actions vary by State (follow normal state procedures) • Notify Health Department senior leadership • Activate the State Health Emergency Operations Center • Publish internal notifications as per state protocols (HAN alerts, Everbridge notifications- as State desires) • Schedule and conduct a conference call

		Region V collaboration with Originating State Health Department	PUI confirmed and notification within Region needs to occur	☐	Schedule and conduct the appropriate notification calls
					CONFERENCE CALL #1 - NOTIFICATION CALL
					NOTIFICATION CALL AGENDA:
					• Describe the current situation
					• Verbalize patient presentation
					  ○ Symptoms
					  ○ Travel history for last 21 days (CONUS AND OCONUS)
					  ○ Ambulatory or non-ambulatory
					• Identify current treatment being provided
					• Discuss lab specimens collected and disposition of those samples
					  ○ Transportation of lab specimens to appropriate locations
					  ○ Time to lab results returned/completed
					• Discuss medical care and treatment protocols for the patient while at originating healthcare facility
					  ○ Consult with Regional Treatment Center (RTC) medical team
					  ○ Consult with Center for Disease Control and Prevention (CDC) as needed
					• Determine the need for additional medical support
					• Discuss what type of transport method may be needed to move the patient(s)
					• Determine the time to conduct the next call
					• Thoughts on transportation preferences
					SUGGESTED PARTICIPANTS: (will vary by state)
					✓ *Originating State Health Department Leadership (Incident Management personnel)*
					✓ *Originating State Health Department Duty Officer*
					✓ *Originating State EPI*
					✓ *Originating healthcare facility that is treating patient*
					✓ *Regional EPI/Local Health Department*
					✓ *Local or State Laboratory where EBV testing will occur*
					✓ *HHS REC – will vary by State*
					✓ *CDC Consultation Team*

3	EBV Confirmation	Local or State Health Laboratory	Labs are sent by Originating Local Healthcare Facility (HCF)	☐	Receive and begin laboratory testing of specimens as requested
		Local or State Health Laboratory	Labs are tested	☐	Notify originating healthcare facility, Local and/or State Heath Department of specimen results
		Local or State Health Laboratory	Secondary confirmation by CDC required	☐	Send additional laboratory specimen to CDC for additional confirmation

		CDC Consultation Team	State lab sends specimen to CDC	☐	Ensure confirmatory specimen have arrived to CDC for processing and notify the state health department
		CDC Consultation Team	Specimen received by CDC	☐	Confirm results and provide consultation services to originating state, as needed
		Originating State Health Department	Positive result received	☐	Call **1-866-PUB-HLTH (866-782-4584),** Georgia Department of Public Health (GDPH) • Ask for the Med Epi Officer on call • Provide information about suspected patient and relay the need for transport to a RTC
		Originating State Health Department	Positive result received	☐	Schedule and conduct a conference call to report laboratory results. **CONFERENCE CALL #2 – EBV CONFIRMATION CALL** **EBV CONFIRMATION CALL AGENDA:** • Describe lab specimen results received • Identify differential diagnoses • Identify additional support (i.e., PPE, SME, staff) needed at originating healthcare facility • Determine the time to conduct the next call **SUGGESTED PARTICIPANTS: (will vary by state)** ✓ *Originating State Health Department's Leadership/Incident Management personnel* ✓ *Originating healthcare facility staff (physician, nursing, Incident Management personnel)* ✓ *Originating State Laboratory personnel* ✓ *Originating State EPI/ Regional EPI/Local Health Department* ✓ *HHS REC* ✓ *Georgia Department of Health Leadership* ✓ *Georgia Department of Health EPI* ✓ *CDC Consultation Team*
4	Transportation Decision	HHS Region IV REC	A potential need for state to state air transport is identified	☐	REC contacts HHS ASPR State Department Liaison to determine availability of an US State Department contracted aircraft for transportation of a PUI to a RTC
		HHS Region IV REC	State Department logistics need to be determined for air transport	☐	REC calls ASPR HQ and State Department to discuss logistics of potential air transportation (small federal call)
		HHS Region IV REC	Air transportation is available	☐	REC confirms availability of air transportation availability from US State Department
		HHS Region IV REC	RTC bed availability required	☐	REC call with GDPH 1-866-PUB-HLTH (866-782-4584) to confirm the availability of a bed at Emory University Hospital
		Georgia Department of Health	RTC bed availability required	☐	GDPH contacts Emory University Hospital to verify bed availability

		Georgia Department of Health	Bed at Emory University Hospital is available	☐	GDPH confirms bed availability with Emory
		Georgia Department of Health	Bed at Emory University Hospital is available	☐	GDPH notifies the HHS Region IV REC of bed availability
		HHS Region IV REC	Bed at Emory University Hospital is **NOT** available	☐	If a bed at Emory University Hospital is NOT available, identify alternate RTC through the federal process and with consultation from the National Ebola Training and Education Center (NETEC)
		Originating State Health Department in collaboration with the HHS Region IV REC	Bed is available and transportation to an RTC is required	☐	As part of a team assessment, discuss the transportation options (both air and ground) Schedule and conduct a conference call to discuss best transportation option, air vs ground **CONFERENCE CALL #3 – TRANSPORTATION DECISION CALL** ***Air transport considerations:*** • Air transportation is available and is the preferred method ***Ground transport considerations:*** • The patient is located within the four (4) hour ground transport time of the RTC - EUH • Phoenix Air is unavailable (confirm if unavailability is long-term or short-term) • Consider: if wait time for Phoenix Air is less than total ground transport time, patient condition, and facility capability, transport services (states) capabilities (discuss possibility of sending a ground transport assistance team) • Weather conditions warrant ground transport **TRANSPORTATION DECISION CALL AGENDA:** • Discuss best transportation method: ○ Transport time durations from current location to RTC ○ Weather status at originating and receiving locations ○ Patient fitness for travel ○ Type of aircraft necessary and its availability ○ Airport determination at originating and receiving locations (Flight Services location on airport property) ○ Ground transportation route to be taken ○ Transfer Point discussions ○ Number of individuals to be transported (patient, Non-medical attendant) ○ Identify time to next calls (clinician's call and transportation coordination calls)

					• REC confirms to originating State Health Department that air transport will commence **SUGGESTED PARTICIPANTS: (will vary by state)** ✓ *Originating State Health Department's Leadership/Incident Management personnel* ✓ *Originating healthcare facility staff (physician, nursing, Incident Management personnel)* ✓ *Georgia Department of Health Leadership* ✓ *HHS Region IV REC* ✓ *CDC Consultation Team* ✓ *HHS RECs in the NCR and R-VII*
	Air Transport Decision	HHS Region IV REC	Air transportation mode is determined as the best option	☐	Begin air transport coordination calls
			Contracted air provider confirmed	☐	Request flight itinerary from US State Department
			Itinerary received from DoS	☐	Provide air itinerary to originating and receiving facilities when received
	Ground Transport Decision	HHS Region IV REC	Ground transportation mode is determined as the best option	☐	REC will coordinate a call between GDPH, originating state, and pass through state(s) public health departments to notify respective jurisdiction(s) of the transfer and discuss each states/agencies requirements
5	Inter-Facility Clinical Coordination	HHS Region IV REC	Patient is to be transferred to RTC	☐	Schedule and conduct a conference call to discuss the inter-facility clinical coordination between all partners **CONFERENCE CALL #4 – INTER-FACILITY CLINICAL COORDINATION CALL** **This is a limited call and by invitation only to ensure patient personal information (PII) protection.** **INTER-FACILITY CLINICAL COORDINATION CALL AGENDA:** • Exchange patient information between originating healthcare facility staff and receiving facility staff • Brief out current patient status ○ history of illness; ○ relevant past medical history including vaccination history and date of vaccination, as applicable; ○ ambulatory or non-ambulatory ○ active signs/symptoms (wet/dry) ○ medical treatments/actions performed or in process and patient response ○ treatment plan/protocols in process or anticipated

					• Personal Protective Equipment (PPE) for clinicians and transportation crew(s) at originating and receiving facilities; • Medical Records to be sent to receiving facility (hard copy) • Health and risk communications plans at originating and receiving facilities • Transport concerns to be addressed • Determination for additional calls (also based on actual transport times) • Additional questions/needs to be addressed (either originating or receiving facilities) **SUGGESTED PARTICIPANTS: (will vary by state)** ✓ *Originating and receiving State Health Departments/ESF8 representatives* ✓ *Originating healthcare facility staff (physicians, nurses, invited staff)* ✓ *RTC clinical team (physicians, nurses, invited staff)* ✓ *HHS (RECs* ✓ *ASPR State Department Liaison* ✓ *US State Department Medical Officer* ✓ *Air transport provider medical team* ✓ *Ground Transport provider medical team* ✓ *CDC Consultation Team* ✓ *National Ebola Training and Education Center (NETEC) representative* ✓ *State EPI originating and receiving states (optional)*
6	Transportation Logistics Coordination	HHS Region IV REC	Logistical coordination of transport is required	☐	Schedule and conduct a conference call to discuss the transportation logistics of the transport with all pertinent partners **CONFERENCE CALL #5 – TRANSPORTATION LOGISTICS COORDINATION CALL 1** **TRANSPORTATION COORDINATION CALL (1st Logistics) AGENDA:** ✓ **IF TRANSPORTING BY AIR** ○ Report patient fitness for travel ○ Validate receipt of air itinerary from US State Department ○ Identify airport to be used (including flight services location) at originating location ▪ Airport Manager name and phone number ▪ Flight Services location and phone numbers ▪ Fuel availability and type ○ Transportation from originating healthcare facility to originating airport (airfield A) ▪ Determine transportation route ▪ Confirm transportation provider (EMS/ambulance) from originating location

					▪ Confirm law enforcement escort from originating location ▪ Identify rally points for EMS and Law enforcement on originating healthcare facility property o Identify and coordinate patient transportation needs ▪ Medical Records (hard copy) ▪ PPE for crew ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) o Transportation from receiving airport (airfield B) to RTC ▪ Determine transportation route to RTC ▪ Confirm transportation provider (EMS/ambulance) from airfield B ▪ Confirm law enforcement escort from airfield B to RTC ▪ Identify rally points for EMS and Law enforcement on airfield B property o Identify and coordinate patient transportation needs at receiving location ▪ Receive patient medical records (hard copy) ▪ PPE for crew ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) ✓ **IF TRANSPORTING BY GROUND:** o Report patient fitness for travel o Coordinate ground transportation routes with local/state Department of Transportation (DOT) and law enforcement (LE) ▪ Plan a primary and a secondary route with DOT and LE ▪ Secure all locations where transfers and/or stops may be necessary o Identify pass-through states (if warranted) o Discuss in transit requirements ▪ Primary vehicle is operable ▪ Backup vehicle(s) are available ▪ Escort vehicle type and phone numbers ▪ Communications plan between vehicles ▪ Fuel needs and anticipated stops/transfer points ▪ Use of lights/siren during route (not recommended) ▪ Waste management o Identify and coordinate patient transportation needs ▪ Medical Records (hard copy)

					▪ PPE for crew (replacement PPE as well) ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) ▪ Patient Care Plan: will be faxed/e-mailed/ (secured) to each transport team lead • Plans would have pertinent medical history, current medical care and expected medical care detailed • Actions for changes in medical conditions while en-route o Transfer points are confirmed ▪ Logistical needs are available (fuel, water, waste) ▪ Crew transfer if distances are prolonged o Discuss Medical Control determination for en-route issues ▪ Actions for changes in medical conditions while en-route o Provide contact sheets/information Sheets: ▪ Contact Sheets: On-line Medical Control at Emory University Hospital (SCDU), GDPH, GA IDTN Lead, Pass through State(s) Transportation Leads **SUGGESTED PARTICIPANTS: (will vary by state)** ✓ *Air service provider, if transporting by air* o *Airport Operations Manager at originating/receiving locations* o *US State Department* o *ASPR HQ Patient Movement Coordinator* ✓ *Ground service provider, if transporting by ground* o *LE escort service at originating/receiving locations* o *DOT providers at originating/receiving locations* ✓ *Originating/Receiving State Health Department Leadership/Incident Management personnel* ✓ *Local/Regional EPI/Local Health Department* ✓ *Originating healthcare facility staff (physician, nurse, Incident Management personnel, security)* ✓ *County/State Emergency Management (originating/receiving locations)* ✓ *Emergency Medical Services (EMS) and/or the Ambulance Services Provider that will conduct transport of patient from originating healthcare facility to airport* ✓ *Law Enforcement Agency in jurisdiction of healthcare facility and/or State Police Agency for originating and receiving locations*

					✓ *Department of Transportation representatives at originating and receiving locations* ✓ *Pass-through affected State(s) Department of Public Health* ✓ *RTC staff (physician, nurse, Incident Management personnel, security)* ✓ *Pass-through state(s) Transportation Leads* ✓ *HHS Region IV REC* ✓ *National Ebola Training and Education Center (NETEC) representative* ✓ *Federal Emergency Management Agency Region(s)* ✓ *Federal Law Enforcement Agencies as appropriate (optional -Customs & Border Patrol, Immigration & Customs Enforcement, Federal Bureau of Investigation WMD Coordinator)* ✓ *ATL Quarantine Station if appropriate* ✓ *HHS RECs in the NCR and R-VII*
		EMS and/or Ambulance Provider that will perform transport	EMS transport crew notification required	☐	Notify designated EMS and/or ambulance crew members and place them on standby
			Ambulance set-up for transport required	☐	Prepare the designated ambulance to transport highly infectious patient
		Originating Healthcare Facility	Law enforcement notification required	☐	Notify local law enforcement of patient transport activities and request escort support for patient movement operations and best route to the airport or transportation corridor to be used by ground providers
			Patient pick-up coordination need is identified	☐	Coordinate with local EMS and/or ambulance provider on times and location for patient transport, to include procedures on how patient is to be moved from the patient care room to the ambulance
			Coordination of patient movement from facility to airport or ground vehicle required	☐	Ensure all movement done in synchrony with the contracted air provider or ground service provider prior to arrival
			Preparation of patient for transport required	☐	Don PPE and begin preparing the patient for transport
			Preparation of HCF teams for transport required	☐	Ensure housekeeping staff and security are placed on standby for patient transport through the healthcare facility and for disinfection of the room, equipment hallways if required
			Coordination of intra-facility HCF patient transport required	☐	Coordinate with local EMS and/or ambulance provider on times and location for patient transport to airport if transporting by air and with identified ground service provider(s) if transporting by ground, to include procedures on how patient is to be moved from the patient care room to the ambulance
		Local Health Department/ Originating healthcare facility/contracted air provider	Coordination of patient transport with airport operations required	☐	Coordinate with designated airport officials to identify location of where patient transport and transfer is to occur onto the aircraft • Flight services location on airport property

					• Hours of operation for flight services • Fuel sources available to aircraft
7	Final Logistics Coordination	Local Health Department/ Originating healthcare facility/ ground service provider	Coordination of patient transport with ground transportation required	☐	Coordinate with ground provider(s) and LE escort team on routes to be followed to receiving healthcare facility • Fuel sources and locations • Hours to transfer points
		HHS Region IV REC	Final logistical coordination of transport is required prior to patient movement	☐	Schedule and conduct a conference call to discuss final transportation coordination and the associated logistics on the originating and receiving locations **CONFERENCE CALL #6 – TRANSPORTATION LOGISTICS COORDINATION CALL 2** • IF patient movement is to occur over a two-day period then a transportation coordination (logistics) and an inter-facility clinical coordination call **SHOULD** be conducted prior to any movement • Done at the requested of all parties involved to confirm logistics at either the originating or receiving location **TRANSPORTATION COORDINATION CALL (2nd Logistics) AGENDA:** ✓ **IF TRANSPORTING BY AIR** ○ Report patient fitness for travel ○ Validate receipt of air itinerary from US State Department ○ Identify airport to be used (including flight services location) at originating location ▪ Airport Manager name and phone number ▪ Flight Services location and phone numbers ▪ Fuel availability and type ○ Transportation from originating healthcare facility to originating airport (airfield A) ▪ Determine transportation route ▪ Confirm transportation provider (EMS/ambulance) from originating location ▪ Confirm law enforcement escort from originating location ▪ Identify rally points for EMS and Law enforcement on originating healthcare facility property ○ Identify and coordinate patient transportation needs ▪ Medical Records (hard copy) ▪ PPE for crew ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) ○ Transportation from receiving airport (airfield B) to RTC ▪ Determine transportation route to RTC

					▪ Confirm transportation provider (EMS/ambulance) from airfield B ▪ Confirm law enforcement escort from airfield B to RTC ▪ Identify rally points for EMS and Law enforcement on airfield B property o Identify and coordinate patient transportation needs at receiving location ▪ Receive patient medical records (hard copy) ▪ PPE for crew ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) ✓ **IF TRANSPORTING BY GROUND:** o Report patient fitness for travel o Coordinate ground transportation routes with local/state Department of Transportation (DOT) and law enforcement (LE) ▪ Plan a primary and a secondary route with DOT and LE ▪ Secure all locations where transfers and/or stops may be necessary o Identify pass-through states (if warranted) o Discuss in transit requirements ▪ Primary vehicle is operable ▪ Backup vehicle(s) are available ▪ Escort vehicle type and phone numbers ▪ Communications plan between vehicles ▪ Fuel needs and anticipated stops/transfer points ▪ Use of lights/siren during route (not recommended) ▪ Waste management o Identify and coordinate patient transportation needs ▪ Medical Records (hard copy) ▪ PPE for crew (replacement PPE as well) ▪ Transport care plan for patient (medical equipment: ventilator, IV therapy, PPE) ▪ Patient Care Plan: will be faxed/e-mailed/ (secured) to each transport team lead • Plans would have pertinent medical history, current medical care and expected medical care detailed • Actions for changes in medical conditions while en-route

					○ Transfer points are confirmed ▪ Logistical needs are available (fuel, water, waste) ▪ Crew transfer if distances are prolonged ○ Discuss Medical Control determination for en-route issues ▪ Actions for changes in medical conditions while en-route ○ Provide contact sheets/information Sheets: ▪ Contact Sheets: On-line Medical Control at Emory University Hospital (SCDU), GDPH, GA IDTN Lead, Pass through State(s) Transportation Leads **SUGGESTED PARTICIPANTS: (will vary by state)** ✓ *Air service provider, if transporting by air* ○ *Airport Operations Manager at originating/receiving locations* ○ *US State Department* ○ *ASPR HQ Patient Movement Coordinator* ✓ *Ground service provider, if transporting by ground* ○ *LE escort service at originating/receiving locations* ○ *DOT providers at originating/receiving locations* ✓ *Originating/Receiving State Health Department Leadership/Incident Management personnel* ✓ *Local/Regional EPI/Local Health Department* ✓ *Originating healthcare facility staff (physician, nurse, Incident Management personnel, security)* ✓ *County/State Emergency Management (originating/receiving locations)* ✓ *Emergency Medical Services (EMS) and/or the Ambulance Services Provider that will conduct transport of patient from originating healthcare facility to airport* ✓ *Airport Operations Manager - (originating/receiving locations)* ✓ *Law Enforcement Agency in jurisdiction of healthcare facility and/or State Police Agency for originating and receiving locations* ✓ *Contracted Air Provider (Operations Manager)* ✓ *Ground service provider* ✓ *Georgia Department of Public Health* ✓ *RTC staff (physician, nurse, Incident Management personnel, security)* ✓ *HHS Region IV REC* ✓ *HHS/ASPR State Department Liaison* ✓ *HHS/ASPR Patient Movement Coordinator* ✓ *US State Department Medical Officer* ✓ *HHS Secretary's Operations Center (SOC)*

					✓ *CDC Consultation Team* ✓ *National Ebola Training and Education Center (NETEC) representative* ✓ *Federal Emergency Management Agency R-IV* ✓ *Federal Law Enforcement Agencies as appropriate (optional -Customs & Border Patrol, Immigration & Customs Enforcement, Federal Bureau of Investigation WMD Coordinator)* ✓ *ATL Quarantine Station if appropriate* ✓ *HHS RECs in the NCR and R-VII*
		Originating EMS and/or Ambulance Provider	EMS patient pick-up required	☐	Assemble personnel and report to the designated location at the originating healthcare facility and ready for transport escort
			EMS transport to airport is required	☐	Transfer the patient to the aircraft ensuring the proper paperwork is sent with the patient and notify receiving facility that the patient has been transferred to the aircraft
			Movement coordination between EMS and Law Enforcement required	☐	Transport the patient to the designated airport while being escorted by the local law enforcement and/or state police
			Patient hand-off to aircrew notification required	☐	Notify originating healthcare facility that the patient has been transferred to the aircraft
			EMS transport via ground is required	☐	Transfer the patient to the ground service provider vehicle ensuring the proper paperwork is sent with the patient and notify receiving facility that the patient has been transferred
		Local law enforcement and/or State Police in originating jurisdiction	EMS transport escort required	☐	Assemble personnel and report to the designated location at originating healthcare facility and ready for transport escort
				☐	Provide escort for EMS and/or ambulance provider to airport for loading of patient to the aircraft or ground service provider vehicle
		Originating healthcare facility/Local Health Department	Post patient hand-off duties required	☐	Begin disinfecting the patient care room and applicable equipment and dispose of infectious waste following protocols
				☐	Doff PPE (with trained observer) and perform personal disinfection ensuring infection prevention and control protocols are followed and ensure all PPE and infectious waste is disposed of per protocols
				☐	Notify originating State Health Department officials/ESF8 personnel
		Originating State Health Department	Air or ground transport en-route notification required	☐	Notify the HHS Region IV REC
				☐	Notify GDPH when the patient is transferred to the aircraft or in the ground service provider vehicle and departs for receiving healthcare facility
		HHS Region IV REC	Patient is en-route via ground to patient transfer point or end destination	☐	Situation update calls will occur at each transfer point prior to each patient movement Agenda for these calls will focus on: • Current patient status

					• Changes in patient condition • Incidents during transport • Any concerns
8	In-flight Activities	Contracted air provider	Ongoing assessments during transport are conducted	☐	Monitor clinical condition en-route
			Clinical updates to receiving healthcare facility	☐	Communicate with RTC as needed
		HHS Region IV REC / Secretary's Operations Center	Patient tracking Patient tracking to final destination	☐	
				☐	Communicate with US State Department as necessary
				☐	Track flight progress
				☐	Communicate with ASPR Leadership
9	Arrival Coordination	Receiving EMS and/or Ambulance Provider	Receiving EMS crew required for pick-up at airfield B	☐	Assemble personnel and report to the designated location at receiving airport and ready for transport escort
			Aircraft has arrived at airfield B	☐	Transfer the patient from the aircraft ensuring the proper paperwork is received with the patient and notify receiving healthcare facility that the patient has arrived and been transferred to the transport vehicle
			Notification to receiving healthcare facility about final leg of transport required	☐	Notify receiving healthcare facility that the patient has been transferred to the ambulance for transport
			Receiving EMS transport to final destination required	☐	Transport the patient to the designated receiving healthcare facility while being escorted by the local law enforcement and/or state police
			Ground arrival at receiving healthcare facility	☐	Ground service provider vehicle has arrived at the designated receiving healthcare facility while being escorted by the local law enforcement and/or state police
			EMS post patient hand-off duties required	☐	Decontaminate vehicle per protocol and dispose of waste appropriately
		HHS Region IV REC	Patient has arrived at receiving healthcare facility	☐	Schedule and conduct a conference call to discuss the transportation logistics of the transport with all pertinent partners **CONFERENCE CALL #7 – ARRIVAL COORDINATION CALL** (This may also be accomplished by email) **ARRIVAL COORDINATION CALL AGENDA:** Notify all groups when "wheels up" and "wheels down" at all locations **SUGGESTED PARTICIPANTS or Email Participants: (will vary by state)** ✓ *Originating/Receiving State Health Department Leadership/Incident Management personnel* ✓ *Local/Regional EPI/Local Health Department*

					✓ *Originating healthcare facility staff (physician, nurse, Incident Management personnel, security)* ✓ *County/State Emergency Management (originating/receiving locations)* ✓ *Emergency Medical Services (EMS) and/or the Ambulance Services Provider that will conduct transport of patient from originating healthcare facility to airport* ✓ *Airport Operations Manager - (originating/receiving locations)* ✓ *Law Enforcement Agency in jurisdiction of healthcare facility and/or State Police Agency for originating and receiving locations* ✓ *Contracted Air Provider (Operations Manager)* ✓ *Ground service provider* ✓ *Georgia Department of Public Health* ✓ *RTC staff (physician, nurse, Incident Management personnel, security)* ✓ *HHS Region IV REC* ✓ *HHS/ASPR State Department Liaison* ✓ *HHS/ASPR Patient Movement Coordinator* ✓ *US State Department Medical Officer* ✓ *HHS Secretary's Operations Center (SOC)* ✓ *CDC Consultation Team* ✓ *National Ebola Training and Education Center (NETEC) representative* ✓ *Federal Emergency Management Agency R-IV* ✓ *Federal Law Enforcement Agencies as appropriate (optional -Customs & Border Patrol, Immigration & Customs Enforcement, Federal Bureau of Investigation WMD Coordinator)* ✓ *ATL Quarantine Station if appropriate* ✓ *HHS RECs in the NCR and R-VII* ✓
		Receiving healthcare facility	Patient receiving and patient care required at receiving healthcare facility	☐	Receive and admit PUI
				☐	Provide medical care

APPENDIX H: Response Playbook

Person Calls 911 to request an ambulance - UNKNOWN risk for EVD	Person walks into Emergency Department - UNKNOWN risk for EVD	Person walks into Emergency Department - KNOWN risk for EVD	**Person walks into frontline facility - UNKNOWN risk for EVD**	**Monitored Person Calls LHD from HOME/Public Location to report signs/symptoms**
EMS Agency identifies potential for EVD like symptoms & travel history - proper PPE precautions taken	Emergency Department identifies potential for EVD like symptoms & travel history and places in isolation within 5 minutes	Emergency Department in proper PPE moves patient into isolation room within 1 minute	Emergency Department identifies potential for EVD like symptoms & travel history and places in isolation within 5 minutes	LHD should record information on signs/symptoms and other necessary travel history information not already known
Notification made to NCEM Ops Center - NC DPH EPI On-Call to initiate Risk Assessment	Notification made to NC DPH EPI On-Call to initiate Risk Assessment	Notification made to NC DPH EPI On-Call to initiate Risk Assessment - THIS STEP MAY HAVE ALREADY OCCURRED	Notification made to NC DPH EPI On-Call to initiate Risk Assessment	Notification made to NC DPH EPI On-Call to initiate Risk Assessment
RISK ASSESSMENT (-) continue treatment as per normal protocol	RISK ASSESSMENT (-) continue treatment as per normal protocol	RISK ASSESSMENT (-) continue treatment as per normal protocol	RISK ASSESSMENT (-) continue treatment as per normal protocol	RISK ASSESSMENT (-) deter best location for medical assessment (MD Office, ER, Telemedicine)
RISK ASSESSMENT (+) continue playbook	**RISK ASSESSMENT (+) continue playbook**	**RISK ASSESSMENT (+) continue playbook**	**RISK ASSESSMENT (+) continue playbook**	**RISK ASSESSMENT (+) continue playbook**
If patient is STABLE then transportation to closest Ebola Assessment Hospital should be facilitated	If patient is STABLE and testing is indicated then EAH should be activated to be preparing to receive patient	If patient is STABLE and testing is indicated then EAH should be activated to be preparing to receive patient	If patient is STABLE and testing is indicated then EAH should be activated to be preparing to receive patient	If patient is STABLE then transportation to closest Ebola Assessment Hospital should be facilitated
If patient is UNSTABLE and/or transport to EAH is too far then notification should be made to closest ER to determine if capability exists to care for patient	**If patient is unstable determination is needed if patient can be transferred to EAH or if additional support is needed at frontline hospital**	**If patient is unstable determination is needed if patient can be transferred to EAH or if additional support is needed at frontline hospital**	**If patient is unstable determination is needed if patient can be transferred to EAH or if additional support is needed at frontline hospital**	**If patient is UNSTABLE and/or transport to EAH is too far then notification should be made to closest ER to determine if capability exists to care for patient**

APPENDIX I: Procedures for Safe Handling and Management of Ebola-Associated Waste

Preparing a Waste Management Plan as Part of Ebola Patient Care

1. Comply with your State and local regulations for handling, storage, treatment, and disposal of Ebola- associated waste.
2. Determine whether Ebola-associated waste will be inactivated onsite at the hospital or transported offsite for inactivation.
3. Identify a dedicated waste management team with specific training on standardized procedures for waste handling, including wearing appropriate PPE, and protocols for safely bagging and packaging waste, storing waste, and transporting packaged waste.
    - Onsite inactivation: Ebola-associated waste may be inactivated through incineration or by autoclaving using properly maintained equipment with appropriate biological indicators.
    - Offsite inactivation: Comply with regulations for packaging, transport and disposal of Ebola- associated waste.
4. When selecting emergency department triage areas for the evaluation of patients with possible Ebola, a designated area should be identified for waste storage pending a determination of whether the patient has Ebola or not. The storage space should meet all applicable fire codes and principles of maintaining a clutter-free, safe environment.
    - Waste bags should never be over-filled. Bags should be closed when two thirds full.
    - If stored within the patient room, all filled solid waste bags and sharps containers should undergo primary closure procedures as outlined below.
    - If stored outside the patient room, all filled solid waste bags and sharps containers should undergo both primary and secondary closure, and be removed as outlined below.
5. Be sure healthcare personnel and environmental services staff handling waste are trained to wear recommended PPE (same used for patient care) and follow appropriate putting on and taking off procedures. Use the OSHA PPE Selection Matrix for Occupational Exposure to Ebola Virus to guide selection of appropriate PPE for environmental services and waste collection workers handling, transporting, and disposing of waste.
    - Handling and primary packaging of waste should occur in the patient room and the area where PPE is removed and be performed by the primary healthcare workers (i.e., doctors and nurses) wearing PPE as designated in the guidance for hospitals.

Supplies for Hand Hygiene, Cleaning and Disinfection, and Packaging Waste

- Leak-proof labeled biohazard bags: The film bags must have a minimum film thickness of 1.5 mils (0.0015 inch) and be 175 liters or smaller (46 gallons).
- Approved sharps waste container
- Waste container in patient's room

- Transport cart
- Absorbent disposable towels
- EPA-registered hospital disinfectant for use against the Ebola virus
    - Select a hospital grade disinfectant available as wipe, spray, pull-top, or refill bottles (depending on application) with a label claim for one of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect hospital environmental surfaces.
- Disposable cleaning cloths
- Alcohol-based hand rub (ABHR) that is at least 60% alcohol
- Rigid outer receptacle that conforms to U.S. DOT HMR requirements for transport of Category A DOT waste provided by approved waste vendor
    - Note: Outer package must be either a rigid United Nations Standard- or DOT-approved non-bulk packaging. If the outer packaging is fabricated from fiberboard, it must be a minimum of triple wall and contain a 6 mil polyethylene liner. Reference DOT Guidance for Preparing Packages of Ebola Contaminated Waste for Transportation and Disposal.
    - Waste should be packaged with an installed liner provided by the waste vendor.
    - Absorbent material sufficient to absorb potential free liquid (if any) should be placed in the bottom of the rigid outer packaging or the liner of the fiberboard outer packaging.

Primary Packaging of Medical Waste in Patient's Room

Procedures for management of **solid** waste generated during Ebola patient care are outlined in CDC's Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus. Examples of solid waste include medical equipment, sharps, linens, privacy curtains, and used healthcare products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used PPE [gowns, masks, gloves, goggles, face shields, respirators, booties, etc.] or byproducts of cleaning). All placement of receptacles (including sharps containers) and primary packaging by double-bagging of waste should occur in the patient's room and be performed by the primary healthcare workers (i.e., doctors and nurses) wearing PPE as designated in the guidance for U.S. Emergency Departments and Hospitals.

1. Line appropriate-sized waste containers with a leak-proof biohazard bag.
2. Place non-sharps solid waste in the biohazard bag. Bags should not be filled beyond two thirds full to allow safe closure.
3. Carefully place sharps waste in appropriate disposable sharps container and close the container. Containers should not be filled beyond two thirds full to allow safe closure.
4. Prepare filled bags and sharps containers for **onsite inactivation (step 5) or offsite inactivation/incineration (step 6)**.
5. Prior to closure of bag and sharps container, prepare waste for **onsite autoclaving**:
    - Non-sharps waste: if required by the validated procedures, add a sufficient volume of water to primary bag.
    - Sharps waste: if required by the validated procedures, add sufficient volume of water.
6. For **offsite inactivation**, no liquid should be added.
7. Place closed sharps containers in a biohazard bag.

8. Close the bag with a method that will not tear or puncture the bag (e.g., tying the neck of bag with a goose-neck knot) and will ensure no leaks.
9. Apply EPA-registered hospital cleaner/disinfectant (wipe or spray) to the outside surface of the closed bag.
10. Place the wiped/sprayed closed bag into a second biohazard bag.
11. Close the bag with a method that will not tear or puncture the outer bag and will ensure no leaks (e.g., tying the neck of bag with a knot).
12. Apply EPA-registered hospital cleaner/disinfectant (wipe or spray) to the outside surface of the secondary bag.
13. Store the disinfected closed bags in a designated area to await removal.
14. Follow recommended procedures for disinfecting visibly soiled PPE and taking off PPE.

Secondary Packaging and Removal of Waste

1. The healthcare workers (i.e., doctors and nurses) caring for the patient and wearing PPE as designated in the guidance for hospitals should spray or wipe the outside surfaces of double-bagged waste with an EPA-registered hospital disinfectant immediately before removing waste from the room.
2. Upon removing the double-bagged waste from the patient's room, the healthcare worker should place the double-bagged waste in a designated transport cart (for onsite inactivation or a rigid outer receptacle (with absorbent material and liner as described above, for offsite inactivation). The designated container should be located at the periphery of the area for taking off PPE so that removal from the area is efficient and does not create a risk of recontamination of the outer container.
3. Environmental services personnel removing the waste from the care area should only handle the outer container/transport cart and should never open the container or handle the double-bagged waste. PPE should be used according to the OSHA PPE Selection Matrix for Occupational Exposure to Ebola Virus.
4. For **onsite inactivation, environmental services personnel wearing appropriate PPE according to the OSHA PPE Selection Matrix for Occupational Exposure to Ebola Virus[PDF - 3 pages] should**:
    - Safely transfer waste in a transport cart to dedicated waste autoclave room or secured storage location.
    - Refer to http://www.cdc.gov/vhf/ebola/hcp/survivability-ebola-medical-waste.html for guidance on inactivation of Ebola virus in waste.
5. For **offsite inactivation**, refer to U.S. DOT Guidance for Transporting Ebola Contaminated Items, a Category A Infectious Substance:
    - Before removal from the area, the healthcare workers wearing appropriate PPE should close the liner (either by zip tie or similar means of closure as specified by the manufacturer of the packaging), and close the outer lid and packaging. Disinfect the entire exterior surface of the container with an EPA-registered hospital disinfectant (wipe or spray).
    - Environmental services personnel wearing appropriate PPE according to the OSHA PPE Selection Matrix for Occupational Exposure to Ebola Virus should secure the outer lid and packaging and apply the special Category A DOT Waste labels provided and as directed by the manufacturer of the

packaging.
- Safely transport to a designated and secure storage area that is preferably isolated and with limited access for approved waste vendor pickup.

Procedures for Handling Liquid Waste (Body Fluids Including Blood, Urine, Vomit, Feces)

Consult with State or local regulations regarding pretreatment of waste. Sanitary sewers may be used for the safe disposal of patient waste.

1. Primary handling of liquid waste should occur in the patient's room and be performed by the primary healthcare workers (i.e., doctors and nurses) wearing recommended PPE as designated in the guidance for hospitals.
2. Pour waste, avoiding splashing by pouring from a low level, into the toilet.
3. Close the lid first, and then flush toilet.
4. Clean and disinfect flush handles, toilet seat, and lid surfaces with EPA-registered hospital disinfectant/cleaner.
5. Discard cleaning cloths in biohazard bags.
6. Discard emesis and portable toileting containers as solid waste.
7. Follow recommended procedures for disinfecting visibly soiled PPE and removal of PPE.

Handling Spills: Basic principles for spills of blood and other potentially infectious materials are outlined in the U.S. Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard, 29 CFR 1910.1030 and guidance for Bloodborne Pathogens and Needlestick Prevention.

1. Spills should be managed by the doctors and nurses caring for the Ebola patient and by wearing recommended PPE as designated in the guidance for hospitals.
2. Isolate the area of the spill; do not let other individuals access the area until disinfection is completed.
3. Place absorbent material on the spill (a solidifier agent can be used). Pour the EPA-registered disinfectant over the spill and allow sufficient contact time (according to manufacturer's instructions for treating spills).
4. Use disposable absorbent towels to remove bulk spill material. Dispose of the towels in a biohazard bag as specified above.
5. Apply the EPA-registered hospital disinfectant to the cleaned surface and allow the specified contact time.
6. Use disposable cleaning cloths or wipes to wipe the treated area.
7. Follow handling of solid waste protocol as described above to discard materials used for containing the spill and for cleaning and disinfection.
8. Follow recommended procedures for disinfecting visibly soiled PPE and taking off PPE.

https://www.cdc.gov/vhf/ebola/clinicians/cleaning/handling-waste.html

APPENDIX J: Ambulance Decontamination

Example: Standard Operating Procedure (SOP) for Decontamination of an Ambulance that has Transported a Person under Investigation or Patient with Confirmed Ebola
Drafted by John Lowe, PhD, in collaboration with the EMS Biosafety Transport Consortium (Emory University/Grady EMS, University of Nebraska Medical Center/Omaha Fire Department, US Department of State/Office of Operational Medicine, NIH Div. of Fire and Rescue Services/NIH Div. of Occupational Health and Safety, Fire Dept. of New York, Phoenix Air Group, American Medical Response). This Model Standard Operating Procedure (SOP) is adapted from the Emory/Grady EMS Bio Containment Transport Protocol, the University of Nebraska Medical Center Biocontainment Transport Protocol, and the United States Department of State Office of Medical Services Operational Medicine Biocontainment Ground Transport Standard Operating Procedures.

Purpose
This SOP can serve as a model for emergency medical services (EMS) transport agencies to standardize the procedures and responsibilities for the decontamination and disinfection of an ambulance that has transported a person under investigation (PUI) for Ebola or a patient with confirmed Ebola. It is highly recommended that procedures and responsibilities for decontamination and disinfection of the ambulance be clearly defined before transporting a PUI. All personnel should be trained in donning and doffing (putting on and taking off) techniques for personnel protective equipment (PPE).

The following key assumptions are being made:

- All healthcare workers (hospital and out-of-hospital) who are involved will have received education and training and demonstrated the necessary competencies for management of patients with serious communicable diseases.
- Healthcare facilities and transporting ambulance agencies have procedures for the management of patients with serious communicable diseases.
- Facilities and transporting ambulance agencies are conducting tabletop and operational exercises that test and refine procedures for the transfer of patients.
- This guidance complements other CDC guidance for management of patients with serious communicable diseases.

Safety
Ebola is transmitted through contact with infected body fluids, so infection control measures must be implemented that prevent contact with blood or infectious body fluid throughout the decontamination process. This process is designed for a 3-person team. Two people will be donned in PPE and perform the decontamination. A third person, not donned in PPE, will be available to document the decontamination

and for other assistance as needed.

Decontamination site setup

- Select an appropriate site for ambulance decontamination that protects the vehicle and the decontamination team from weather elements, preferably a well-ventilated large enclosed structure.
- Establish a secure perimeter for safety of the public and decontamination personnel.
- Include considerations for waste management, security plan, public perception, and media visibility when selecting decontamination site.
- Depending on the location, the ability for climate control is beneficial.
- Define and mark hot, warm, and cold zones of contamination [1] around the ambulance that require PPE to enter.

[1] - The hot zone is considered an area that is known or suspected to be contaminated and has a high risk of exposure. It should only be entered with full PPE. In ambulance decontamination, this would be the vehicle and an area about a meter beyond the ambulance. The warm zone can be considered a transitional area between the hot and cold zones that has no known contamination but has a moderate risk of exposure. It should only be entered when wearing full PPE. This is also the area where one begins the initial portion of the doffing process (following a full suit wipe down within the hot zone) when leaving the hot zone. For ambulance decontamination, the warm zone can also be the place where waste barrels are pre-positioned so that the waste bags can be placed directly into the containers without entering the hot zone. The cold zone is considered an area that has no contamination and no potential risk for exposure. The individuals in this area are not required to wear PPE, although the cold zone will often also serve as the PPE donning area.

<u>Transport unit decontamination</u>

Note: All disinfection should use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces at appropriate concentration and contact time.

Before decontamination

- To limit the number of people exposed to potentially contaminated materials, the vehicle operator and patient care provider may be responsible for decontamination and disinfection of the transport unit. However, a separate team may also be used to do this.
- All waste, including PPE, drapes, and wipes, should be considered Category A infectious substance, and should be packaged appropriately for disposal.
- Two people in PPE should decontaminate and disinfect. A third person should be available to document the decontamination and be available for other assistance as needed.
- PPE should be donned and doffed according to organizational protocols.

- PPE selection should consider worker protection for biological exposures and potential chemical exposures based on the disinfectant used.

During decontamination

- Disinfect the outside of any prepositioned but unused medical equipment (still inside the protective bags they were placed in) and pass it to the warm zone. If the equipment was removed from a protective bag in transit, assess the equipment to determine if it can be properly decontaminated and disinfected, or disposed of.
- Any areas that are visibly contaminated with the patient's body fluids should be decontaminated first with an approved EPA-registered disinfectant for the appropriate contact time before soaking up the fluid with absorbent materials.
- If the interior of the ambulance was draped prior to transport, remove the draping by rolling the drapes down outside in, from the ceiling to the floor of the unit starting at the front of the compartment and moving to the rear.
- Roll flooring drapes from the front to rear of the compartment, rolling drapes outside in.
- To facilitate packaging and transport, drapes can be gently cut into segments.
    - It is important that all drape materials are in sections that are small enough to facilitate the insertion of the biohazard bags into an autoclave or pre-determined Category A infectious substance packaging for disposal.
- Two people in PPE should manually disinfect the interior of the patient care compartment with particular detail for high-touch surfaces such as door handles and steps using care to limit mechanically generated aerosols and using the surface wipe method to disinfect.
- Disinfect the interior as a team so that the team members can talk each other through the process and expedite the decontamination process.
- Once the manual interior wipe down has been completed, collect and package all waste as Category A waste.
- Manually wipe down the ambulance's exterior patient loading doors and handles, and any areas that may have been contaminated, with disinfectant. The exterior of the ambulance does not require a full disinfectant wipe down.
- Once the outside of all surfaces (including waste bags) has been wiped with disinfectant, then doffing can occur.

After decontamination

- A third person who has been in the cold zone should supervise doffing, which should be performed according to organization doffing protocols.
- Dispose of all waste according to organization protocols as well as local and federal regulations for Category A infectious substances.
- Additional cleaning methods can also be used. While not required, this may provide additional assurance to personnel and public prior returning the

vehicle to service.
    - Ultraviolet germicidal irradiation, chlorine dioxide gas, or hydrogen peroxide vapor can be used for an additional disinfection step. However, these should not replace the manual disinfection, as their efficacy against organisms in body fluids has not been fully established and these methods may require specialized equipment and PPE.
- The ambulance can then be returned to service.

Materials and equipment needed to decontaminate an ambulance (for two people performing the decontamination)	#
Items	
Fluid-resistant or impermeable coveralls (appropriate sized suits)	4
Fluid-resistant or impermeable boot covers	4
Powered air-purifying respirator (PAPR)	2
PAPR batteries	6
PAPR filters	6
PAPR hoods	3
PAPR hose and clamp	
OR	
Full-face respirators with appropriate cartridges for protection against particles and EPA-registered hospital disinfectant (OV/AG/P95 organic vapor/acid gas cartridges)	2
Biobags (Large)	30
Garbage bags (Large)	20
Nitrile gloves box (Small, Medium, Large, Extra-large)	1EA
Hand sanitizer (bottle)	10
Absorbent rags (package)	2
Caution tape (yellow 200' roll)	2
Duct tape (roll)	2
Bucket	1
Healthcare bleach (wipes) or other EPA-registered hospital disinfectant wipes	4
Scissors	1
Documentation	
Bio-safety check-off sheet, donning check-off sheet, doffing check-off sheet, contact list	

Mortuary Guidance Job Aid: Postmortem Preparation in a Hospital Room

Appropriate personal protective equipment (PPE) must be worn while performing these tasks.

1. Turn on thermal sealer.
2. Use digital camera or mobile phone to take a photograph of the deceased's face. Send photo via Wi-Fi, e-mail, or text message to site manager through secure means. Decontaminate or properly discard camera or mobile phone.
3. Position gurney with three pre-opened body bags next to hospital bed.
4. Pull bed sheet(s) up and around body. Do not wash or clean body. Do not remove inserted medical equipment from body.
5. Remove first bag from gurney. Gently roll body wrapped in sheets while sliding first bag under body.
6. Complete transfer of body to first bag. Zip up bag. Minimize air in bag.
7. Disinfect gloved hands using alcohol-based hand rub (ABHR). If any areas of PPE have visible contamination, disinfect with an EPA-registered disinfectant wipe.
8. Disinfect outside of first bag with an EPA-registered hospital disinfectant.
9. Transfer first bag with body to gurney, placing it on top of second bag.
10. Disinfect gloved hands using ABHR.
11. Fold second bag around first bag and heat seal approximately 2" from edges. Remove air from second bag. Heat seal bag again approximately 1" below initial seal and heat seal diagonally across corners. Use scissors to trim off any excess material along seam. Turn off or unplug thermal sealer. Decontaminate thermal sealer before it is removed from hot zone or reused.
12. Disinfect outside of second bag with EPA-registered hospital disinfectant.
13. Disinfect gloved hands using ABHR.
14. Work third bag around second bag. Zip up third bag. Zip tie the zipper shut.
15. Disinfect gloved hands using ABHR.
16. Wheel gurney to decontamination area.
17. Decontaminate surface of body bag with EPA-registered hospital disinfectant.
    - Begin by applying the hospital disinfectant to top of bag and any exposed areas of gurney's cot.
    - Roll bag to one side to decontaminate half of bottom of bag and newly exposed portion of gurney's cot.
    - Repeat with other side of bag and gurney.
    - After visible soil has been removed with EPA-registered disinfectant wipe, reapply EPA-registered hospital disinfectant and allow sufficient contact time, as specified by manufacturer.
18. Disinfect surfaces of gurney from handles to wheels with an EPA-registered hospital disinfectant.
19. Disinfect gloved hands using ABHR.
20. Push gurney so only gurney and decontaminated body bag enter cold zone. Do not enter cold zone. A new set of workers will receive the body.
21. Proceed to PPE removal area.

For more information: Guidance for Safe Handling of Human Remains in U.S. Hospitals and Mortuaries.
http://www.cdc.gov/vhf/ebola/healthcare-us/hospitals/handling-human-remains.html

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK T. BENTON • Assistant Secretary for Public Health
Division of Public Health

Ebola Guidance for Non-Hospital Healthcare Facilities

August 28, 2019 – 3 pages *(Replaces version dated August 15, 2018)*

This memo is intended to provide general guidance for identification and initial management of suspected Ebola virus disease (EVD) cases in non-hospital facilities. This is not intended to replace specific plans or policies that may be in place for your facility or healthcare network.

This guidance follows the CDC guidance of "Identify, Isolate and Inform".

IDENTIFY exposure history and signs or symptoms

- **Post signage for patients to encourage prompt notification of travel.** An example poster for triage/waiting room areas is available at http://epi.publichealth.nc.gov/cd/ebola/TravelPosterNC.pdf.
- **Obtain a travel history from all patients.** Obtain a travel history from all patients presenting for care. Consider adding travel history to phone triage protocols.
- **For patients with recent travel to countries or geographic area within a country with ongoing Ebola outbreaks and stated exposure, assess for fever or other compatible symptoms.** A list of recent and current Ebola outbreaks is available at https://www.cdc.gov/vhf/ebola/history/chronology.html. Initial EVD symptoms may include fever, headache, joint and muscle aches, sore throat, and weakness, followed by diarrhea, vomiting, and stomach pain. Skin rash, red eyes, and internal and external bleeding may be seen in some patients. Fever may not be present early in the illness.

ISOLATE any patient with recent travel to countries or geographic area within a country with ongoing Ebola outbreaks and compatible illness

- **Avoid direct patient contact unless needed to meet emergent clinical needs.** Efforts should be made to minimize taking vital signs and other patient contact except as absolutely needed to provide acute care. Avoid sample collection, laboratory testing, and diagnostic imaging (e.g., blood draws, X-rays).
- **Lead patient to a single patient room and then close the door.** Room should contain a private bathroom or bedside commode if available. Consider placing a digital

thermometer in the room so the patient can check his/her own temperature. Facilities should maintain a log of persons entering the patient's room. Persons accompanying the patient should be asked to wait in a separate, private room.

- **Implement additional infection prevention measures.**
    1. If patient contact is required, all persons entering the patient's room should use the following personal protective equipment (PPE) at a minimum:
        a. Impervious gown,
        b. Surgical mask,
        c. Face shield (or goggles if not available),
        d. Double gloves (extended cuffs, if available),
        e. Hair cover (optional), and
        f. Booties/shoe covers (optional).
    2. If patient contact is required, a trained observer should monitor every step of donning and doffing of PPE. If a trained observer is not available, another healthcare worker should be present to observe donning and doffing and document any potential exposures.
    3. PPE recommendations differ for the hospital vs. non-hospital setting and the corresponding level of anticipated patient care. CDC recommendations for PPE in hospital settings are available at http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html.
    4. Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces in rooms of patients with suspected Ebola virus infection.
    5. Place all used PPE in a regulated medical waste bag and store in patient's room. DO NOT reuse any medical devices (e.g. thermometers) for other patients. Seal off room.

INFORM public health and prepare for safe transport

- **Contact your local health department and the state Communicable Disease Branch (919-733-3419; available 24/7).** Physicians are required to report as soon as Ebola is reasonably suspected. Public health officials can assist with transfer and laboratory testing, if necessary. Public health officials can also assist with control measures, including identification and management of potentially exposed healthcare workers or patients and providing advice on environmental disinfection and waste disposal.

- **Ensure that the receiving facility and transport team are notified before transport so that appropriate precautions can be taken.** Private transport is not recommended for patients in whom Ebola is being considered.

For any patient with recent travel to countries or geographic area within a country with ongoing Ebola outbreaks and NO exposure or fever/compatible symptoms: Provide patient care as normal.

Contact your local health department and the state Communicable Disease Branch (919-733-3419; available 24/7) with questions.

We encourage all facilities to identify an appropriate local health department contact now. A directory of local health departments is available at https://www.ncdhhs.gov/divisions/public-health/county-health-departments.

We will continue to monitor for ongoing outbreaks and provide updates as new information becomes available. For additional information, see: https://www.cdc.gov/vhf/ebola/index.html.

High Consequence Pathogens
(Ebola Virus Disease, EVD)

EMS Dispatch Center/PSAP

1. Use Emerging Infectious Disease (EID), or equivalent, Surveillance Tool with the following chief complaints:

Typical Flu-Like Symptoms, Respiratory Illness, Hemorrhagic Fever, and/or Unexpected Bleeding (not trauma or isolated nose bleed related)

2. Use EID Card (or equivalent) with the following protocols (or equivalent)

Breathing Problem	**Headache**	**Sick Person**
Chest Pain	**Hemorrhage (medical)**	

3. Ask the following:

In the past 21 days have you been to affected areas or been exposed to someone who has?
If YES:
Do you (or does he/she) have a fever? (≥100.4°F) Do you (or does he/she) have chills? Do you (or does he/she) have unusual sweats? Do you (or does he/she) have unusual total body aches? Do you (or does he/she) have a headache? Do you (or does he/she) have recent onset of diarrhea, vomiting, or bloody discharge from the mouth or nose? Do you (or does he/she) have abdominal or stomach pain? Do you (or does he/she) have unusual (spontaneous/non-traumatic) bleeding from any area of the body?

4. Advise the caller/patient to not allow any further close contact with others.

Evolving Protocol:
Protocol subject to change at any time dependent on changing outbreak locations.

Monitor for protocol updates.

YES →

DO NOT DISPATCH FIRST RESPONDERS

Dispatch EMS Unit only
Discretely notify EMS Supervisor or command staff. EMS providers/ supervisors should contact the NC EOC at 919-733-3300 before making patient contact for assistance with the EVD Risk Assessment.

NO ↓

EMS: Do not rely solely on EMD personnel to identify a potential EVD patient – constrained by time and caller information. Obtain a travel history / exposure history and assess for clinical signs and symptoms

Affected Areas
Democratic Republic of the Congo (DRC)

EMS Immediate Concern

1. Traveler from area with known EVD (Ebola) with or without symptoms
2. Traveler from affected areas within past 21 days

AND

Fever, Headache	Joint and Muscle aches	Weakness, Fatigue
Vomiting and/or Diarrhea	Abdominal Pain	Unexplained Bleeding

NO → Exit to Appropriate Protocol(s)

YES ↓

EMS Personal Protective Equipment ↔ Refer to page 2
Place surgical mask on patient
Use Non-rebreather mask if Oxygen Needed
Donning and Doffing Guidelines

NO Routine Aerosol Generating Procedures ↔ Avoid aerosol generating procedures unless medically necessary
NIPPV / Nebulizer therapy / Intubation / BIAD / Suctioning

No Routine IV or IO Lines ↔ Avoid routine IV or IO access unless medically necessary
If IV / IO necessary:
Stop vehicle to lessen exposure risk

EMS Personnel / Equipment / Transport Unit Requires Decontamination ↔ Refer to Page 3

Notify Destination as soon and as discretely as possible
DO NOT ENTER facility with patient until instructed
Follow entry directions from hospital staff

Special Circumstances Section

High Consequence Pathogens
(Ebola Virus Disease, EVD)

PARTICULAR ATTENTION MUST BE PAID TO PROTECTING MUCOUS MEMBRANES OF THE EYES, NOSE, and MOUTH FROM SPLASHES OF INFECTIOUS MATERIAL OR SELF INOCULATION FROM SOILED PPE / GLOVES.
THERE SHOULD BE NO EXPOSED SKIN

DONNING PPE: BEFORE you enter the patient area. Trained observer should be present to monitor donning process.

Recommended PPE

PAPR: A PAPR with a full face shield, helmet, or headpiece. Any reusable helmet or headpiece must be covered with a single-use (disposable) hood that extends to the shoulders and fully covers the neck and is compatible with the selected PAPR.

N95 Respirator: Single-use (disposable) N95 respirator in combination with single-use (disposable) surgical hood extending to shoulders and single-use (disposable) full face shield. If N95 respirators are used instead of PAPRs, careful observation is required to ensure healthcare workers are not inadvertently touching their faces under the face shield during patient care.

Single-use (disposable) fluid-resistant or impermeable gown that extends to at least mid-calf or coverall without integrated hood. Coveralls with or without integrated socks are acceptable.

Single-use (disposable) nitrile examination gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.

Single-use (disposable), fluid-resistant or impermeable boot covers that extend to at least mid-calf or single-use (disposable) shoe covers. Boot and shoe covers should allow for ease of movement and not present a slip hazard to the worker.

Single-use (disposable) fluid-resistant or impermeable shoe covers are acceptable only if they will be used in combination with a coverall with integrated socks.

Single-use (disposable), fluid-resistant or impermeable apron that covers the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea. An apron provides additional protection against exposure of the front of the body to body fluids or excrement. If a PAPR will be worn, consider selecting an apron that ties behind the neck to facilitate easier removal during the doffing procedure

DOFFING PPE: OUTSIDE OF PPE IS CONTAMINATED! DO NOT TOUCH

1) PPE must be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials.

Use great care while doffing your PPE so as not to contaminate yourself (e.g. Do not remove your N-95 facemask or eye protection BEFORE you remove your gown). There should be a dedicated monitor to observe donning and doffing of PPE. It is very easy for personnel to contaminate themselves when doffing. A dedicated monitor should observe doffing to insure it is done correctly. Follow CDC guidance on doffing.

2) PPE must be double bagged and placed into a regulated medical waste container and disposed of in an appropriate location.
3) Appropriate PPE must be worn while decontaminating / disinfecting EMS equipment or unit.
3) Re-useable PPE should be cleaned and disinfected according to the manufacturer's reprocessing instructions.

Hand Hygiene should be performed by washing with soap and water with hand friction for a minimum of 20 seconds.
Alcohol-based hand rubs may be used if soap and water are not available.
EVEN IF AN ALCOHOL-BASED HAND RUB IS USED, WASH HANDS WITH SOAP AND WATER AS SOON AS FEASIBLE.

THE USE OF GLOVES IS NOT A SUBSTITUTE FOR HAND WASHING WITH SOAP & WATER

For any provider exposure or contamination contact occupational health.
If the patient is being transported via stretcher then a disposable sheet can be placed over them.

Special Circumstances Section

Pearls

- **Transmission to another individual is the greatest after a patient develops fever. Once there is fever, the viral load in the bodily fluids appears to be very high and thus a heightened level of PPE is required.**
- **Patient contact precautions are the most important consideration.**
- **Incubation period 2-21 days**
- **Use of a trained observer to assist with Donning/Doffing of PPE can potentially help the healthcare worker avoid 21 day quarantine period. It is strongly urged to utilize trained observer personnel.**
- **Ebola must be taken seriously; however using your training, protocols, procedures and proper Personal Protective Equipment (PPE), patients can be cared for safely.**
- When an infection does occur in humans, the virus can be spread in several ways to others. The virus is spread through direct contact (through broken skin or mucous membranes) with a sick person's blood or body fluids (urine, saliva, feces, vomit, and semen) objects (such as needles) that have been contaminated with infected body fluids.
- Limit the use of needles and other sharps as much as possible. All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers. Safety devices must be employed immediately after use.
- **Ebola Information: For a complete review of Ebola go to:**
  http://www.cdc.gov/vhf/ebola/index.html
  https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html

High Consequence Pathogens
(Ebola Virus Disease, EVD)

EMS Personal
Requires Decontamination

If EMS personnel are exposured to blood, bodily fluids, secretions, or excretions from a patient with suspected or confirmed Ebola should immediately:

1) Stop working and wash the affected skin surfaces with soap and water.
2) Mucous membranes (e.g., conjunctiva) should be irrigated with a large amount of water or eyewash solution;

EMS Equipment / Transport Unit
Requires Decontamination

1) EMS personnel performing decontamination / disinfection should wear recommended PPE
   When performing Decontamination EMS Personnel MUST wear appropriate PPE, which includes:
   - •Gloves (Double glove)
   - •Fluid resistant (impervious) Tyvek Like Full length (Coveralls)
   - •Eye protection (Goggles)
   - •N-95 face mask
   - •Fluid resistant (impervious)-Head covers
   - •Fluid resistant (impervious)-Shoe / Boot covers
2) Face protection (N-95 facemask with goggles) should be worn since tasks such as liquid waste disposal can generate splashes.
3) Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and should be decontaminated and disinfected after transport.
4) A blood spill or spill of other body fluid or substance (e.g., feces or vomit) should be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient. An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to Ebola (such as, norovirus, rotavirus, adenovirus, poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions.
   (Alternatively, a 1:10 dilution of household bleach (final working concentration of 500 parts per million or 0.5% hypochlorite solution) that is prepared fresh daily (i.e., within 12 hours) can be used to treat the spill before covering with absorbent material and wiping up. After the bulk waste is wiped up, the surface should be disinfected as described in the section above).
5) Contaminated reusable patient care equipment should be placed in biohazard bags (double-bagged) and labeled for decontamination and disinfection.
6) Reusable equipment should be cleaned and disinfected according to manufacturer's instructions by appropriately trained personnel wearing correct PPE.
7) Avoid contamination of reusable porous surfaces that cannot be made single use. Use only a mattress and pillow with plastic or other covering that fluids cannot get through.
8) To reduce exposure, all potentially contaminated textiles (cloth products) should be discarded. This includes non-fluid-impermeable pillows or mattresses. They should be considered regulated medical waste and placed in biohazard red bags. They must be double-bagged prior to being placed into regulated medical waste containers.

Pearls

- **Ebola Information:** For a complete review of Ebola EMS Vehicle Disinfection go to:
  https://www.cdc.gov/vhf/ebola/clinicians/emergency-services/ambulance-decontamination.html

High Consequence Pathogens
(Ebola Virus Disease, EVD)

Special Circumstances Section

Decedent Known or suspected carrier of EVD Requires Transportation

Only personnel trained in handling infected human remains, and wearing full PPE, should touch, or move any Ebola-infected remains. Handling human remains should be kept to a minimum.

Donning / Doffing PPE with Trained Observer present

PPE should be in place **BEFORE** contact with the body

1) Prior to contact with body, postmortem care personnel must wear PPE consisting of: surgical scrub suit, surgical cap, impervious Tyvex-Coveralls, eye protection (e.g., face shield, goggles), facemask, shoe covers, and double surgical gloves.

2) Additional PPE (leg coverings,) might be required in certain situations (e.g., copious amounts of blood, vomit, feces, or other body fluids that can contaminate the environment).

PPE should be removed immediately after and discarded as regulated medical waste.

1) Use caution when removing PPE as to avoid contaminating the wearer.

2) Hand hygiene (washing your hands thoroughly with soap and water or an alcohol based hand rub) should be performed immediately following the removal of PPE. If hands are visibly soiled, use soap and water.

Preparation of Body Prior to Transport

1) At the site of death, the body should be wrapped in a plastic shroud. Wrapping of the body should be done in a way that prevents contamination of the outside of the shroud.
2) Change your gown or gloves if they become heavily contaminated with blood or body fluids.
3) Leave any intravenous lines or endotracheal tubes that may be present in place.
4) Avoid washing or cleaning the body.
5) After wrapping, the body should be immediately placed in a leak-proof plastic bag not less than 150 µm thick and zippered closed The bagged body should then be placed in another leak-proof plastic bag not less than 150 µm thick and zippered closed before being transported to the morgue.

Surface Decontamination

1) Prior to transport to the morgue, perform surface decontamination of the corpse-containing body bags by removing visible soil on outer bag surfaces with EPA-registered disinfectants which can kill a wide range of viruses.
2) Follow the product's label instructions. Once the visible soil has been removed, reapply the disinfectant to the entire bag surface and allow to air dry.
3) Following the removal of the body, the patient room should be cleaned and disinfected.
4) Reusable equipment should be cleaned and disinfected according to standard procedures.

Transportation of EVD Remains

PPE is required for individuals driving or riding in a vehicle carrying human remains. DO NOT handle the remains of a suspected / confirmed case of Ebola The remains must be safely contained in a body bag where the outer surface of the body bag has been disinfected prior to the transport.

Pearls

- **Ebola Information:** **For a complete review of Handling Remains of Ebola Infected Patients go to:**
  http://www.cdc.gov/vhf/ebola/hcp/guidance-safe-handling-human-remains-ebola-patients-us-hospitals-mortuaries.html

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX D

Patient Movement

July 2021

Table of Contents

Purpose

The purpose of the North Carolina Patient Movement Annex is to establish a standardized framework for patient movement that incorporates lessons learned from real events. This annex is comprised of regional and statewide patient movement guidelines to include patient identification, patient placement, patient transportation, patient tracking, patient repatriation, and the overall operational coordination by NCOEMS and Healthcare Coalitions (HCC). Additionally, the plan outlines the expected roles and responsibilities of other state and local emergency response organizations to ensure maximum effectiveness and efficiency. This annex addresses the ability to triage and place patients into appropriate receiving healthcare facilities (to include field hospitals, alternate care sites and medical support shelters) and develops a structure for the coordination for the transportation of patients to their destinations during a statewide emergency activation.

Situation and Assumptions

During emergencies and disasters, circumstances can occur where regional and state support is required to move patients. Primarily this is due to local assets and/or healthcare facilities being overwhelmed and therefore unable to provide their usual level of service. In this situation, it is anticipated that regional, state, or federal assistance to manage patient movement, including the evacuation of existing healthcare facilities, will be required. The following assumptions were made during the development of this plan:

- This annex is intended for use in conjunction with the NCOEMS Emergency Operations Plan.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for Disaster Medical Services and is responsible for the maintenance, planning, coordination, and execution of the Patient Movement Annex.
- The patient movement coordination in this plan assumes activation of the State Emergency Operations Center (SEOC) and a request for support from a local or regional partner for NCOEMS to assist with the movement of patients to and/or from a healthcare facility, an operational field site and/or a residential location during a disaster or emergency.
- All county partners, healthcare systems and facilities should maintain their own primary and backup patient movement/evacuation plans and only request support from the state when they become overwhelmed and need additional resources or support.
- Patient movement operations are slow moving and state activation and access to resources may be delayed. Ample notice and early warning are necessary to provide time to support patient movement operations.
- The concept of operations outlined in this plan can be used for all types of state supported patient movement scenarios regardless of the examples provided in this plan.
- A patient's health generally does not improve with relocation. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or in-route delays due to weather, accidents, or secondary events subsequent to the originating event/incident.
- Ideally, patients should be stabilized prior to being transported. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources, and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process, all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- All evacuations are subject to weather conditions and safety considerations.
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities and the responsibility for costs resulting from patient movement are primarily the obligation of the sending entity.

Concept of Operations

Activation

- The ESF8 Lead has the authority to activate this plan in consultation with North Carolina Emergency Management. This decision is informed by information shared by local and regional partners when there is an immediate or anticipated need to move patients beyond what the local resources can manage.
- This plan may be activated prior to or during any event where there is an anticipated need for state coordinated support to move patients. Different guidelines for the movement of patients exists depending on the originating location and/or destination of the patients (refer to specific appendices for specific guidelines).

Notification

- Upon activation of this plan, the ESF8 lead or designee is responsible to ensure notification to all State Medical Response System partners and North Carolina Department of Health & Human Services (NC DHHS) leadership. This notification will include links to submit all required planning documents, individual patient movement request forms, and the instructions on how to start the process. Additionally, instructions for how to do a bulk upload of patients and the necessary template will be sent in this same notification packet.
- If the evacuation is expected to impact other states and/or state transportation resources are anticipated to be overwhelmed, the HHS Region IV Unified Planning Coalition (UPC) and Assistant Secretary of Preparedness and Response Regional Emergency Coordinators (RECs) should be notified as well in anticipation of Emergency Management Assistance Compact and/or Federal resource requests.

Patient Movement Concepts

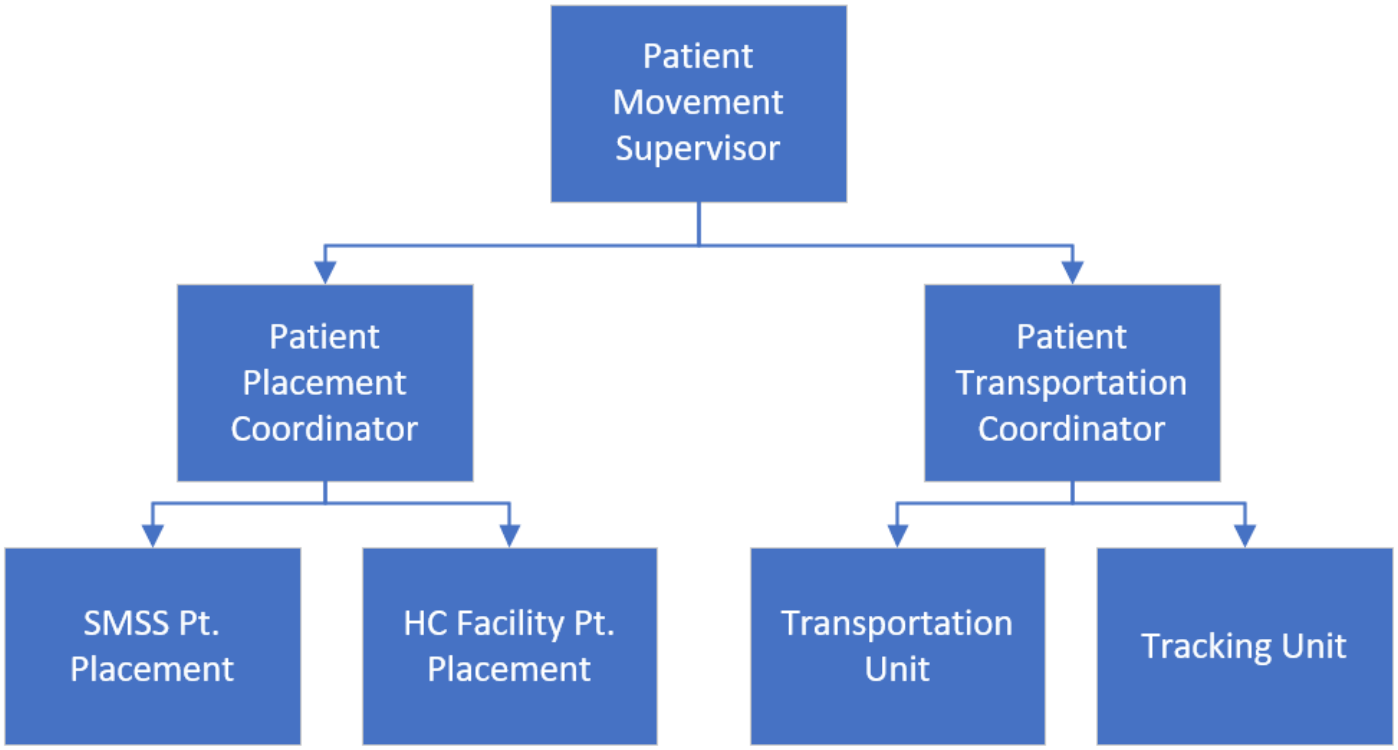
- Hospital Evacuation Patient Movement: Hospital evacuations should be considered a last resort when all other response options, such as sheltering-in-place, lateral/vertical movement within the facility, and providing additional resource or staff support, are exhausted or deemed insufficient. Hospitals are required to have their own primary and secondary plans for facility evacuation in the case of an emergency or disaster. Sending facilities should be prepared to send staff, equipment and supplies with the patients when considering an emergency evacuation. During certain medical surge events an alternate care site (e.g. field hospital or medical support shelter) may be opened to help manage the surge of patients within the healthcare system. During this type incident it is anticipated that the alternate care site will be treated like any other hospital for the purposes of patient movement. Refer to Appendix 7 Hospital Patient Movement Guideline for more details on how this type of patient movement will be coordinated.
- State Medical Support Shelter Patient Movement: During major emergencies or disasters, State Medical Support Shelters (SMSS) may be activated to accommodate individuals that are evacuating and require specialized healthcare attention due to a disruption in their community healthcare support. Patient movement in this circumstance usually involves individuals coming from their homes to a SMSS or returning to their homes from a SMSS. Refer to Appendix 8 State Medical Support Shelter Patient Movement Guidelines for more details on how this type of patient movement will be coordinated.
- Federal Coordinating Centers: As part of the National Disaster Medical System (NDMS) Federal Coordinating Centers (FCC) and Patient Reception Sites may be activated to provide medical care from another state or a federal medical response when the medical care capability in that area has been overwhelmed. FCC activation is a coordinated response between NCEM, NC DHHS, Veterans Affairs Medical Center (VAMC) and ASPR. Patient movement required during a Federal Coordinating Center (FCC) activation will follow a similar framework as a hospital evacuation, but additional nuances can be found in the Appendix 9 FCC Patient Movement Guidelines.

- Transportation: A key part of patient movement is the coordination and oversight of transporting patients safely and efficiently from origin to destination. The ability to maximize the use of available resources and coordinate potentially scarce assets is key to successful patient movement. Refer to Appendix 10 Patient Movement Transportation Guidelines for more details on how the patient transportation process will be coordinated.

Patient Movement Roles

- Patient Movement Supervisor: Upon decision to activate the patient movement annex, the ESF8 lead, or designee will assign an NCOEMS staff member to the role of Patient Movement Supervisor as part of the NCOEMS support cell. The Patient Movement Supervisor has oversight and responsibility for all ESF8 operations that involve patient movement activities (e.g. healthcare facility evacuations, medical support shelter, FCC operations etc.) and can request to add or detract personnel to support the operations as the needs change. This position is responsible to complete the patient movement situation report, at a frequency set by the ESF8 lead, to include total number of patients within each phase of the patient movement process. If this is the only position that is activated, then this individual must ensure all responsibilities outlined in this annex are completed.
- Patient Placement Coordinator: The patient placement coordinator is responsible for supporting the Patient Movement Supervisor and Healthcare Placement Unit (if active). This position is expected to be aware of the total number of patients that need placement, location of patients needing placement, type of patients needing placement and the total number of patients that have been placed.
- Healthcare Placement Unit: This unit is responsible to lead the Statewide Patient Coordination Team and support the Patient Coordination Center Lead when patient movement involves placement into healthcare facilities (e.g. during hospital evacuations). For more details see Appendix 7: NC Hospital Patient Movement
- Medical Support Shelter Placement Unit: This unit is responsible to review, vet, and approve individual patient placement requests for Medical Support Shelters. For more details see Appendix 8 NC State Medical Support Shelter Patient Movement
- Patient Transportation Coordinator: The Patient Transportation Coordinator is responsible for supporting the Patient Movement Supervisor and overseeing all patient movement transportation assets (e.g. Ambulance Strike Teams, Ambulance Buses, Transport resources etc.). This position is responsible for advising ESF8 leadership on the type and quantity of patient movement assets that need to be activated, provide details on number of assets currently deployed and maintaining awareness of assets available for deployment. Additional details on responsibilities are outlined in Appendix 10: Patient Transportation Guideline.
- Transportation Unit: This unit is responsible to review, vet and approve patient transportation requests for all patients that need to be moved as part of the ESF8 coordinated patient movement annex. This unit is also responsible for actual deployment of transportation assets and coordinating closely with the tracking unit. Additional details on responsibilities are outlined in Appendix 10: Patient Transportation Guideline.
- Tracking Unit: This unit is responsible for ensuring that all patient movement activities are tracked from initial request for movement until final destination. Additional details on responsibilities are outlined in Appendix 10: Patient Transportation Guideline.
- Medical Provider: NCOEMS will ensure that at least one of the positions supporting the patient movement operations is a medical provider (Paramedic, Advanced Practice Provider, or Physician) to field any questions from non-clinical support roles regarding patient acceptance and placement. If the assigned medical provider is unable to determine patient placement then the ESF8 lead should be consulted for further direction and engagement with the clinical advisor.

Figure 1.1: Patient Movement Organization Chart



Patient Movement Responsibilities

- Patient Identification: Patient identification is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.) as they have the information necessary to ensure safe decisions are made on the movement of the patient(s). The NCOEMS has an established process to request additional state support for patient movement. This process starts by submitting the required planning form(s), which will aid in identifying the potential number of patients needing to be moved, potential number of transportation assets required, and placement capability needed to support the overall mission. Additionally, individual patient placement request forms will be required once the patients are ready to be moved to provide details on the patient, their medical condition, demographics, and other pertinent details as outlined in each specific patient movement appendix. Form links will be emailed to stakeholders upon activation.
- Patient Placement: Patient placement is the responsibility of the NCOEMS staff member assigned to the role of Patient Placement Coordinator in coordination with the receiving facilities (e.g. hospital, medical support shelter, etc.). The main goal of the patient placement process is to ensure that individuals are moved to the most appropriate receiving location based on the information available about their medical situation. Depending on the size of the activation a Healthcare Placement Unit and/or a Medical Support Shelter Placement Unit may be assigned under the Patient Placement Coordinator to complete these responsibilities. Specific details on the patient placement options are available within each specific patient movement appendix.
- Patient Transportation: Patient transportation is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.). During large-scale events, transportation resources may be limited, and sending entities may need to request state support for the coordination of additional assets to fulfill the mission. Once the patient movement plan has been activated, the coordination of the state patient

transportation assets is the responsibility of the NCOEMS to activate, deploy and track to ensure maximum efficiency and effectiveness in completing the patient movement mission. To accomplish this task, NCOEMS ESF-8 desk will assign a Patient Transportation Coordinator to oversee all patient transportation activities. All transportation coordination and assets assigned to patient movement will be assigned under this position to maintain consistency across multiple operational sites. Additional details on the patient transportation plan is available in Appendix 10: Patient Transportation Guideline.

- Patient Tracking: Patient tracking is the responsibility of the NCOEMS and involves ensuring that all patients being moved as part of this annex are tracked from their originating location to their final destination. Accurate patient tracking is incredibly important as patient's final destination is likely not know when they originally enter the patient movement process. Ensuring that all patients are tracked from when they originally enter the process to their final destination and the timeline for this process should be a top priority through the patient movement process. Depending on the size of the activation a Tracking Unit may be assigned under the Patient Transportation Coordinator to complete these responsibilities. A patient tracking system will range from pen and paper to technology-based tracking systems (such as Appriss Health or ReadyOp). Additional details on patient tracking are available within Appendix 10: Patient Transportation Guideline.
- Patient Repatriation: Patient repatriation is the responsibility of the original sending entity (medical facility, county agency, state agency, or federal agency etc.). Similar to patient transportation support, the original sending entity may request additional support from NCOEMS in the repatriation process.
- Operational coordination: The responsibility for the operational coordination for all State Medical Response System patient movement activities is the responsibility of the NCOEMS. This includes the decision to activate the plan, notification of the partners and leadership entities, assigning staff to appropriate roles and overseeing each step and process for the movement of patients from originating location to destination.
- Deactivation: The decision to deactivate the state coordinated patient movement process is up to the ESF8 lead in discussions with NCEM along with state and local entities. There may be a period of time during a major event, such as a hurricane, when the patient movement process will need to be temporarily deactivated for safety purposes and then reactivated once it has been deemed safe to do so. The deactivation decision, including temporary deactivation decisions, should be shared with the same parties that were notified at the start of the patient movement process and shared widely so all partners are aware. Key decision points to utilize when considering deactivation is primarily based on the point in the activation when the majority of patients have been repatriated and/or the ability to place and/or transport patients through normal processes has returned.

Figure 1.2: Patient Movement Flow Chart

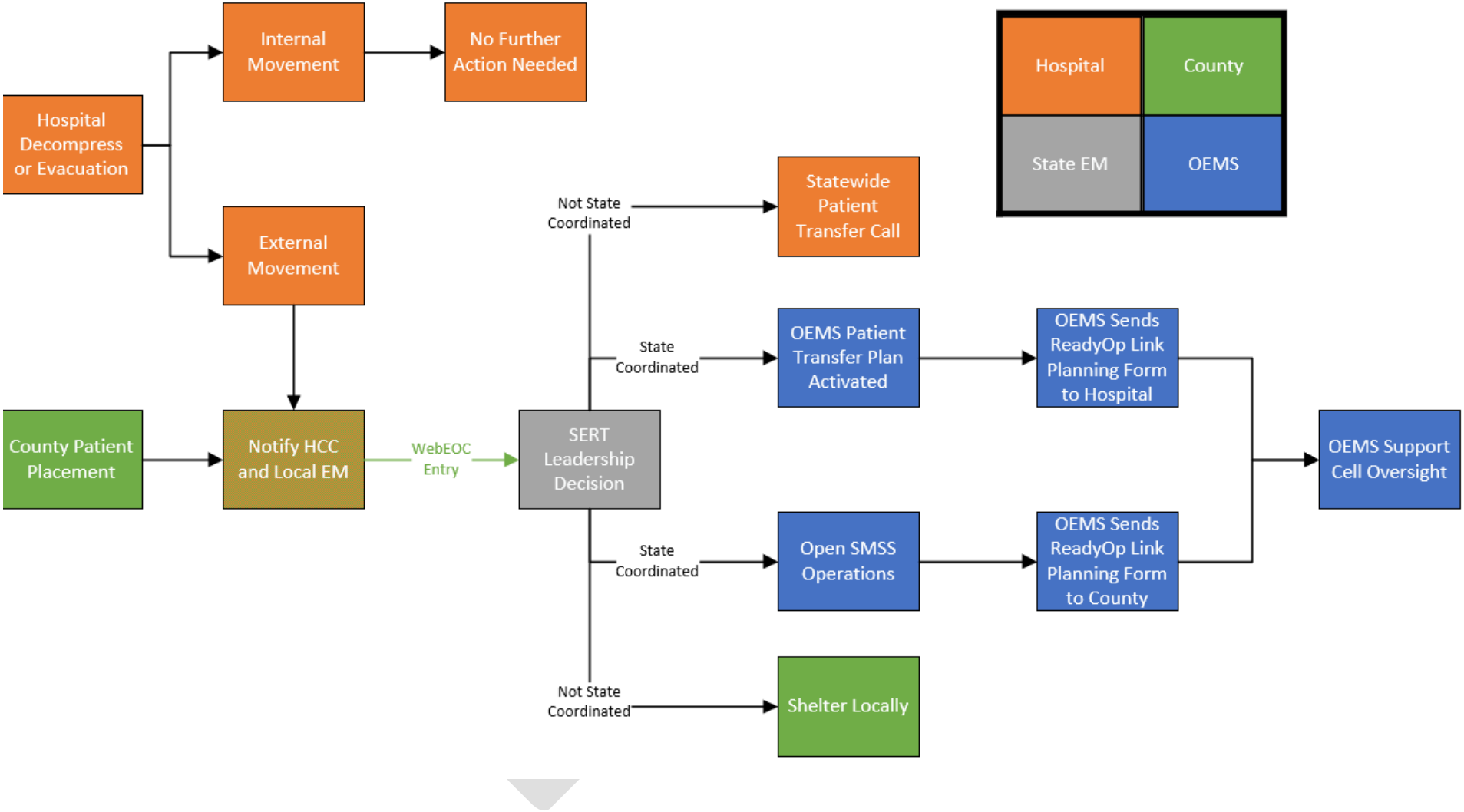


Figure 1.3: Patient Movement High Level Process

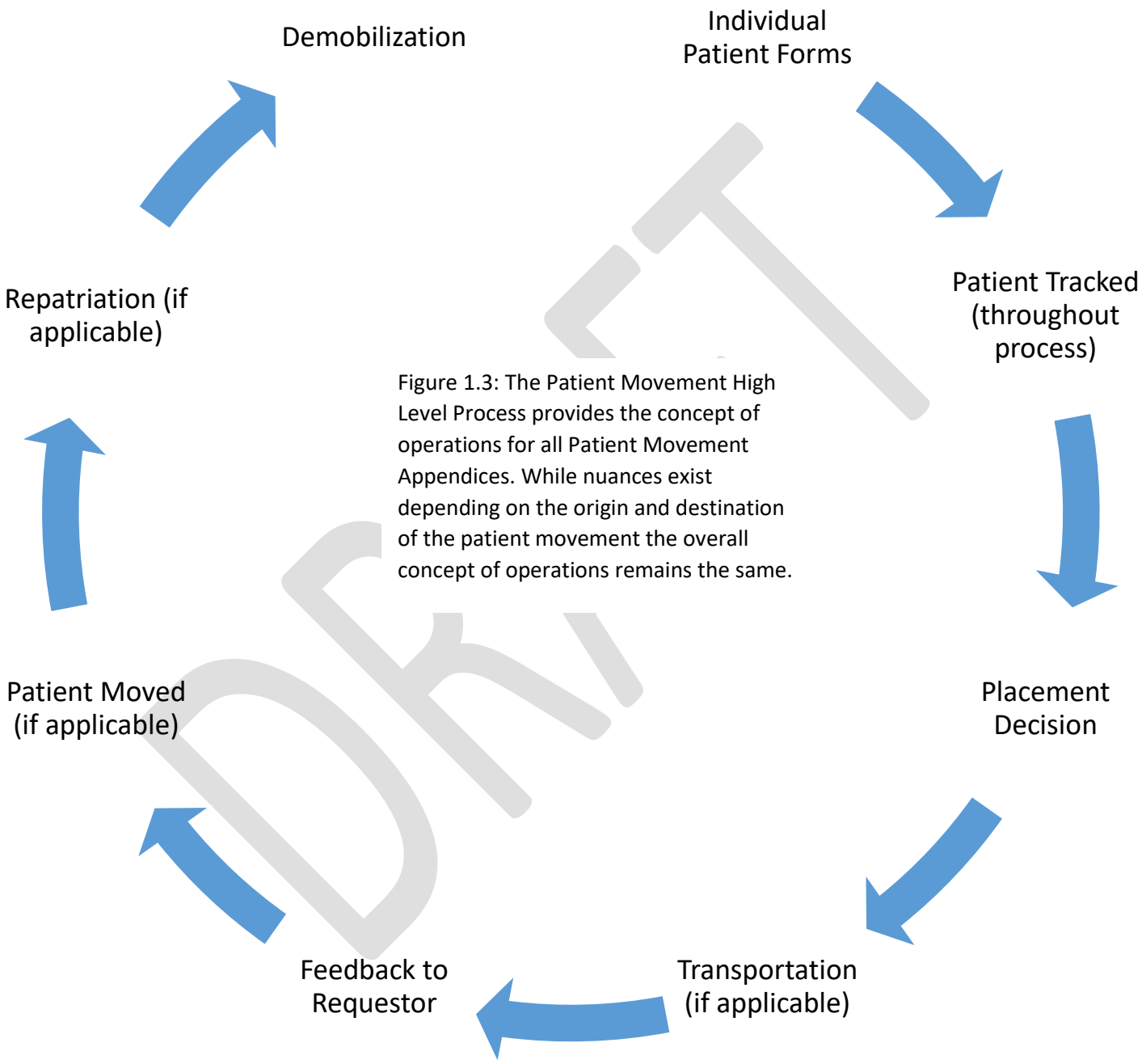


Figure 1.3: The Patient Movement High Level Process provides the concept of operations for all Patient Movement Appendices. While nuances exist depending on the origin and destination of the patient movement the overall concept of operations remains the same.

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX F

Situational Awareness & Information Sharing

November 2021

Table of Contents

Purpose

The purpose of the Situational Awareness and Information Sharing annex is to provide a framework for how the North Carolina Office of Emergency Medical Services (NCOEMS) maintains situational awareness and coordinates information sharing with partners in a timely manner across the Healthcare System in North Carolina. Maintaining day to day situational awareness regarding potential threats that may impact the healthcare system, threats that have impacted the healthcare system, and ensuring this information is shared appropriately is a key component to the mission and goals for NCOEMS role as Emergency Support Function 8: Health & Medical. This annex provides a standard process and mechanism for gathering, analyzing, and ultimately sharing critical situational awareness to healthcare partners during an incident or event.

Assumptions

- This annex is intended for use in conjunction with the NCOEMS Emergency Operations Plan.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for ESF8 and is responsible for providing situational awareness and sharing information across the healthcare system on a day-to-day basis.
- Detailed information may not be available immediately following an incident resulting in the need to prioritize the most critical pieces of information early on and gather more in-depth details as the incident progresses
- Healthcare Organizations are autonomous entities and choose what information to share with NCOEMS
- Transparency and proactive communication are essential for accurate situational awareness and maintaining trust with partners is key to ensuring good situational awareness

Concept of Operations

Activation

- Appendix 2: The NCOEMS Shift Duty Officer SOG, outlines a 24/7 process for maintaining situational awareness and sharing information across the healthcare system every day. Appendix 2 also outlines the process for activation of the NCOEMS Emergency Operations Plan (EOP). Upon activation of the EOP, the Situational Awareness & Information Sharing Annex will simultaneously be activated as a core component of the coordination, collaboration and communication required to respond to any emergency or disaster that may impact the healthcare system.

Notification

- Initial notification of the activation of the NCOEMS EOP to healthcare partners is considered situational awareness and information sharing therefore no additional notifications shall be required.

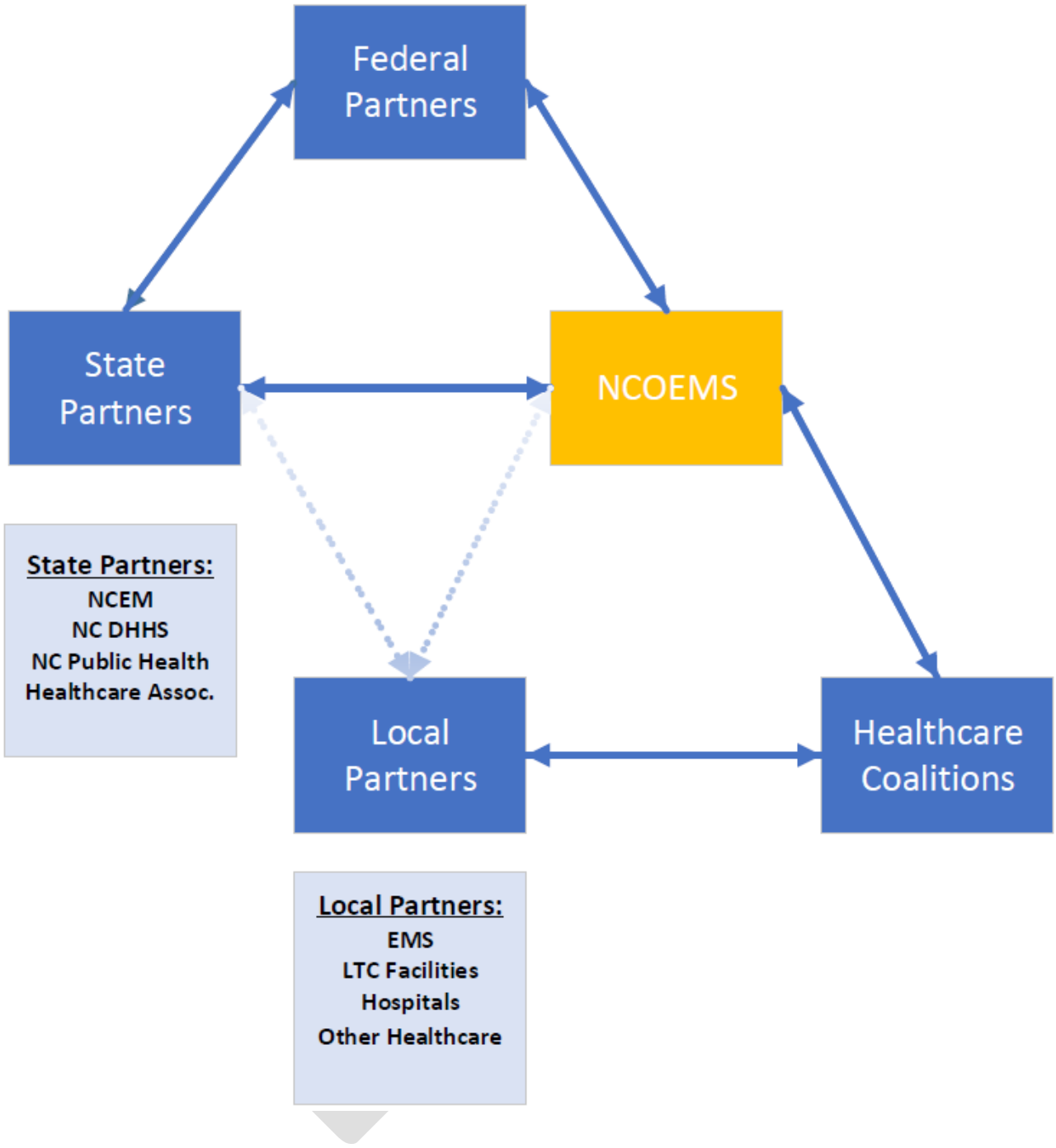
Situational Awareness

- Purpose: Situational awareness is defined as maintaining knowledge of what is going on around you or your agency. In the context of this annex, specifically if impacts have occurred or are anticipated to occur to the

healthcare system, the primary purpose of sharing the information is to provide an early warning. Providing initial and ongoing situational awareness can allow federal, state, regional and local healthcare partners to initiate preparedness and response actions, such as identifying potential resources, activating staff, turning on emergency contracts, and making decisions on patient evacuations etc. For the most effective situational awareness a low threshold for sharing information should be utilized by all healthcare entities and local, regional, state, and federal partners (see triggers outlined below).

- Process: The process for maintaining situational awareness is based on bidirectional communication between federal, state, regional and local partners. Communications regarding real or potential impacts to the healthcare system should flow from local partners (county emergency management and/or healthcare partners), to Regional Healthcare Preparedness Coalitions (HCCs), to NCOEMS, to other state partners (NCEM, NCDHHS, Healthcare Associations etc.), and to federal partners (ASPR Regional Emergency Coordinators) as applicable. Other state and federal entities (NCEM, NCDPH, Healthcare Associations, ASPR RECs etc.) have their own established communication channels so many times the communications may flow laterally or top-down (see figure 1.1 Situational Awareness Communications Diagram). NCOEMS has the responsibility to maintain and provide situational awareness to the North Carolina Healthcare System (e.g. EMS Agencies, Long-Term Care Facilities, Hospitals, Dialysis Centers etc.) through the Regional Healthcare Preparedness Coalitions which is a key facet of the bidirectional communication.
- Process Exceptions: In some circumstances, NCOEMS will make the decision to communicate directly to the local partners. This is most commonly due to a need for expediency, privacy concerns and/or the regional HCC staff being overwhelmed. Additionally, the local healthcare partner emergency managers and/or emergency preparedness coordinators may contact NCOEMS directly. These two exceptions should be considered rare occasions and not the primary method of communications. The final exception in this process, which is more common, is when a local partner (e.g. county emergency manager, local public health department etc.) will contact a state level partner (e.g. NCEM, NC DPH etc.) directly to notify them of the situation and these state level partners will notify NCOEMS. All efforts will be made to ensure the HCC staff are aware of the communications when possible. Process exceptions are outlined in Figure 1.1 by the dotted lines showing these occasional alternate pathways of communication.

Figure 1.1 Situational Awareness Communications Diagram:



Information Sharing

- Purpose: Information Sharing is a key component of ensuring that situational awareness is maintained by the many partners and stakeholders to the North Carolina Healthcare System. Information sharing is defined as the ability to share healthcare system related status updates and essential elements of information to maintain a common operating picture and pertinent healthcare system data.
- Process: The process for information sharing relies on bidirectional communication between federal, state, regional and local partners. This may be in the form of situation reports, data collection and reporting, coordination calls and individual discussion between partners.

- Secure Info: Information regarding potential or real impacts to the healthcare system should be considered secure messages in most circumstances. NCOEMS will utilize one of the following methods to ensure the messages are handled appropriately:
    - *For Official Use Only* (FOUO): This marking on a document or email shows that the information is unclassified but considered controlled information. This marking can be used when sensitive information is being shared to indicate that it cannot be shared beyond those on initial distribution unless specifically authorized in the notification. Additionally, this information should not be posted or shared publicly.
    - *Homeland Security Traffic-Light Protocol* (TLP): This protocol helps ensure sensitive information is not inappropriately shared and will be utilized to ensure messages that should have limited distribution have a standard system for identification. Information shared should have the TLP labels, outlined below, in subject lines and the body of notifications.
        - TLP: RED: Should be utilized when information cannot be effectively acted upon by additional parties, and could lead to impacts on a party's privacy, reputation, or operations if misused. Recipients may not share TLP: RED information with any parties outside of the specific exchange, meeting, or conversation in which it is originally disclosed.
        - TLP: AMBER – Should be utilized when information requires support to be effectively acted upon, but carries risk to privacy, reputation, or operations if shared outside of the organizations involved. Recipients may only share TLP: AMBER information with members of their own organization, and only as widely as necessary to act on that information.
        - TLP: GREEN – Should be utilized when information is useful for the awareness of all participating organizations as well as with peers within the broader community or sector. Recipients may share TLP: GREEN information with peers and partner organizations within their sector or community, but not via publicly accessible channels.
    - *Encryption:* Information that could potentially contain sensitive information (such as Protected Health Information or PHI) must be sent via a HIPAA compliant platform or via encrypted email (as last resort) to ensure that the information is properly handled.
    - *Specific Groups:* Information that is allowed to be distributed but is intended for a specific subset of partners (e.g. Hospital Emergency Managers) should have the group specifically identified in the notification to provide awareness to the Healthcare Preparedness Coalitions who the intended audience is for distribution. If the information is not marked with FOUO or TLP specifically then the HCCs can choose what audience to distribute the message but at a minimum the identified audience should receive the email as soon as possible.
    - *HIPAA Compliant Information Sharing platforms*: NCOEMS maintains several HIPAA complaint platforms for use during an emergency. The below list outlines the systems used by NCOEMS and denotes whether they are considered HIPAA compliant or not.
        - NCSPARTA – WEBEOC: Not HIPAA compliant
        - NCTERMS: Not HIPAA compliant
        - OWNCLOUD: HIPAA compliant
        - READYOP: HIPAA complaint

- Methods: NCOEMS maintains a variety of methods for sharing information with healthcare partners for the purpose of maintaining situational awareness during an event. Each of the below sections describes different tools used to share the pertinent information.
    - *Website:* NCOEMS maintains two different websites with pertinent information and updates: www.nchpp.com and www.ncems.org
    - *Coordination Calls:* NCOEMS utilizes a variety of coordination calls to ensure the bidirectional sharing of information can occur during an activation. Typically the calls will be based on the operational

period (e.g. 24 hours operational period will have one coordination call per day). The frequency of calls is the decision of the NCOEMS ESF8 Lead & NCOEMS Operations Manager. Coordination call types may include the following:

- NCOEMS Staff
- NCOEMS & Operational Sites
- NCOEMS & NC Regional Healthcare Coalitions
- NCOEMS & Statewide Patient Coordination Team
- NC Regional Healthcare Coalitions & Healthcare Coalition Partners
- NCOEMS and NC Healthcare Associations/Partners/Stakeholders
- Region IV Unified Planning Coalition

- *Email Groups & List-Servs:* NCOEMS maintains a variety of email groups and list-servs to help ensure continuity of operations during an activation. These email addresses and list-servs hit a group of people to ensure the information is shared even when certain staff are off-duty. Primarily outgoing information is sent via ReadyOp but there are email groups and list-servs that can be utilized to share information with staff and partners:
  - dhsr.ncoems.sdo@dhhs.nc.gov – this email group goes to all NC HPP Shift Duty Officers (SDOs) – anyone can send a message to this group email.
  - dhsr.ems.esf8@dhhs.nc.gov – this email group goes to all NCOEMS deployable staff – anyone can send a message to this group email.
  - hppsystemssupport@dhhs.nc.gov – this email group goes to the HPP Systems Support Team and can be used for system support requests (e.g. ReadyOp, WEBEOC, iCAMs etc.) – anyone can send a message to this group email.
  - dhsr.oems.regional.hpp@lists.ncmail.net – this list-serv goes to all Regional Healthcare Preparedness Coalition Staff and Leadership. All NC HPP SDOs have the ability to send messages via this list-serv.
  - OEMSSEOC@dhhs.nc.gov – this email group is used for any staff working at the State Emergency Operations Center during an activation
  - oemssupportcell@dhhs.nc.gov– this email group is used for any staff working in the OEMS Support Cell during an activation – anyone can send a message to this group email.
  - oemspatientmovement@dhhs.nc.gov– this email group is used for any staff working as part of the OEMS Patient Movement team during an activation – anyone can send a message to this group email.
  - oemsstaffingsupport@dhhs.nc.gov– this email group is used for any staff working as part of the OEMS Staffing Support team during an activation – anyone can send a message to this group email.
  - oemslogistics@dhhs.nc.gov – this email group is used for any staff working as part of the OEMS Logistics team during an activation – anyone can send a message to this group email.
- *Situation Reports:* Written situation reports are crucial to providing key stakeholders and partners with information about the incident/event that has resulted in the EOP activation. The frequency of the situation report is the decision of the NCOEMS ESF8 Lead & NCOEMS Operations Manager. See Appendix 11 for more information on situation reports. (methods, frequency, EEIs)

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX G

State Coordinated Sheltering Concept of Operations

March 2022

Table of Contents

Purpose

The purpose of the North Carolina State Coordinated Sheltering Annex is to outline the concepts and coordinated frameworks used to establish medical and medical-supported sheltering operations in North Carolina. This annex is comprised of regional and statewide guidelines to include initial siting, capacities, management, staffing, community support, populations, establishment, and the overall operational coordination between NCOEMS, NCEM, and Healthcare Coalitions (HCC). Additionally, the plan outlines the expected roles and responsibilities of other state and local emergency response organizations to ensure maximum effectiveness and efficiency.

Situation

During emergencies and disasters, circumstances can occur where regional and state support is required to shelter the public. Primarily this happens when large areas of a community containing homes and healthcare facilities are temporarily deemed unsafe and local populations are asked to evacuate and/or healthcare facilities and resources become overwhelmed and unable to provide their usual level of service. In these situations, it is anticipated that regional, state, or federal assistance to establish and manage State Coordinated Sheltering operations will be required.

Planning Assumptions

The following planning assumptions were made during the development of this annex:

- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for Disaster Medical Services and is responsible for the maintenance, planning, coordination, and execution of the State Coordinated Sheltering Annex
- State Coordinated Sheltering includes both medical and medical-supported sheltering models.
    - Medical sheltering refers to sheltering for individuals with medical conditions requiring active monitoring and management by a credentialed medical professional during incidents that result in medical surge. The concept of operations for this model is contained in the State Medical Support Shelter (SMSS) Plan
    - Medical-supported sheltering refers to sheltering for the general population including individuals, with or without accompanying caretakers, that need some assistance to meet their daily medical needs. The concept of operations for this model is contained in the State Coordinated Shelter Medical Support (SCSMS) Plan
- The coordination of medical and medical-supported sheltering in this plan assumes activation of the State Emergency Operations Center (SEOC) and a request for support from a local or regional partner for NCOEMS and/or NCEM to assist with sheltering siting, establishment, and management during a disaster or emergency
    - NCOEMS will act as the operational and technical (medical) lead organization for siting, establishment, and management of State Medical Support Shelters in accordance with the SMSS Plan
    - NCEM will act as the operational and technical (mass care) lead organization for siting, establishment, and management of State Coordinated Shelters in accordance with the North Carolina State-Coordinated Regional Shelter Plan (NCSCRSP). NCOEMS will assist NCEM as the technical (medical) lead organization for providing medical support to these shelters in accordance with the SCMS Plan
- This annex will be used in conjunction with the NCOEMS Emergency Operations Plan to support operations outlined in the State Medical Support Shelter and/or the State Coordinated Shelter Medical Support Plans
- The concept of operations outlined in this plan can be used for all types of state supported State Coordinated Sheltering scenarios regardless of the examples provided in this plan
- State Coordinated Sheltering operations are slow moving and state activation and access to resources may be delayed. Ample notice and early warning are necessary to provide time to support State Coordinated Sheltering operations
- An individual's health may not improve within mass sheltering operations. Mass sheltering operations may expose individuals to additional risks associated with exposure to new environments, living in close proximity to unfamiliar people, the exacerbation of existing medical conditions, or other stresses subsequent to the originating event/incident

- Ideally, all North Carolina families and residents, government jurisdictions (city/county, etc.), healthcare systems and facilities should maintain and execute their own sheltering/evacuation plans to maximize positive health outcomes and preserve limited state sheltering resources for individuals and entities whose plans are untenable and are in need of additional sheltering support
- During the State Coordinated Sheltering process, all efforts are directed toward maintaining safe, secure, and sanitary environments and ensuring that continuity of care is maintained for those individuals requiring medical care
- All sheltering operations are subject to weather conditions and safety considerations
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with State Coordinated Sheltering activities and the responsibility for costs resulting from State Coordinated Sheltering are primarily the obligation of the requesting entity

Concept of Operations

Pre-Activation Operations

- Shelter Siting and Identification: The activation and execution of State Coordinated Sheltering operations must be preceded by a planning process which adequately identifies sites that meet requirements basic to their successful establishment, operation, and demobilization. These requirements include adequate facilities, essential services, and community support. Summary examples of these requirements are provided below however, more specific detail is provided within the SMSS and SCSMS plans.
    - Adequate Facilities are those that:
        - Contain adequate space to house their planned capacity for patients or residents and their pets/service animals in addition to the staff, equipment, supplies, and vehicles (cars, trucks, trailers, etc.) necessary for operations
        - Address access issues for patients, residents (including children), and staff and are compliant with Americans with Disabilities Act (ADA) requirements for shelters
        - Have utility services adequate to serve their planned capacities plus staff and include at a minimum, power, water, sewer, communications (including internet), and functional HVAC systems (with service support)
        - Are located in areas with adequate infrastructure, close to major highways to ease operational access, markets, pharmacies, healthcare facilities to ease patient/resident needs, but outside of flood plains, and high crime areas
    - Essential Services include those that provide support to patients, residents and staff, the facility, and shelter operations. These services include:
        - Feeding (patient and resident), staff lodging, site security, laundry/linen, and mobile showering/toileting/handwashing
        - Health/Safety (Public Health/Fire inspection), environmental (janitorial and waste management), material handling (forklifts/pallet jacks), fuel, lighting, and back-up power (light tower/generator), water/ice, and mortuary
        - Medical/non-medical transportation, hospital, pharmacy, dialysis, telemedicine, repatriation/relocation (when return home is safe or not) shelter administration and communication support
    - Community Support includes the ability establish and maintain Facility Use Agreements, Memoranda of Agreement, contracts, etc. with facility owners, service providers, local healthcare facilities, and social service organizations necessary to maintain State Coordinated Sheltering operations as planned.

- Shelter Review and Selection: Facilities considered for use as a State Coordinated Shelter undergo a series of reviews, including walk-through inspections, prior to selection to ensure that they substantially meet the requirements summarized above. Ideally, this process should be ongoing and be executed well ahead of any need however, no-notice disasters and situations in which previously established shelter sights are inaccessible (flood) or unusable (damaged) may require that the process be completed within a 24-to-72-hour time period. Participants in these reviews/inspections include leadership and potential members of shelter Incident Management Teams, medical support teams, and logistics support teams representing NCEM and NCOEMS, shelter facility ownership, and representatives of essential service providers. As stated in the planning assumptions above, NCOEMS is the lead agency for coordination of review and selection processes for SMSS shelters while NCEM is the lead agency for SCS shelters. More specific details on how processes should be conducted can be found in the operational plans for each type of facility. The end goal of these processes is to ensure that all potential participants are aware of what is needed of their organizations and can endorse the Facility Use Agreements, Memoranda of Agreement, contracts, etc. necessary to establish safe, secure, and sanitary, medical, and medical-supported shelters.

Activation

- The ESF8 Lead has the authority to activate this annex in consultation with North Carolina Emergency Management. This decision is informed by information shared by local and regional partners when there is an immediate or anticipated need to shelter individuals beyond what the local resources can manage.
- Activation is usually initiated by an official request for sheltering support to the SERT through the WebEOC system. However, this annex may be activated prior to or during any event where there is an anticipated need for state coordinated support for sheltering. The specific plans addressing the sheltering of individuals (SMSS, NCSCRSP with SCMS) will be activated, in turn, depending on the situation, needs of the request, or the anticipated need for sheltering exists depending on the location (e.g., coastal areas, etc.), refer to specific plans for detailed guidelines.

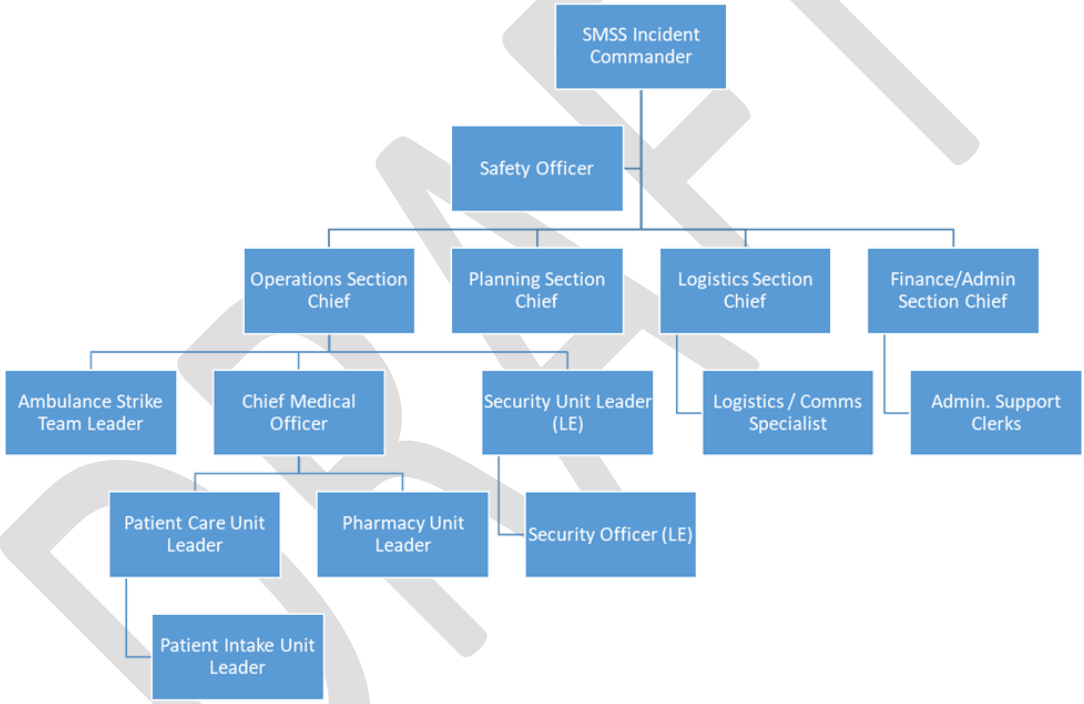
Notification

- Upon activation of this annex, the ESF8 lead, or designee is responsible to ensure notification to all State Medical Response System partners and North Carolina Department of Health & Human Services (NC DHHS) leadership and other organizations essential to the ability to provide sheltering such as representatives of sheltering facilities and service providers as detailed in the SMSS and SCMS plans. In these situations, it is likely that the NCOEMS EOP has already been activated to, at least, Level Orange and much of the internal notification and coordination with SMRS organizations with sheltering assets (HCCs) has occurred.
- If the sheltering operations are expected to impact other states and/or state sheltering resources are anticipated to be overwhelmed, the HHS Region IV Unified Planning Coalition (UPC) and Assistant Secretary of Preparedness and Response Regional Emergency Coordinators (RECs) should be notified as well in anticipation of Emergency Management Assistance Compact and/or Federal resource requests.

State Coordinated Sheltering Concepts

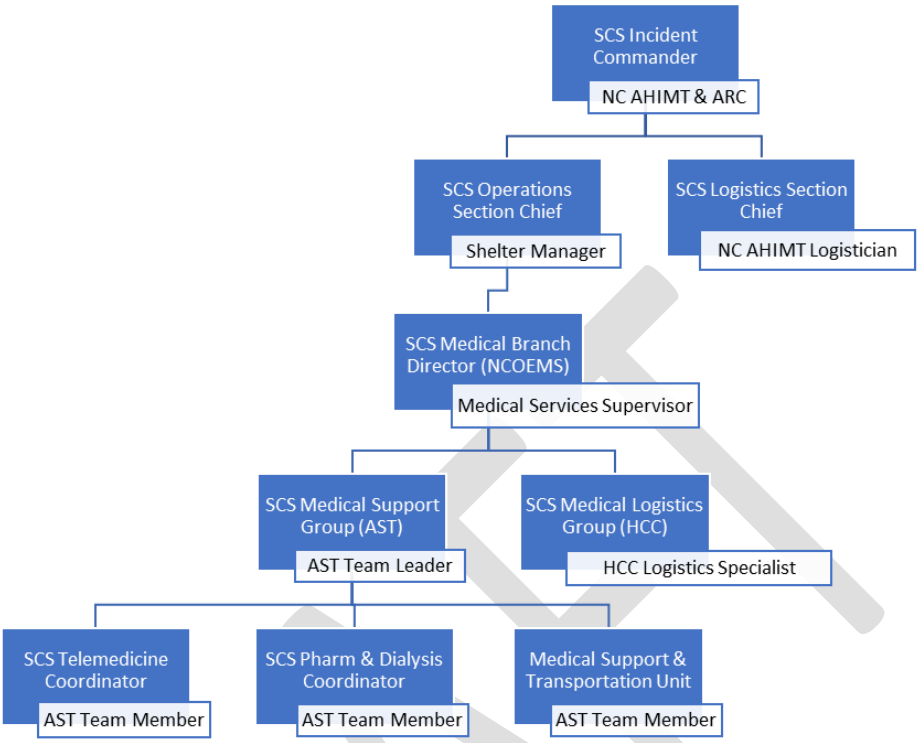
- State Coordinated Sheltering: Medical and medical-supported sheltering should be considered a last resort when all other options, such as sheltering at homes, hotels, or other facilities, outside of areas expected to be affected by an event is no longer an option. As stated in the Planning Assumptions, all North Carolina families and residents, government jurisdictions (city/county, etc.), healthcare systems and facilities should maintain and execute their own sheltering/evacuation plans. This maximizes positive health outcomes and preserves limited state sheltering resources for individuals and entities who will need sheltering support. Jurisdictions in need of sheltering support should encourage residents to bring whatever medical supplies (e.g., pharmaceuticals, durable medical equipment, oxygen, etc.) and support (e.g., caregivers) they usually rely on with them. Healthcare facilities in need of sheltering support should be prepared to send staff, equipment and supplies with the patients.

- Shelter Management: The management of medical (SMSS) and medical-supported (SCS) shelters will follow Incident Command System (ICS) guidelines for Incident Management Teams (IMTs). The role of NCOEMS within the IMT will change to reflect the different levels of responsibility that NCEM and NCOEMS hold depending on the type of shelter. However, regardless of the type of shelter, medical personnel assigned by NCOEMS have authority and direct responsibility for all medical operations. A summary of the management structures is provided below.
    - *SMSS:* NCOEMS is responsible for staffing the entire IMT for this type of shelter. The SMSS is managed using a standard IMT structure with most positions filled by NCOEMS, HPP, HCC, personnel or vetted SMRS medical volunteers. Ideally, some or all of the individuals selected for these positions will have participated in the pre-activation activities summarized above for the facility being used. Positions not held by these personnel are non-medical in nature and provide essential services to the SMSS Incident Commander. These include Case Workers from Social Services agencies and Law Officers from law enforcement agencies. All members of the established SMSS IMT report through the chain of command up to the SMSS Incident Commander and are expected to manage their assigned functions and advise the SMSS IC of any issues that need to be addressed to better meet the mission of the shelter. The basic organization of an SMSS IMT is shown below.



    - *SCS:* NCOEMS is responsible for staffing the Medical Branch of the established IMT for this type of shelter. Similar to the SMSS, Medical Branch positions are filled by NCOEMS, HPP, HCC, personnel or vetted SMRS medical volunteers, in particular those associated with Ambulance Strike Teams (ASTs). The Medical Lead assigned to the shelter will lead the Medical Branch as the Medical Services Supervisor and reports through the NCEM-assigned IMT to the Operations Section Chief who is the Shelter Manager. All other IMT positions including the Incident Commander in this management structure are assigned by NCEM. In a support role, the Medical Services Supervisor is expected to work closely with the Shelter Manager and other members of the NCEM IMT in support of the mission and in order to build trust and foster good teamwork. However, as stated above, in matters regarding the health or medical status of a sheltered individual, the Shelter Manager should defer to the Medical Service Supervisor. Additionally, any unmet health or medical need for the Medical Branch should be communicated as soon as possible to the ESF8 Lead or their designee and copied to the Shelter Manager for situational awareness purposes. All members of the established SCS Medical Branch report through the chain of command up to the Medical Service Supervisor (MSM) and are expected to manage their

assigned functions and advise the MSM of any issues that need to be addressed to better meet the mission of the shelter. The basic organization of an SCS Medical Branch in relation to the SCS IMT is shown below.



- Shelter Capacities and Space for Medical Care: The configurations of both types of shelters are meant to be flexible and tailored to the situation with varying capacities based on the anticipated need from displaced patients (pts.) and individuals. Shelter capacities by shelter type are provided below.
    - SMSS - Type III Shelter; 0 - 50 pts.; Type II Shelter; 51 – 100 pts.; Type I Shelter; 101 – 150 pts.
    - SCS - 500 Shelter – 500 individuals; 1000 Shelter – 1000 individuals; 2000 Shelter – 2000 individuals

  The overall space needed for SCS operations may be greater due to the greater population capacities however, the area(s) actually needed to provide health and medical services to sheltered individuals will likely be much smaller than an SMSS. This is due to the differences in medical sheltering where the entire population requires care at all times and medical-supported sheltering where some fraction of the population may need care some of the time. The differences in the medical mission (First Aid vs. Total Care) do not result in large differences in the space needed per patient (or potential patient for the SCS), approximately 100 square feet should be planned per patient. Using this information, the following space estimates for patient areas are provided:
    - SMSS operations - 3500-5000 square feet per 50 patients
    - SCS operations - 400-1000 square feet per 500 sheltered individuals

  These estimates are based on real world experience, e.g., the provision of 4 – 10 medical beds (cots) were adequate to meet basic medical aid and observation needs in an SCS 500 type shelter during Hurricane Dorian and are congruent with available guidance. More detailed information on this subject is provided in the respective SMSS and SCS operational plans.

- Establishment of Shelter Operations: Both SMSS and SCS shelters require extensive coordination and support from NCOEMS, NCEM, and other organizations to establish and, the work to do so must be undertaken under safe conditions. For these reasons, requests to establish shelters should be made as early as possible prior to the impact of any anticipated event (e.g., hurricane) and alternatively, may not be able to be acted upon until safe conditions have returned following unanticipated events (e.g., tornado). The time necessary to establish these shelters will vary depending on multiple factors but for planning purposes a time factor of 24 to 72 hours

should be considered with 24 hours representing perfect situations where all necessary facilities, services, assets, personnel, and weather are available and 72 hours representing less than perfect situations where the readiness of one or more of these elements hinders progress.

Also, close coordination between NCOEMS, NCEM, and local jurisdictions requesting sheltering, concerning the types and locations of shelters being established, and what populations they are suited for, is essential to ensure that each shelter receives the populations that they are designed to serve. An SCS shelter is not equipped to accept patients requiring total care and an SMSS shelter does not have the space or resources to shelter the general population. In addition, whenever an SMSS is established, it is important for the ESF8 Lead, their designee, or Support Cell staff to confirm, through NCEM-Operations and Human Services (ESF6 Lead) that separate, general population sheltering operations have been established to serve the requesting jurisdiction(s). More detailed information on this subject is provided in the respective SMSS and SCSMS operational plans.

- Transportation: A key part of State Coordinated Sheltering is the coordination and oversight of the transportation of patients and residents safely and efficiently from affected areas to established shelters. Additionally, once these individuals are sheltered (SMSS or SCS) medical and non-medical transportation resources must be available to transport them to nearby Emergency Departments, if they have a health emergency that requires a higher level of care (e.g., seizure, trauma, etc.) or to other healthcare facilities, if they have health issues that require routine maintenance (e.g., dialysis treatment). Transportation assets of Ambulance Strike Teams (ASTs) are planned to be utilized in both sheltering operations as noted in the organization charts listed above however, the ability to maximize the use of available transportation resources and coordinate these potentially scarce assets is key to successful State Coordinated Sheltering operations. Additional non-medical transportation resources should be sought and utilized to transport patients or residents whose health condition allows it. This is most applicable to SCS sheltering situations due to the healthier population and is a reason that these services should be considered in the establishment of SCS shelters. For details regarding patient transportation, refer to Annex D Patient Movement Concept of Operations and its appendices covering SMSS Patient Movement (Appendix 8) and Patient Transportation (Appendix 10).

- Repatriation and Demobilization of Shelter Operations: As the danger which initiated the establishment and operation of SCS sheltering passes, most individuals in medical-supported shelters (SCS) will return home on their own while most individuals in medical shelters (SMSS) will need medical transportation back home. Prior to the release of patients from an SMSS, housing assessments need to be made to ensure the homes that patients are returning to are safe, habitable, and have operational utilities. Sheltered individuals with intact homes will be returned home via available medical transportation services as soon as possible in accordance with procedures found in Annex D Patient Movement Concept of Operations and its appendices covering SMSS Patient Movement (Appendix 8) and Patient Transportation (Appendix 10). If homes cannot be returned to, sheltered individuals must be repatriated to temporary housing that is capable of meeting their medical needs prior to the demobilization of the activated SMSS. Typically, this work is conducted by state or local Division of Social Services (DSS) case managers/discharge planners that have been assigned to the SMSS through NCEM Human Services (ESF6). Additional details and a job action sheet for this function can be found in the SMSS plan.

State Coordinated Sheltering Roles

- State Coordinated Sheltering Leadership: Upon decision to activate the State Coordinated Sheltering annex, the ESF8 lead, or designee will assign an NCOEMS staff member to the role of SMSS Incident Commander (SMSS) or ESF8 Medical Lead (SCSMS) depending on the type of shelter being opened. These individuals have oversight and responsibility for all ESF8 operations at their respective shelters and can request to add or detract personnel to support the operations as the needs change. These positions are responsible to complete Situation Reports for their shelters, at a frequency set by the ESF8 lead, to include total number of residents / patients within each phase of the sheltering process (incoming, sheltered, outgoing).

- State Coordinated Sheltering Personnel: Detailed roles and responsibility information about each of the staff positions listed on the organization charts listed above under Shelter Management, including job action sheets, are provided in the operational plans for each shelter type. Refer directly to the SMSS and SCSMS plans for this information.

State Coordinated Sheltering Responsibilities

- Identification of Sheltered Individuals:
  - *SMSS:* Identification of sheltered individuals is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.) as they have the information necessary to ensure safe decisions are made on the sheltering of these individuals. The NCOEMS has an established process to request additional state support for Patient Movement, see SMSS Patient Movement (Appendix 8). This process includes the submission of patient placement request forms to the Support Cell for review prior to transport and results in the identification of each individual patient being transported to the SMSS as well as their medical needs
  - *SCS:* Identification of sheltered individuals is the responsibility of the SCS Incident Commander and IMT assigned by NCEM. Details on this process can be found in the North Carolina State-Coordinated Regional Shelter Plan (NCSCRSP)

- Placement of Sheltered Individuals: The placement of residents and patients seeking shelter into the appropriate type of shelter is the joint responsibility of the SERT and the jurisdictions or healthcare facilities seeking shelter for their residents and patients. NCOEMS patient movement plans detail a process for patient placement and include a statewide Patient Placement Guideline (PPG) which is actively shared with the SERT, local jurisdictions, and healthcare systems to facilitate this process.
  - *SMSS:* An NCOEMS Patient Placement Coordinator and Medical Provider assist organizations with the proper placement of individuals planned for transport to SMSS shelters. Using their expertise and the PPG, they provide recommendation for placement to sending organizations to ensure that patients are properly placed to an SMSS, hospital emergency department, local population shelter, or an SCS
  - *SCS:* Members of the assigned SCS Medical Support Group conduct health checks/initial triage on individuals entering an SCS. Using their expertise and the PPG, they provide recommendation for placement to the individual to ensure that the individual is properly placed to an SMSS, hospital emergency department, or the SCS

- Treatment of Sheltered Individuals:
  - *SMSS:* Treatment of patients in an SMSS, including decisions to move to a higher level of care, falls under the responsibility of the assigned Chief Medical Officer (CMO). SMSS patients are constantly monitored and the CMO is responsible for providing medical treatment orders to the Patient Care Unit Leader and their medical staff as necessary in order to maintain and/or improve their medical condition. Additional information including job actions sheets can be found in the SMSS plan.
  - *SCS:* Treatment of residents, including decisions to move to a higher level of care, falls under the responsibility of the Medical Services Supervisor. SCS residents are periodically monitored for health issues but also self-report to the established SCS patient care area. There, residents may be placed in an area for observation, or basic First Aid and similar care may be rendered by members of the Medical Support Group (AST members) or through a telemedicine service. If higher levels of care are needed, medical staff are expected to notify the MSM so that transportation of the resident to an appropriate healthcare facility can be coordinated.

- Transportation of Sheltered Individuals:
  - *SMSS:* Transportation to deliver patients to an SMSS and return them home after the danger has passed, is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.). However, when sending entities need state support to do this, NCOEMS will assign a

patient Transportation Coordinator to assist with state patient transportation assets. Transportation of patients to other healthcare facilities during a patients stay at an SMSS would be coordinated by the SMSS IMT and executed through the assigned Ambulance Strike Team Leader. Additional details on the patient transportation plan are available in Appendix 10: Patient Transportation Guideline

- *SCS:* Transportation to deliver residents to an SCS and return them home after the danger has passed, may be by any means necessary and may not be controlled by any one organization. However, once sheltered individuals have been in-processed, and for the duration of their stay in the shelter, a combination of medical and non-medical transportation resources may be utilized by the SCS IMT in coordination with the NCOEMS-assigned Medical Service Supervisor to transport them to and from medical appointments, see Transportation under State Coordinated Sheltering Concepts above

- Tracking of Sheltered Individuals:
  - *SMSS:* Tracking of patients at an SMSS is the responsibility of the NCOEMS SMSS IMT working in conjunction with the NCOEMS Support Cell Patient Transportation Coordinator and/or Tracking Unit. A patient tracking system will range from pen and paper to technology-based tracking systems (such as Appriss Health or ReadyOp). Additional details on patient tracking are available within Appendix 10: Patient Transportation Guideline
  - *SCS:* The tracking of sheltered individuals is the responsibility of the SCS Incident Commander and IMT assigned by NCEM. Details on this process can be found in the North Carolina State-Coordinated Regional Shelter Plan (NCSCRSP). However, the tracking of sheltered individuals who leave and return to the SCS to receive medical services is the responsibility of the assigned Medical Services Supervisor and the Medical Support Group Leader

Figure 1.0: State Coordinated Sheltering High-Level Process

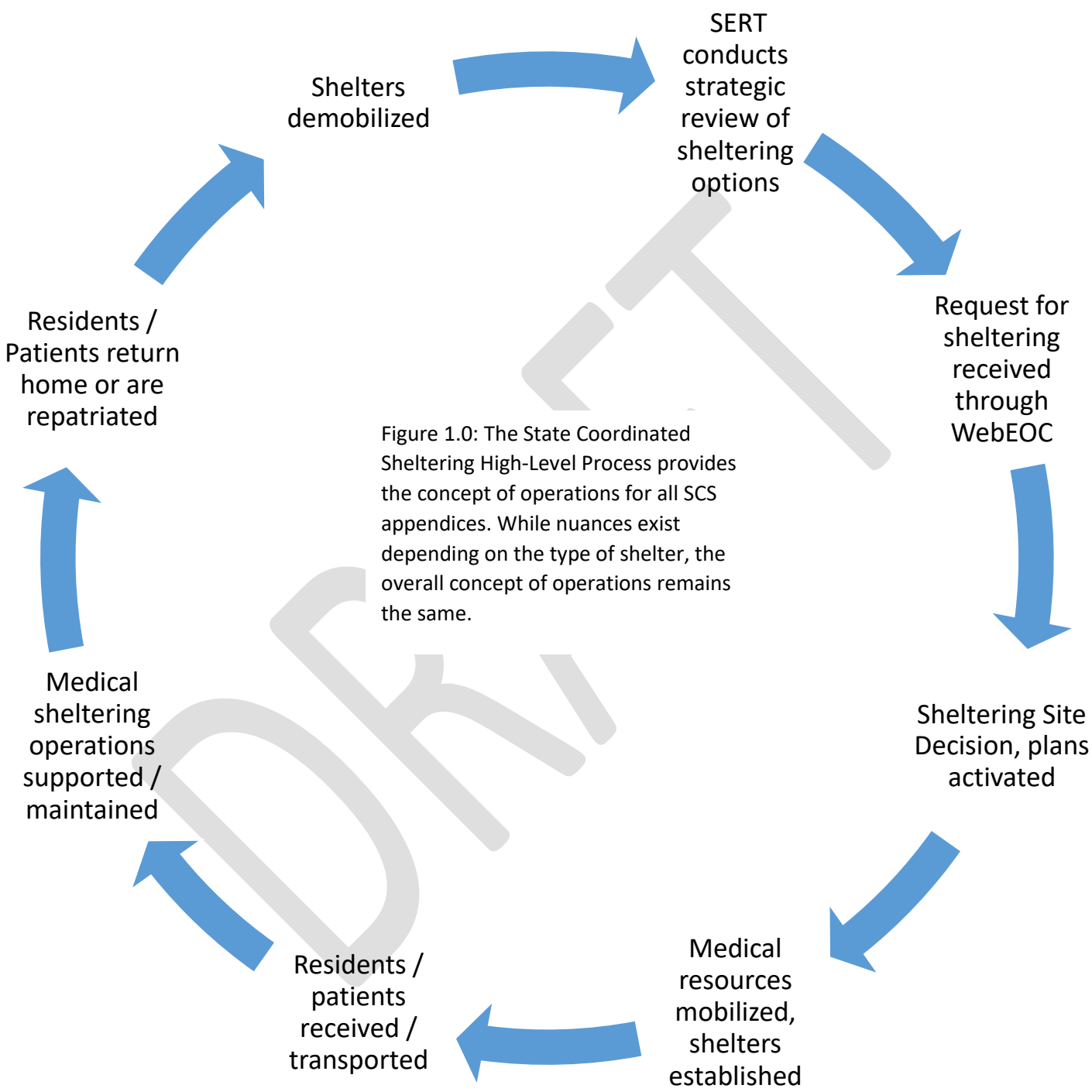


Figure 1.0: The State Coordinated Sheltering High-Level Process provides the concept of operations for all SCS appendices. While nuances exist depending on the type of shelter, the overall concept of operations remains the same.

Appendix 1: ESF8 SEOC/Support Cell Staffing and Sustainment SOG

PURPOSE & SCOPE: These guidelines cover the development and dissemination of staffing plans, notification of activated personnel, battle rhythm, and the sustainment of ESF8 SEOC/Support Cell operations over a 24-hour schedule.

STAFFING PLANS: Once activation is decided, the ESF8 Lead, or their designee, will be responsible for the development, dissemination, and management of the Staffing Plan for the SEOC ESF8 Desk, Support Cell, and other ESF8 operational locations. Staffing plans should be initiated and completed as soon as possible after notification of an event/incident that may result in the activation of the SEOC ESF8 Desk. Initial staffing plans should cover the first 72-hours of operations and should be provided to the SERT-ESG Supervisor when requested.

STAFFING PLAN DEVELOPMENT: The following planning factors need to be considered in the development of any staffing plan:

- Personnel: The NCOEMS staff listed below should be considered first for positions upon initial activation. If additional personnel are needed to meet staffing requirements, it should be coordinated between the ESF8 Lead, or their designee, and the appropriate manager.
    - NCOEMS Shift Duty Officers
    - NCOEMS Managers,
    - Other staff meeting NCOEMS training requirements in the Training, Exercise, Response Management System (TERMS)
- Staffing Levels: Will vary according to the situation and NCOEMS Activation Level. Once established, levels may be adjusted by the ESF8 Lead or their designee.
- Rotation: Once established, the staffing of the SEOC ESF8 Desk will rotate on a schedule maintained by the ESF-8 Desk Manager or their designee.
- Shift Times: SEOC ESF8 Desk Shift times will vary according to the situation and NCOEMS activation level. The first hour of every shift will be used to brief and orient oncoming personnel to the current operational situation and mission support issues. In general:
    - Yellow Activation (day operations only):
        - Day shift - 0700-1900
    - Orange/Red Activation (24-hour operations):
        - Day shift – 0600-1600
        - Swing shift - 1200-2200
        - Night shift - 2100-0700

Staffing Availability Survey and Plan: Utilizing the ReadyOp program (https://nc.readyop.com/), the ESF8 Desk Manager, or their designee, will develop a survey to capture personnel availability (refer to ReadyOp User Guide). The survey will be disseminated via email to NCOEMS deployable personnel (DHSR.EMS.ESF8@lists.ncmail.net) and the results of the survey will be used to develop the staffing plan. Staff sending the survey should monitor ReadyOp for returned availability surveys. The content of surveys will vary depending on the situation, but the survey and the resulting staffing plan should include the following essential elements of information:

- Incident/Event Name
- Date Prepared
- Staff Name (Full Name)
- Staff Contact Information (Phone, E-mail, etc.)
- Day (of week) and Date (Month/Day) staffing is needed

- Shift Times
- Comments (issues affecting availability, optional)

STAFFING PLAN DISSEMINATION: Staffing plans, once complete, should be posted to ownCloud and emailed to:

1. DHSR.EMS.ESF8@lists.ncmail.net
2. DHSR.OEMS.Regional.HPP@lists.ncmail.net
3. SERTEmergencyServices@ncdps.gov

Any event specific information (reporting time, location, applicable maps, meal plan and specific equipment that may be required etc.) should be emailed out with the staffing plan. Map to the SEOC is listed at the bottom of this plan for individuals that may not be familiar with the location.

STAFFING PLAN MANAGEMENT: Once staffing plans have been developed and disseminated, SEOC ESF8 Desk staff will update and/or initiate the extension of these plans as necessary beyond the initial 72-hours of response/recovery operations or to otherwise meet the requirements of the situation. Update and expansion of these plans will be conducted in coordination with the ESF8 Lead or their designee.

BATTLE RHYTHM: The schedule for ESF8 operations (e.g. personnel work shifts, times for situation reporting and conference calls, etc.) will be determined by the Activation Level selected by the ESF8 Lead. Once determined, selected ESF8 Desk staff will be responsible for managing and maintaining the established battle rhythm, refer to Operational Activity and Reporting Schedule below.

Operational Activity/Reporting Schedules State Emergency Operations Center (SEOC) and NCOEMS Day Shift: 0600 – 1600; Swing Shift: 1200 - 2200, and Night Shift: 2100 - 0700			
SEOC Schedule		**ESF8 Desk/Support Cell Schedule**	
0500	NWS Advisory		
0600	NCDPS Conference Call with RCCs/Branches	0600	NCDPS Conference Call with RCCs/Branches
0700	SERT Briefing (Situation Room) and Shift Change	0700	ESF8 Sit-Rep/NCOEMS objectives information due to SEOC ESF8 Desk Rep. Reports assembled. **Attend SERT brief and conduct shift change.**
0800	Counties update County Summary Board in WebEOC		
0900	Situation Report information due to SEOC Planning Section (IS-209)	0900	**ESF8 Situation Report completed, forwarded to SERT ESG Supervisor, and published to WebEOC by ESF8 Desk Representative and emailed to staff & partners**
1000	SERT Operations Tactics Meeting	1000	NCOEMS personnel as requested by the SERT Lead attend (ESF8 Lead and/or SEOC ESF8 Desk Rep.)
	SERT Situation Report published in WebEOC		
	SERT Finance Report published		
1030	SERT Senior Staff Meeting	1030	NCOEMS personnel as requested by the SERT Lead attend (ESF8 Lead and/or SEOC ESF8 Desk Rep.)
1100	NWS Advisory	1100	**NCOEMS Conference Call with SEOC ESF8 Desk Representative, regional healthcare coalition staff, and invited ESF8 partners.** Led by ESF8 Lead, ESF8 Operations Manager or designee
1200	NCDPS Conference Call with RCCs/Branches	1200	NCDPS Conference Call with RCCs/Branches
1300	SERT Planning Meeting	1300	
1400	County Sit-Rep information due to RCCs	1400	NCOEMS all Staff Call
1500	Situation Report information due to SEOC Planning Section (IS-209)	1500	ESF8 Situation Report update (optional).
	Counties update County Summary Board in WebEOC		ESF8-specific information requested by the SERT Lead/SERT ESG Supervisor for inclusion in the SERT IAP due to SEOC ESF8 Desk Rep.
1600	SERT Situation Report published in WebEOC	1600	
1700	NWS Advisory	1700	ESF8-specific information requested by the SERT Lead/SERT ESG Supervisor for inclusion in the SERT IAP is forwarded to SERT ESG Supervisor.
	RCC IAP due to SEOC Planning Section		
1800	NCDPS Conference Call with RCCs/Branches	1800	NCDPS Conference Call with RCCs/Branches
1900	SERT Briefing (Situation Room) and Shift Change	1900	**ESF8 Situation Report information due to SEOC ESF8 Desk Rep. Reports assembled. Attend SERT brief and conduct shift change.**
2000	SERT IAP published for next Operation Cycle	2000	SERT IAP published for next Operation Cycle
2100	Situation Report information due to SEOC Planning Section (IS-209)	2100	**ESF8 Situation Report completed, forwarded to SERT ESG Supervisor, and published to WebEOC by ESF8 Desk Representative**
	Counties update County Summary Board in WebEOC		
2200	SERT Situation Report published in WebEOC		

SUSTAINMENT OF SEOC OPERATIONS:

STAFFING: During 24-hour operations the acting ESF8 Lead may adjust the staffing levels of active sections in consideration of the activation level and their judgment of the operational situation.

SHIFT CHANGES: Shift changes will follow the established 24-hour schedule for SEOC operations (day - 0600-1600, swing - 1200-2200, and night - 2100-0700) or otherwise as determined by the ESF8 Lead. Staggered shifts support operational continuity and the accurate transfer of operational information within each active section. To facilitate this, each active section must maintain a situation report and, in preparation for a shift change, the ESF8 Desk Manager, ESF8 Support Cell Coordinator, or other staff designated, will:

- Update the Situation Report in ReadyOp
- Brief the updated Situation Report to on-coming staff and ensure that on-coming staff are aware of:
    - Current operational schedule
    - Past missions, open missions, and planned missions
    - Open actions, deadlines, and expectations
    - Anticipated staffing requirements

EQUIPMENT & SUPPLIES: Staff is expected to utilize equipment regularly assigned to them (e.g. laptops, smart phones, radios, vehicles, etc.) during their active shifts. Staff should notify the ESF8 Desk Manager or ESF8 Support Cell Coordinator, as appropriate, for any additional equipment or supply needs. Requests for resupply will go through the NCOEMS administrative staff and follow established NCOEMS procedures as appropriate.

MEALS & LODGING: These services may need to be coordinated and provided for SEOC and Support Cell staff involved in extended or 24-hour operations. Typically, NCEM Logistics provides meals for all staff working at the SEOC without formal request however, meals for staff working at the Support Cell and lodging for staff at both locations usually requires a formal request from the ESF8 Desk. In these situations, the ESF8 Desk Manager and ESF8 Support Cell Coordinator, in coordination with the ESF8 Lead, are expected to arrange for meals and/or lodging for staff through the ESF8 Desk. ESF8 Desk will coordinate with NCEM Logistics to provide these services.

The Wright Building provides designated areas for meals, food storage (dry, refrigerated), and food preparation (cook, reheat, water, and beverage ice), personal care (sink, toilet), and facility maintenance (mop sinks).

FACILITIES: The sustainment of operations at the SEOC and Support Cell are dependent on 24-hour access to secure work areas with adequate space and personnel support facilities (kitchen, showering, sleeping, etc.), and the continued function of communication (internet, radio, cell, etc.) and utility systems (power, water, HVAC, etc.) provided at the Joint Force Headquarters and Wright Building respectively. The amenities provided by the Wright Building and the Joint Force Headquarters (maintained by NCEM) support most of these needs however, food services are not available at the Wright Building, and specific areas for lodging (e.g. showering and sleeping) are not available at either location. If needed, these services should be coordinated through NCEM Logistics, refer to Meals & Lodging above.

Support Cell Facility Sustainability Matrix: The capabilities and limitations of the Wright Building for sustainment of 24-hour operations are provided in the matrix below. The matrix identifies essential operational and utility systems, their purpose/service, vulnerability to power outage, and contacts for maintaining these systems during operations.

Resource	Type	Service	Notes	Back-Up Power
Back-Up Power Sources	Generator	Equipment on red electrical outlets Rooms: 107 (Support Cell) & 124 lighting Building emergency lighting UPS (connected to red outlets)	Dedicated to building Starts automatically when power drops. Run time: 1 week, tested monthly No local access.	Fuel
	UPS (Battery)	Local Area Network (D wall jacks) VIPER Control Station Satellite phone system	Comes on at power loss before generator starts up. Run time: 14 minutes	N/A
FAX	Standard Send/Receive unit	Normal, non-secure facsimile transmission	Located in room 129	No
HVAC	Complete air handling system with AC and heat	Services entire building.	Dedicated to building, controls housed locally but local temperature control limited and system access restricted	No
Local Area Network	Servers	Internet access including access to remote internet servers (UNC). All local network operations for computers and printers	Located in the Harvey building. Dedicated back-up power system provided by UPS and generator	Yes
	LAN Switch	Connect servers, computers, and printers in the network.	Located in Room 137	Yes
	Computers	Use of internet/cloud-based services Local data handling, data storage (local drives)	Multiple units individually assigned. Additional units dedicated to the Support Cell (Room 107) are available.	Yes, if: Plugged into a red outlet or with battery.

	Network Printers	Printing (b/w and color), copying, scanning	Located in rooms 121, 123, 129, and 139.	No
Radio Comms Systems	VIPER Control Station	Allows connection with VIPER medical network talk groups	Located in room 137, remotely controlled from Room 124	Yes
Telephone Comms Systems	Voice Over IP	Primary telephone communication system for the Support Cell	Accessed through D wall jacks. Available in all offices, work areas, & conference rooms.	No
	Copper Wire Phone	Secondary telephone communication system for the Support Cell	Located in Support Cell (Room 107) and accessed through wall jack V9. Requires pulse-dial telephone to operate. Pulse-dial telephone stored in Room 124 (Comm.) Service runs through line from FAX machine in Room 129.	
	Satellite	Tertiary telephone communication system for the Support Cell	Active unit in Communications Room (Room 124)	Yes
		Allows for communication with regional offices and disaster scenes where satellite units have been deployed and HCC regions	Regional units are not live and must be notified with activation instructions.	
Water	Municipal Water Supply	Services entire building.	Steam Plant provides hot water campus-wide. No local control.	No

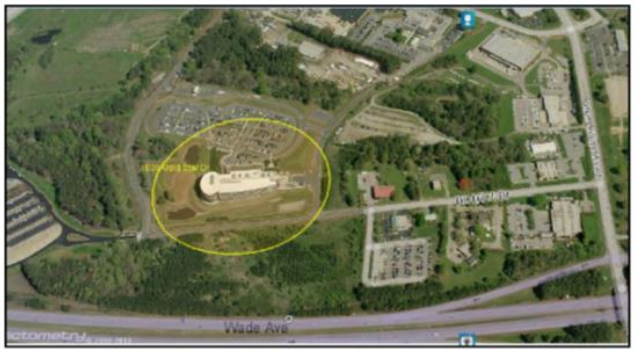
Emergency support or facility maintenance for the above items should primarily run through normal processes as outlined below:

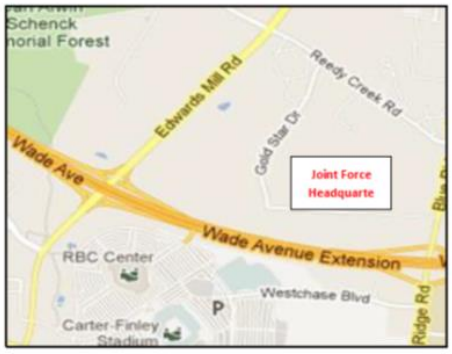
1. Power, Utilities and HVAC:
    a. Normal business hours: DIX Facility Maintenance (919) 855-4740
    b. After hours: State Capitol Police (919)733-3333
2. Local Area Network, Telephones (exception Satellite phones), Fax lines:
    a. Normal business hours: Service Now Ticket: https://ncgov.servicenowservices.com/sp_dhhs
    b. After hours: Elevate request through ESF8 Lead to NC DHHS Leadership for support
3. Radios & Satellite phones:
    a. Normal business hours & After hours: NCOEMS Communications Director (919) 855-3955

DIRECTIONS TO SEOC

Joint Force Headquarters 1636 Gold Star Drive, Raleigh, NC 27607 (919) 825-2500

Joint Force Headquarters is home to North Carolina National Guard, Emergency Management, the Department of Transportation Statewide Transportation Operations Center (STOC) and State Highway Patrol-Troop C Communications. Located between Reedy Creek Road and District Drive (both off of Blue Ridge Road very near Wade Avenue) on Gold Star Drive.





From I-40:

- Take Exit 289, Wade Ave.
- Exit on the Blue Ridge Road Exit
- Turn Left onto Blue Ridge Road.
- Go to the first left, District Drive, turn Left.
- Go to Gold Star Drive, turn Right.

From US-264 West :

- Take exit 419 to merge onto I-440 W toward US-1 Wake Forest
- Take exit 4B toward I-40 W towards RDU International Airport
- Merge onto Wade Ave.
- Take the Blue Ridge Road exit.
- Turn Right onto Blue Ridge Road.
- Take the 1st Left onto District Drive.
- Go to Gold Star Drive, turn Right

From US-64 East:

- Merge onto US-1N/US-64 E via the ramp on the left to Raleigh.
- Continue to follow US-1N.
- Continue onto I-440E.
- Take exit 4 for Wade Ave toward Cameron Village.
- Turn left onto Wade Ave.
- Take the Blue Ridge Road exit.
- Turn Right onto Blue Ridge Road.
- Take the first Left onto District Drive.
- Go to Gold Star Drive and turn Right.

When nearing on District Drive or Reedy Creek Road look for the black wrought iron fence that surrounds the property. There are two entrances (guard stations). If you come from District Drive, enter into the first entrance. If you come in from Reedy Creek Road, enter into the second entrance.

- If you have a **NCNG JFHQ ID** badge, use the middle gate to let yourself in.
- If you have a **EM/DOT ID** badge, use the lane closest to the guard station and show your ID.
- If you have **NO** badge, use the lane closest to the guard station and show your personal ID. Your name should have been given to security by the person you are visiting beforehand. If Security does not have your name, have them call the ground floor reception desk at 825-2500 (during office hours) or the STOC at 825-2603 (during non-office hours).

Once in the parking lot, park in any unsigned or Visitor spot in the lot and move toward the main entrance (with the soldier and fountain.) To the right of the statue, look for the Emergency Operations Center sign. Take the stairs down to the ground floor lobby. You will see the EM/DOT entrance at the bottom. Once you enter you will see the receptionist to your left. Let the receptionist know whom you are visiting. The State EOC Situation Room is also on the left.

APPENDIX 2: SHIFT DUTY OFFICER STANDARD OPERATING GUIDELINE (SDO SOG)

Purpose: To ensure the efficient provision of emergency medical support and direction in response to emergent events with the potential for affecting the health and medical welfare of North Carolina residents and visitors.

Scope: This SOG identifies the primary on-call staff, defines on-call duty, and outlines the initial actions of these individuals upon notification of an incident in which NCOEMS is a lead or supporting agency.

Policy:

The Shift Duty Officer (SDO) will be available 24/7 to provide support, as requested, for emergency activations or responses across the state and to acknowledge and respond to requests for information. The SDO will be available via phone and email:

- Phone: 919-855-4687
- E-Mail: DHSR.NCOEMS.SDO@dhhs.nc.gov

The Admin on Call (AOC) is a leadership position to provide internal direction, advice, support, and backup for the SDO in a 24/7 capacity.

General duty responsibilities:

- Expected response time to messages is within 15 minutes. Greeting messages on phones utilized during SDO duty and which may be received by callers contacting the SDO for assistance must, at a minimum, confirm that the caller has reached an HPP staff member and that their call will be returned as soon as possible
- Staff scheduled for duty must be able to maintain availability to meet response time expectations. For this reason:
    - Staff scheduled to be out of state during their rotation cannot serve as SDO
    - Staff that are committed to activities that may temporarily cause them to be unable to meet the expected response time (e.g. training, conference presentations, etc.) must coordinate with other HPP SDO staff to temporarily cover the duty and notify the AOC.
- SDO will contact the AOC if assistance is needed in responding to a request for support or if there may be an unforeseen break in coverage of the SDO phone
- When the response to ongoing incidents results in the activation of the State EOC, the SDO may be responsible for the initial opening of the ESF8 Desk:
    - During major activations (24/7 operations), the SDO, should be integrated into the regular NCOEMS staffing plan for the SEOC and the SDO line transferred to the ESF8 Desk with all responsibilities for the SDO integrated into the ESF8 role
    - During minor activations (daytime operations) or during planned activities (exercises, etc.), the SDO should not be integrated into the staffing plan for the SEOC, when possible, and should expect to maintain their responsibilities as SDO outside the State EOC

- If due to low staffing it is not possible for the SDO to maintain their role separate from the SEOC the staffing plan should consider rotation of the ESF8 desk and SDO responsibilities to ensure that staff receive adequate time away from being in response mode

Staffing:

1. SDO duty will rotate between identified staff every two (2) weeks on a schedule maintained by the HPP Program Manager or their designee. Primary on-call staff includes, but is not limited to, HPP Program personnel. All changes to the established shift schedule due to illness, previous commitments, or other reasons will be coordinated through the AOC and are the responsibility of the SDO to coordinate coverage.
2. AOC duty will rotate between the HPP Program Manager and the HPP Operations Manager every four (4) weeks on a schedule maintained by the HPP Program Manager or their designee.

Shift Times & Shift Change: SDO shifts will run over a two-week period and AOC shifts will run over a four-week period. Shift changes will take place every other Monday at 0900. At that time, the SDO coming off shift is responsible to:

- Provide an informal briefing to the oncoming SDO. At a minimum this briefing should outline any ongoing responses that required SDO action and include:
  - Emergency medical resources alerted/activated (organization, type, and quantity)
  - Date/time of activation/response, SDO actions, and resolution
  - Current situation and any required follow-up actions for the oncoming SDO
- Provide any documents, maps, etc. to the oncoming SDO that are pertinent to current activities

The SDO coming on shift is responsible to:

- Forward the SDO phone - (919) 855-4687 – to their NCOEMS-issued mobile phone. The SDO phone is in the Wright Building. Test the SDO line to ensure that it is working appropriately after the transfer

Situational Awareness: During the duty period the SDO is expected to maintain situational awareness through the active monitoring of:

- All phone calls and email to the SDO contact number and email address. Overnight (2200-0600) the SDO can shift to phone only monitoring.
- The SDO is also expected to maintain access to the VIPER 800MHz radio system at all times.

Resources: The SDO should be provided/have access to and may utilize the following equipment and supplies in performance of their duties.

Communication:

- Portable VIPER 800mhz radio with charger and extra battery
- NCOEMS-issued smart phone with car and wall chargers
- GETS card

Transportation:

- NCOEMS staff vehicle with portable VIPER capable radios and plug-in power inverter (for running laptop, etc. off of vehicle battery)

Operation:

- NCOEMS-issued laptop with appropriate emergency management programs and applications and chargers
- NCOEMS-issued WiFi-enabled hotspot or smart phone with chargers
- Plans/access to plans, paper, pens, calculator, and other supplies necessary for planning and reporting

Notification and Initial Actions: Notification for emergent or potential incidents involving emergency response may be via:

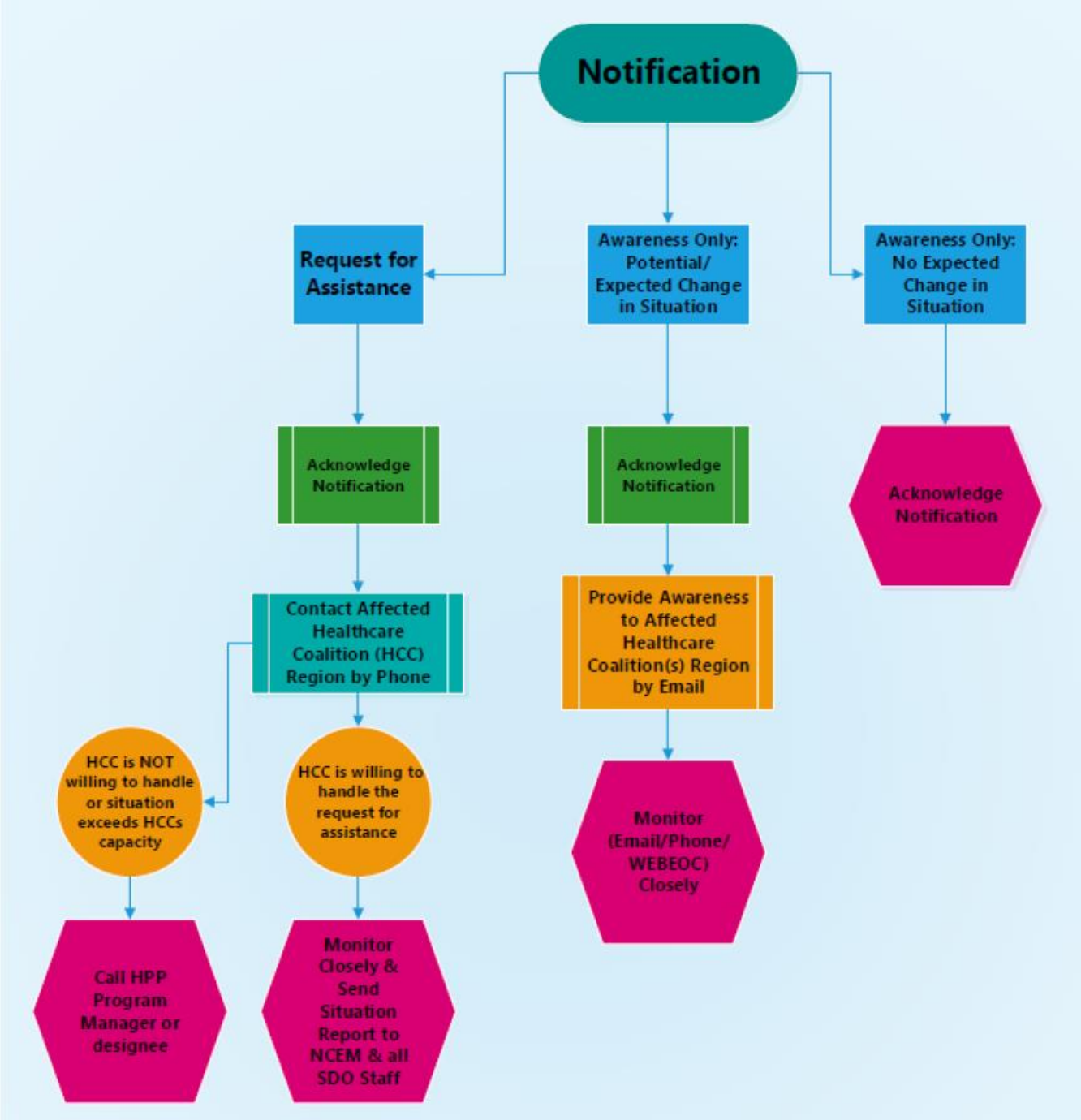
1. NCEM 24-Hour Operations Center/Warning Point – (Usually a notification of a potential incident and delivered via e-mail)
2. NCEM Emergency Services Group Supervisor of the State Emergency Response Team (SERT) – (Usually a notification of an emergent incident and delivered via phone call or text)
3. Regional Healthcare Preparedness Coordinators - (Usually a phone/email notification of an issue that the HPC is already involved with and foresees the need for additional support)

Upon receiving notification of a potential or actual incident or request for support through one of these routes, the SDO is expected to make an assessment of the need and determine what type of action is necessary, if any.

- If no state resources are requested and there are no expected changes to the situation (i.e. train struck a pedestrian and situation has ended) acknowledge that the notification has been received and take no further action
- If no state resources are requested but there is a potential for a change in the situation thereby necessitating resources in the future (i.e. A skilled nursing home has lost power and county emergency management is investigating the need for HVAC/Generators), acknowledge that the notification has been received and:
    - Forward the notification and information to the Healthcare Preparedness Coordinator (HPC) responsible for the affected location area for their awareness
- If the notification is for the coordination of health and medical resource support, acknowledge that the notification has been received and:
    - Contact the Healthcare Preparedness Coordinator (HPC) responsible for the affected facility/jurisdiction and/or utilize the on-call number for the Healthcare Coalition (HCC) found on Ready-Op.
    - Ensure the HCC is willing to handle the request for assistance. If they are unwilling/unable, then contact the HPP Program Manager or designee for additional support
    - Forward the notification and information to the Healthcare Coalition Designee responsible for the response and request that they:
        - Verify the reported information with local partner organizations to confirm what is needed,

        - Utilize Healthcare Coalition (HCC) resources to meet the requested need (this includes resources from other HCCs)
        - Provide initial situation report back to the SDO within 30-60 minutes or when reasonably able to do so via ReadyOp, Text, Phone or Email.
        - Post situation reports on the HC-Significant Events (Statewide) board in NC SPARTA WebEOC every 8-12 hours depending on the situation. For quickly evolving situations the need may be more frequent and may be provided via ReadyOp, Test, Phone or Email.
    - Maintain contact with HCC designee, monitor HC-Significant Events, and be available to expand/support HCC requests.
    - Provide initial situation reports/updates (ReadyOp template) within first 60-90 minutes based on the information provided by the HCC designee and other official sources to, at minimum the:
        - SDO email
        - Activated HPCs, and
        - Regional NCOEMS Manager for the affected location
        - Ongoing Situation Reports should be sent out every 8-12 hours based on the situation. For quickly evolving situations the need may be more frequent.
- If the notification is for the coordination of health and medical resource support, and the HCC designee has determined that the need is greater than what the HCC of the affected facility/jurisdiction is capable of handling with the resources available:
    - Notify the HPP Program Manager, or their designee, to provide a brief situation report, discuss the situation, and coordinate further action including, if necessary:
        - Activating additional HPP/HCC staff and assets
        - Activating the NCOEMS-HPP EOP or other plans
        - Request posting a separate event in NCSPARTA WebEOC

SDO Notification Decision Tree

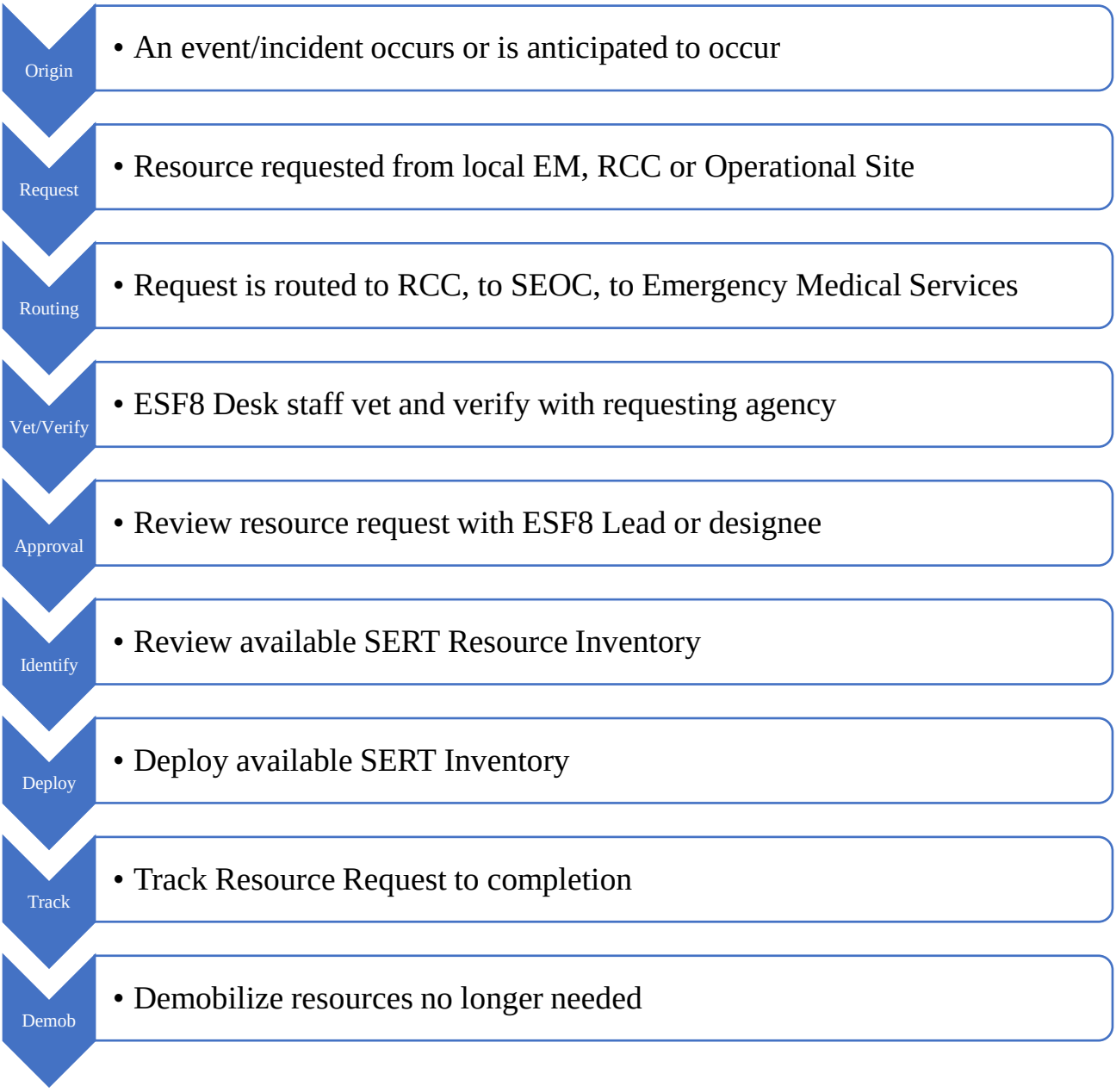


Appendix 3: Medical Resource Management SOG

PURPOSE: To provide greater understanding of the processes and procedures for handling requests for ESF8 resources.

SCOPE: Requests for resource support (personnel, equipment, supplies) can come to staff assigned to the ESF8 Desk or Support Cell through different pathways and may require different actions to manage and ensure that resources are delivered as quickly and efficiently as possible. The processes outlined here cover requests for resources during a statewide activation.

PROCESSES AND PROCEDURES:
In most cases, the management of resource requests from receipt to closeout will be documented in the Resource Request Form (RRF) on the Resource Tracker Board of the NCSPARTA WEBEOC system.



General Procedures: The following procedures outline the steps that should be taken by ESF8 staff to manage medical resource requests assigned to ESF8:

- Origin of need
  - An event/incident occurs or is anticipated to occur, that requires additional resources beyond the local capability. Local officials activate existing mutual aid agreements.

- Resource Requested
  - Local Emergency Management will request additional resources through NCSPARTA WEBEOC to their Regional Coordination Center. Regional Healthcare Preparedness Coalitions (HCC) may request additional resources to support the Healthcare System if the Local Emergency Manager is unable or unwilling to enter the request. Local Emergency Managers should be made aware of all requests entered by the HCCs on behalf of their county.
  - Regional Coordination Center will request resources on an ICS 215 in NCSPARTA WEBEOC in anticipation of potential needs and/or to fulfill local county requests within their region.
  - NCOEMS Incident Management Teams needing support should enter the resource request into NCSPARTA WEBEOC with details on the resource needed and routing instructions to assign to Emergency Medical Services.
  - State EM is responsible to coordinate ESF8 resource requests from other North Carolina State Agencies, requests from other states and/or federal support requested through FEMA, these resource requests will be routed from NCEM ESG to Emergency Medical Services

- Resource Routing
  - Regional Coordination Center (RCC): NCEM RCCs receive the initial resource request from county partners to fill the request based on their available resources (regionally owned assets or assets that have been pre-deployed to the RCC). If no resources are available, then the request will be routed to the State Emergency Operations Center (SEOC). A 215 request will route to the North Carolina Emergency Management Operations Chief for review and assignment to SERT partners upon approval.
  - SEOC: SERT-ESG Supervisor reviews the resource request and makes appropriate assignment.
  - Emergency Medical Services: Healthcare support resource requests are assigned to Emergency Medical Services in NCSPARTA WEBEOC for processing.

- Resource Vetting & Verifying:
  - Determine if resource request should be handled by ESF8 Desk
    - If yes, continue vetting process
    - If no, make notation in NCSPARTA WEBEOC and “Assign to Lead”
  - Vet need and purpose for the resource requested with Requesting Agency
    - Determine current status
    - Determine gap needing to be filled
    - Identify other potential mitigating factors
  - Confirm NCSPARTA WEBEOC request details with Requesting Agency

- Number and kind of resource
- Use of the resource
- Days of deployment
- Reporting location/time
- Point of Contact (POC) at location (name/contact info)
- Logistics (food/lodging/fuel)
- Any additional relevant information

- ESF8 Lead Resource Approval
  - Review resource request with ESF8 Lead or designee
    - Consider situation and known / anticipated ESF8 needs or obligations
    - Determine if resources are readily available
    - If resource request is approved, update notes in NCSPARTA WEBEOC and move to identify resource
    - If resource request is not approved, notify ESG Lead.

- Resource Identified
  - Review available inventory in the Mission Ready Packages, section 7 of ReadyOp, to determine if resource is already activated and readily available for deployment
    - If yes, add resource to SERT Inventory in NCSPARTA WEBEOC and proceed to resource deployment
    - If no, consider direct coordination with SERT Partners (DPH, OSFM, Business EOC, Logistics, etc.) that may have resources that would meet the request.
      - If SERT Partners have the resource available, add comment in NCSPARTA WEBEOC indicating a reassignment to the specific SERT partner along with a brief summary of communication regarding resource request. Change resource request to "assign to lead."
      - If no SERT Partners have the resource, discuss with ESF8 lead the possibility of EMAC or Federal contracts for fulfillment of resource request.
    - Complex activations, defined as larger scale and/or an extended timeframe, will increase the difficulty for identifying resources to meet the demand. For strategies to respond in these situations refer to **ANNEX: SCARCE RESOURCES**

- Resource Deployment
  - Deploy the resource based on the appropriate SERT Inventory in NCSPARTA WEBEOC, complete ICS 204 if appropriate, and notify the point of contact of assignment. Notes should be added to the resource request and the appropriate log user assigned in NCSPARTA WEBEOC.
  - The log user is responsible for status updates for deployed resources in NCSPARTA WEBEOC.

- Resource Tracking
  - The ESF8 Desk is responsible for monitoring resource statuses in NCSPARTA
    - Assigned to User – ESF8 Desk should act within 30 minutes of assignment

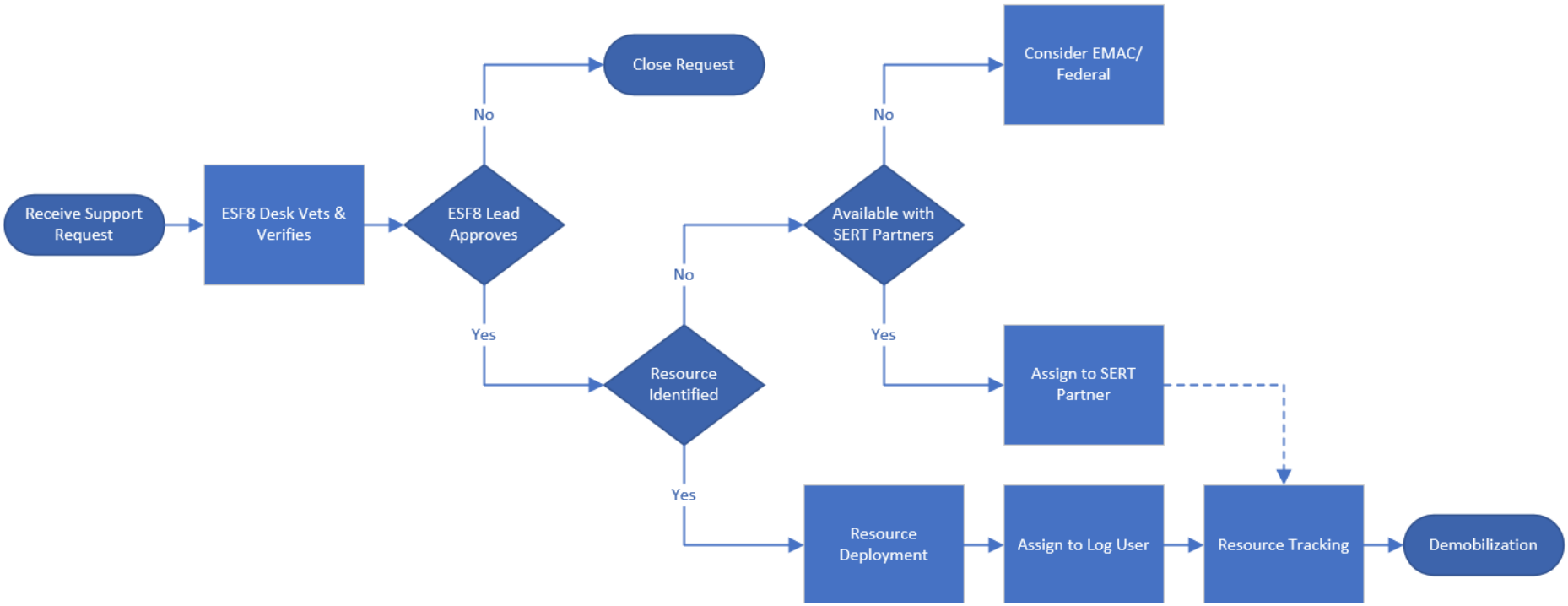
- In Progress – ESF8 Desk should review at least once per shift to track progress of assigned resource / team / contract to resolution
- Need More Information – ESF8 Desk should act within 30 minutes of assignment
- Information Added – ESF8 Desk should act within 30 minutes of assignment
- Enroute – ESF8 Desk should monitor to track progress of assigned resource
- On Scene – ESF8 Desk should monitor to track progress of assigned resource to replace or demobilize. If resource needs to be replaced, then process should start at resource vetting and verifying.

▪ Any outstanding resource requests should be relayed at shift change to ensure ongoing resolution.

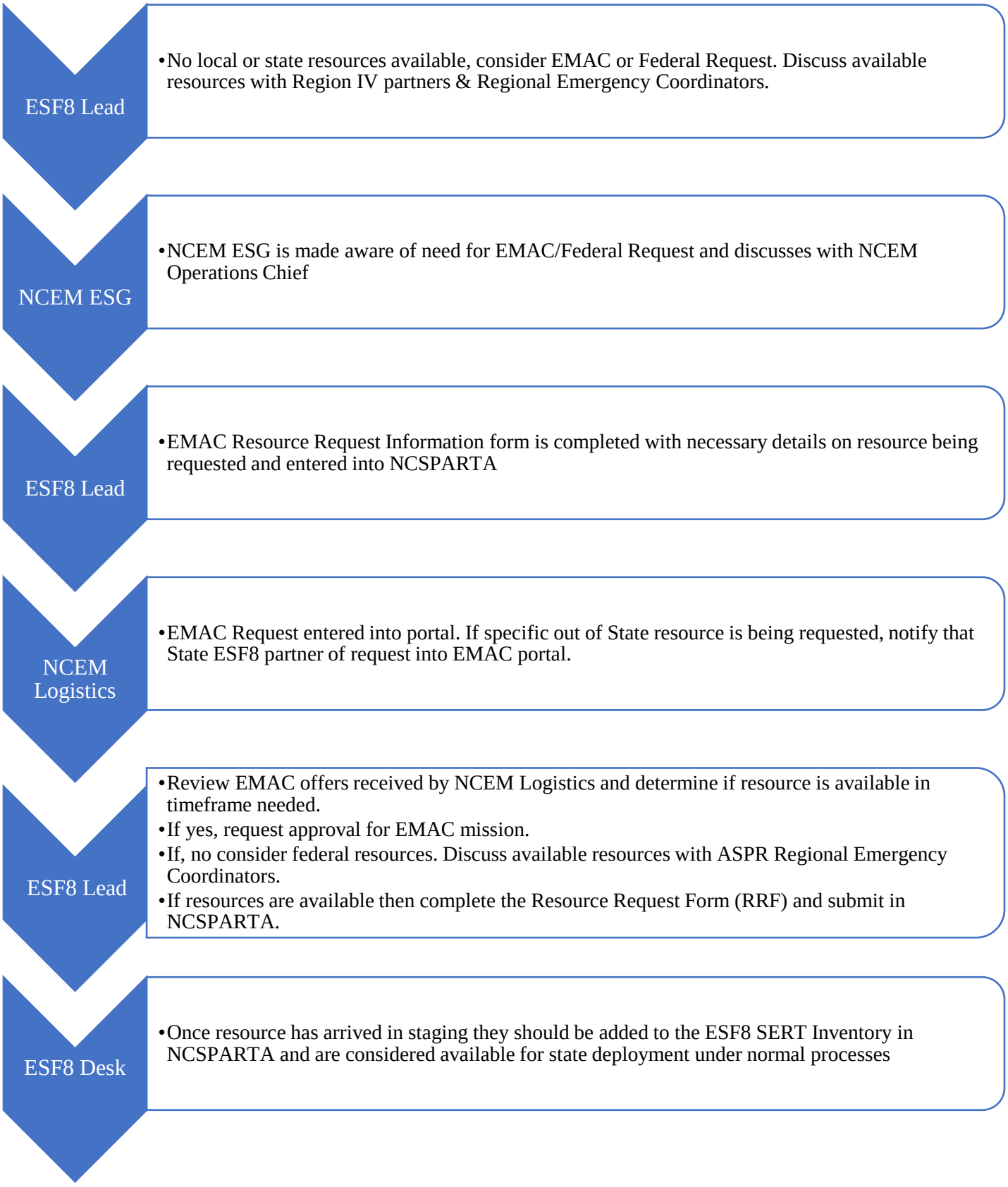
o Demobilization

▪ Once a resource is no longer needed for original resource request then a determination should be made by ESF8 Lead if the resource should be reassigned to another request or returned to staging. If yes, refer back to resource identification step, if no, then refer to **Appendix 6: Demobilization SOG for additional information covering the processes and procedures for the demobilization ESF8/SMRS operational and operations support organizations and teams.**

RESOURCE REQUEST ROUTING FLOW CHART



EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC)/FEDERAL RESOURCE REQUESTS: The general process for the ESF8 "EMAC" or Federal Resources is diagramed below:



Appendix 4: Communications and Information Management Systems

PURPOSE: To provide personnel responsible for staffing the SEOC ESF8 Desk/Support Cell a more complete understanding of the purpose and use of the various information and communication systems available.

SCOPE: This information covers the telephone, email, information management, and radio communication systems assigned and/or available for NCOEMS staff to provide the capability to maintain situational awareness, report essential information, and coordinate the activation and deployment of ESF8 resources.

SYSTEMS: These systems, their primary purposes, and uses are summarized below:

TELEPHONE COMMUNICATION SYSTEMS: Telephone and FAX resources available for use at the SEOC and Support Cell include the following.

Voice-Over-the-Internet-Protocol (VOIP) telephones - SEOC:

- Incoming calls use telephone: (919) 825-2427
- Outgoing calls use telephone: (919) 825-2426

Voice-Over-the-Internet-Protocol (VOIP) telephones – Support Cell:

- All calls use telephone: (919) 855-4688

Facsimile (FAX) telephone - SEOC:

- FAX: (919) 733-7554 (in Operations Center)

Facsimile (FAX) telephone – Support Cell:

- FAX: (919) 733-7021 (in Room 129)

NCOEMS-assigned SMART Phones:

- See OEMS Directory on OwnCloud (DHHS – SDO Resources – OEMS Telephone Listings)

NCOEMS Conference Line:

- Dial-in: (919) 233-7092

NCOEMS Satellite Telephones:

- This emergency telephone/radio system is provided through Light Squared. These phones allow for communication with regional offices and disaster scenes where satellite units have been deployed when the power is out, or other communications systems fail. Unit in the Wright Building Communications Room (Room 124) is active, regionally based units are not live and must be notified with activation instructions.

E-MAIL COMMUNICATION: Staff should utilize the DHHS e-mail accounts through Microsoft 365 as primary means for e-mail communication. https://outlook.office365.com/mail/inbox

INFORMATION MANAGEMENT SYSTEMS: Information Management systems available for use at the SEOC and Support Cell include the following.

CONTINUUM: Primary database for NCOEMS Regulatory components to include: EMS Systems, EMS Agencies, Personnel, EMS Credentials, EMS Vehicles, EMS Educational Institutions, EMS Patient Care Reports, EMS Compliance components and one-way email communication to EMS. https://continuum.emspic.org

ICAM SYSTEM: Inventory Control Asset Management (ICAM) system is used for inventory and resource tracking of State Medical Response System (SMRS) equipment and supplies. http://ncoems.icamservice.com/login.aspx?ReturnUrl=%2fDefault.aspx

MICROSOFT TEAMS: Workplace hub for team collaboration, chat, videoconferencing, and file storage. Program is hosted locally on NCOEMS assigned laptops and SMART phones.

MULTI-HAZARD THREAT DATABASE (MHTD): GIS application providing information on all North Carolina Division of Health Service Regulation (DHSR) licensed facilities (hospitals, nursing homes, mental health, intermediate care facilities, home health, long term, and adult care facilities). Used for gathering facility info, mapping facilities, weather, and hazards. https://www.ncmhtd.com/oems/

NCSPARTA – WEBEOC: Web based interface between the State EOC and State Emergency Response Team (SERT) partners. Primarily used for emergency management operations, maintaining situational awareness, coordination of ESF8 resource requests, reporting (IAP, situation reports, ICS forms) and file library for response / recovery documents. https://www.ncsparta.net/eoc7/default.aspx

NORTH CAROLINA TRAINING EXERCISE RESPONSE MANAGEMENT SYSTEM (NCTERMS): Web based interface between the State EOC and SERT Partners for response team rostering, deployment and tracking during statewide activations. Database for SERT training and exercise offerings as well as providing registration with reporting utilities. https://terms.ncem.org/TRS/

OWNCLOUD: A secure cloud service used primarily as a file library for the storage of SMRS emergency response information (e.g. plans, guidance documents, etc.). https://www.ncmhtd.com/owncloud/index.php/login

READYOP: A secure cloud service used primarily for situational reporting, daily activity logs, customized information gathering, two-way communication, and roster of SMRS personnel and partners by organization with contact information. SMRS Mission Ready Package information and availability status. Hospital diversion status board updates. https://nc.readyop.com/

WEBEX: Web based videoconferencing, online meetings, screen share, and webinars. https://ncoems.webex.com/

RADIO COMMUNICATION SYSTEMS - VIPER MEDICAL NETWORK (VMN): These systems are used to monitor and communicate with North Carolina SERT Partners and SMRS organizations, and other organizations utilizing the VIPER (Voice Interoperability Plan for Emergency Responders) radio system. For additional information: https://info.ncdhhs.gov/dhsr/EMS/technolg.html

Primary communication methods to contact the ESF8 desk will be via telephone or email. In the event of a commercial communications failure, resulting in the inability to contact the ESF8 desk, contact the NCEM 24-Hour Watch Center on VIPER talk group "**EM EOC**" located in the VIPER "Statewide" zone. Advise the watch center that you are experiencing a commercial communications failure and need to contact the ESF8 desk. Once advised by the watch center, the ESF8 desk will contact you on the "**EM EOC**" talk group and advise you which VIPER Medical Network (VMN) talk group to utilize for direct communications with the ESF8 desk (typically this will be "**VML79501** Medical Statewide Disaster Contact"). You will then switch to this ESF8 assigned talk group and contact the ESF8 desk with your traffic.

Equipment and Resource Information

The following VIPER-compatible radio equipment will be available and/or can be requested to fulfill operational needs:

- Portable (hand-held) Radios
  - Incoming/outgoing calls for NCOEMS set one radio to VMJ59101 talk group – (official communications)
  - Incoming/outgoing calls for NCOEMS set one radio to OEMS SECURE talk group – (internal communications, AES-256 Encrypted)
- VMN Reference Information Guide
  - For VMN radio channels, talk group, and use guidance. Refer to it at: http://info.ncdhhs.gov/dhsr/EMS/pdf/dtmfref.pdf

Talk Groups – Purpose and Use

- External ESF8 Coordination - SEOC ESF8 Desk (SMRS Disaster) to Partner Agency/Unit:

    - Find VMN channel of agency in the VMN Reference Information Guide
- Internal NCOEMS Coordination/Conference - NCOEMS Staff to NCOEMS Staff:
    - **OEMSSTAFF and OEMS SECURE**

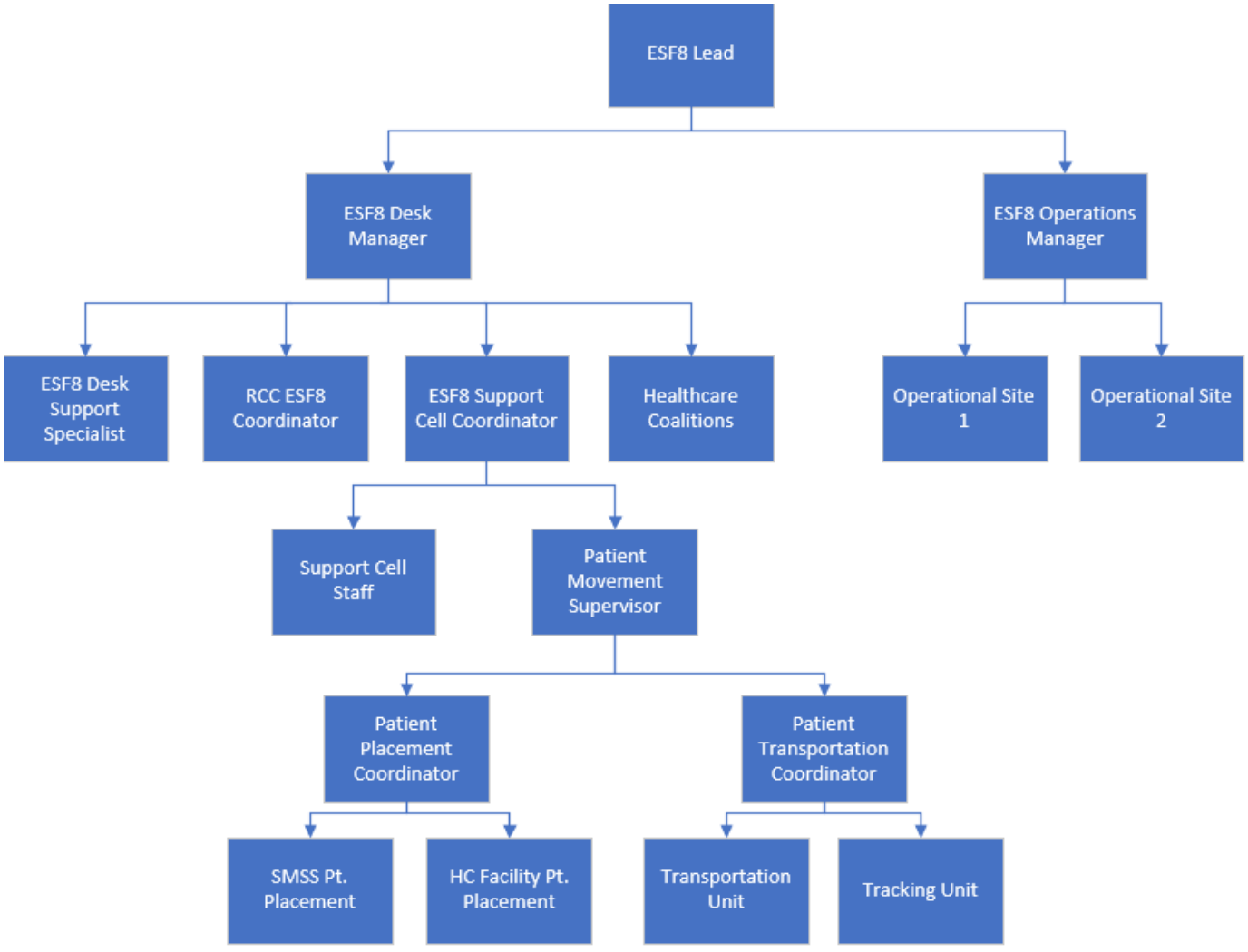
Certain VIPER talk groups, within the VIPER Medical Network (VMN), are available for ESF8 operational assignments. Request for these talk groups should be sent to the ESF8 desk for assignment. If any communications resources are activated (contingency or assigned), the ESF8 desk or designated comms personnel, will produce an ICS205 form for each operational period. Each ICS205 should be shared with the ESF2 desk for situational awareness and conflict resolution. Initial VIPER Medical Network (VMN) talk groups available for assignment are:

- **VML79600**
- **VML79601**
- **VML79700**
- **VML79701**
- **VML79800**
- **VML70801**

Appendix 5: Organization and Assignment of Responsibilities

PURPOSE & SCOPE: To provide greater understanding of the organization and assignments of NCOEMS personnel activated to oversee and coordinate the ESF8 response to emergency events and disasters. These guidelines detail the SEOC and Support Cell roles and responsibilities.

ORGANIZATION: The organization of NCOEMS staff will change to meet necessary oversight and coordination requirements. As operations expand to meet health and medical support needs, they trigger increases in activation level. Activation levels range from Blue (Shift Duty Officer) to Red (SEOC, Support Cell, and 3 or more SMRS operations).



ROLES AND RESPONSIBILITIES: NCOEMS staff may be assigned different roles to meet ESF8 response and recovery requirements as part of the SERT. Each role includes a range of responsibilities necessary to ensure that the organization fulfills its operational or support mission successfully. These organizations are listed below with major role responsibilities identified. For positions outlined below the corresponding job action sheets can be found at the end of this appendix.

SUPPORT ORGANIZATIONS:

ESF8 SEOC: Maintain overall situational awareness of ESF8 response and recovery activities statewide, act as the HPP ESF8 representative to the SERT and federal partners, manage health and medical resource requests, and oversight/support of ESF8 field operations.

- ESF8 Lead – Oversight for all ESF8 response & recovery activities
- ESF8 SEOC Desk Manager – Oversight for all ESF8 SEOC Desk responsibilities
- ESF8 SEOC Desk Support Specialist – Position supports the ESF8 Desk Manager with roles and responsibilities as assigned
- ESF8 Operations Manager - position provides direct support and leadership for all NCOEMS coordinated field operations

ESF8 Support Cell: Assist staff assigned to the ESF8 Desk in meeting their responsibilities for maintaining situational awareness, managing resource requests, and supporting field operations. Including the coordination of patient transfer operations and the vetting of medical supply requests during medical logistics operations.

- ESF8 Support Cell Coordinator - Oversight for all ESF8 Support Cell responsibilities
- ESF8 Support Cell Staff – Provide support to the ESF8 Support Cell Coordinator
- Patient Movement Supervisor - Oversees all patient movement operations (coordination/placement, and transport)
- Patient Placement Coordinator - Provides overall support to the Patient Coordination Center Lead (Healthcare Facility) and Patient Movement Supervisor when North Carolina Patient Movement Guideline is activated.
- Patient Transportation Coordinator - Oversees all patient transportation activities (with exception of standard procedures for emergent patient transfer from a healthcare facility)
- Transportation Unit: Provides support to the Patient Transportation Coordinator
- Tracking Unit: Provides support to Patient Transportation Coordinator

JOB ACTION SHEETS

Position: ESF8 Lead

Objective: Provide oversight and direction for all ESF8 response & recovery activities

Reports to: SERT Leader

Supervises: ESF8 Desk Manager, ESF8 Operations Manager

Actions:

- Advise, set priorities, and provide overall direction for ESF8 response and recovery activities
- Develop and represent ESF8 goals, objectives, and activities to local, state, and federal partners as part of the North Carolina SERT
- Authorize the activation and deployment of state ESF8 resources
- Activate the ESF8 Desk Manager, ESF8 Operations Manager, and other ESF8 organization positions as necessary to meet the objectives of this position
- Coordinate with DHHS/NCOEMS Leadership, State Medical Response System Advisor, and NC SERT partners on:
    - Development and implementation of policies necessary to support ESF8 response activities and the
    - Release of health and medical information to the public
- Lead or participate in various briefings concerning ESF8 response and recovery activities involving the SERT, response partners, and SMRS organization including incident command staff calls
- Authorize the demobilization of state ESF8 resources upon completion of response and recovery activities including the conduct of team debriefings and development of After-Action Reports (AARs)

Position: ESF8 Desk Manager

Objective: Assist the ESF8 Lead in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT

Reports to: ESF8 Lead

Coordinates with: RCC ESF8 Coordinator, Healthcare Coalitions, SERT-ESG Supervisor

Supervises: ESF8 Desk Support Specialist, ESF8 Support Cell Coordinator

Actions:

- Monitor available communication and information technology systems to develop and maintain situational awareness of ESF8 response and recovery activities
- Develop situation reports and lead coordination calls (NCOEMS/HCC) for the purpose of sharing ESF8 situation and mission status information across healthcare organizations and with other local, regional, state, and federal partners, as appropriate
- Manage requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, RCC ESF8 Coordinator, and Healthcare Coalitions (HCCs) as appropriate
- Coordinate with the SERT-ESG Supervisor regarding resource missions assigned to the ESF8 Desk to ensure they are fit within ESF8 responsibilities, their provision, and resource options if the resource cannot be provided by the state
- Coordinate ESF8 resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions
- Coordinate ESF8 resources needed within an RCC area with RCC ESF8 Manager and identify resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs
- Coordinate support for ESF8/SMRS field operations with the ESF8 Operations Manager and ESF8 Support Cell Coordinator
- Field and resolve questions concerning ESF8 response and recovery activities in coordination with the ESF8 Lead
- Delegate position responsibilities to the ESF8 Desk Support Specialist and the management of large ESF8 functions (e.g. patient movement) to the ESF8 Support Cell Coordinator as necessary to meet the objectives of this position
- Conduct the demobilization of ESF8 Desk operations upon completion of response and recovery activities

Position: ESF8 Operations Manager

Objective: Assist the ESF8 Lead in maintaining oversight and management of ESF8 field operations when there is the potential for the activation and deployment of SMRS operational units (e.g. SMSS, MDH, Patient Transfer Centers, etc.)

Reports to: ESF8 Lead

Coordinates with: ESF8 Desk Manager, ESF8 Support Cell Coordinator, Healthcare Coalitions

Supervises: Incident Commanders of NCOEMS Incident Management Teams deployed to establish and maintain ESF8 field operations

Actions:

- Ensure pre-deployment readiness and planning for potential ESF8 operational mission requests
- Conduct assessments of need with requesting jurisdictions/organizations and advise ESF8 Lead on approval of operational mission requests
- Oversee operational site(s) coordination (site assessment, site plans) with response partners
- Coordinate directly with the ESF8 Lead and ESF8 Desk Manager to identify necessary IMT personnel, staffing, and logistics resources
- Provide direct support and leadership to the deployed IMTs and coordinate further support through the ESF8 Lead and ESF8 Desk Lead
- Assign all responsibilities for the operational period and ensure they are completed: (e.g. Operations Tactics Meeting, Command & General Staff Call, and submission of IAP & situation reports
- Act as medical Point-of-Contact for response partners (e.g. Public Health IMTs, NCEM, etc.) and responds to all messages and request for medical information
- Ensure necessary mission support is coordinated with the ESF8 Desk Manager
- Oversee operational site demobilization when authorized

Position: ESF8 Desk Support Specialist

Objective: Assist the ESF8 Desk Manager in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Support Cell Coordinator, Healthcare Coalitions

Actions:

- Monitor available communication and information technology systems to develop and maintain situational awareness of ESF8 response and recovery activities

- Develop situation reports and lead coordination calls (NCOEMS/HCC) for the purpose of sharing ESF8 situation and mission status information across healthcare organizations and with other local, regional, state, and federal partners, as appropriate

- Manage requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, RCC ESF8 Coordinator, and Healthcare Coalitions (HCCs) as appropriate

- Coordinate with the SERT-ESG Supervisor regarding resource missions assigned to the ESF8 Desk to ensure they are fit within ESF8 responsibilities, their provision, and resource options if the resource cannot be provided by the state

- Coordinate ESF8 resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions

- Coordinate ESF8 resources needed within an RCC area with RCC ESF8 Manager and identify resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs

- Coordinate support for ESF8/SMRS field operations with the ESF8 Operations Manager and ESF8 Support Cell Coordinator

- Field and resolve questions concerning ESF8 response and recovery activities in coordination with the ESF8 Lead

- Participate in the demobilization of ESF8 Desk operations upon completion of response and recovery activities

Position: RCC ESF8 Coordinator

Objective: Assist the ESF8 Desk Manager in coordinating the provision of ESF8 resources in support of health and medical facilities or local ESF8 operations within an area under jurisdiction of a Regional Coordination Center (RCC)

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Desk Manager, ESF8 Support Cell Coordinator

Actions:

- Manage ESF8 resources in support of health and medical facilities or local ESF8 operations within the RCC
- Coordinate information pertaining to affected health and medical facilities and services
- Facilitate ESF8 mission support at the RCC level
- Provide direction and support to ESF8 resources assigned to the RCC
- Conduct medical resource tracking
- Advise medical resource allocation decisions
- Assist with the coordination and resolution of operational issues between ESF8 agencies and government jurisdictions

Position: ESF8 Support Cell Coordinator

Objective: Assist the ESF8 Desk Manager in managing ESF8 responsibilities assigned as part of the SERT particularly when the support and/or coordination functions needed cannot be easily conducted from within the SEOC due to volume or complexity (e.g. SMSS patient movement coordination, etc.)

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Desk Manager, ESF8 Desk Support Specialist

Supervises: Patient Movement Supervisor, Support Cell Staff

Actions:

- Coordinate with the ESF8 Desk Manager to define initial ESF8 Support Cell responsibilities and the staff and schedule necessary to support the situation

- Coordinate all aspects of the roles/functions assigned to the ESF8 Support Cell to ensure that the needed support is provided. Potential tasks include:
  - Maintaining situational awareness
  - Managing resource requests
  - Coordinating logistical support for ESF8 field operations
  - Coordination of patient movement operations
  - Vetting of medical supply requests

- Provide support to the Patient Movement Supervisor/Coordinator when activated

- Conduct the demobilization of ESF8 Support Cell upon completion of response and recovery activities

Position: Support Cell Staff

Objective: Assist the ESF8 Support Cell Coordinator in managing ESF8 responsibilities assigned to the Support Cell.

Reports to: ESF8 Support Cell Coordinator

Coordinates with: ESF8 Desk Support Specialist, Submitting/Requesting Organizations, Patient Transportation Organizations, SMSS Incident Management Team

Actions:

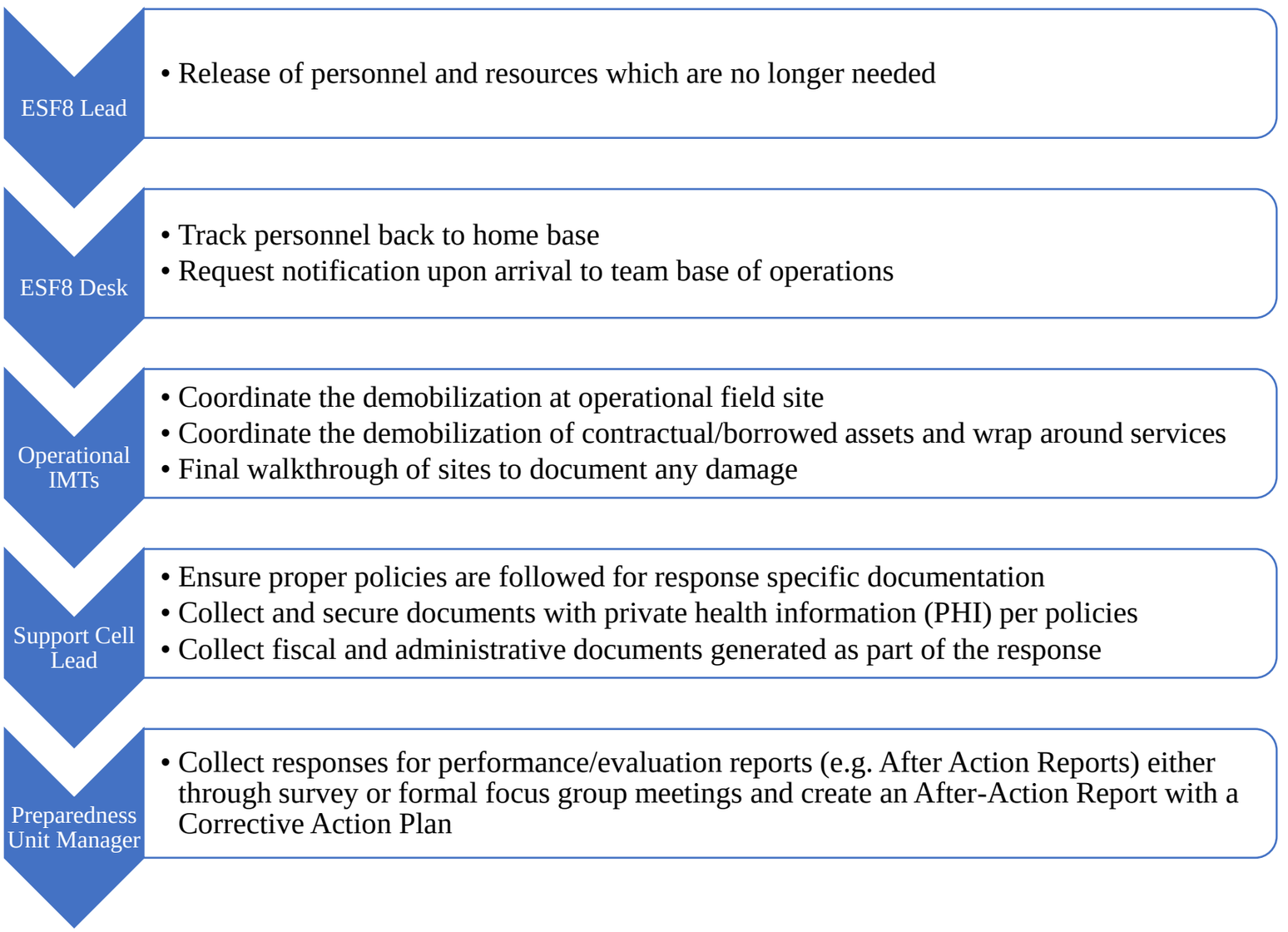
- Execute roles/functions assigned by the ESF8 Support Cell Coordinator to ensure that the needed support is provided. Potential tasks include:
    - Maintaining situational awareness
    - Managing resource requests
    - Coordinating logistical support for ESF8 field operations
    - Coordination of patient movement operations
    - Vetting of medical supply requests
- Provide support to SMSS Facility Patient Placement and Transportation operations by fulfilling the following roles/tasks:
    - Patient Admission Request Review Specialist
        - Review of SMSS PARs utilizing the SMSS Patient Guidance and verify that the placement of individuals into an SMSS is appropriate
        - Consult with the Medical Provider position to resolve requests for additional guidance and resolution of the placement of individuals as needed
        - Forward approved requests requiring transportation to the SMSS to the ESF8 Support Cell Coordinator for resolution
        - Provide resolved PARs to Submitting/Requesting Organizations with SMSS location and contact information
        - Collect from Submitting/Requesting Organizations, point-of contact and Estimated Time of Arrival (ETA) information, and forward that information to the ESF8 Support Cell Coordinator for review
        - Maintain log of PAR review status, transportation, and SMSS placement
    - Medical Provider
        - Review SMSS PARs for additional placement guidance to determine proper placement and make the final determination on patient placement
        - Discuss patient placement with Submitting/Requesting Organizations
        - Consult with the ESF8 Support Cell Coordinator to identify appropriate transportation for SMSS patients requiring transport to the established SMSS
- Participate in the demobilization of ESF8 Support Cell upon completion of response and recovery activities

Appendix 6: Demobilization SOG

PURPOSE: This document is meant to assist the ESF8 Lead and NCOEMS staff by providing a protocol for the smooth and efficient recovery from emergency operations back to normal daily operations. An efficient recovery is essential for ensuring that the transition back to regular operations is safe, controlled, and cost-effective.

SCOPE: This document provides guidance for the phased demobilization and recovery from emergency response operations in which North Carolina Office of Emergency Medical Services is the coordinating agency.

CONCEPT OF OPERATIONS: As response objectives are achieved and the emergency situation comes under control, the ESF8 Lead may direct the demobilization of various response elements. Much of this decision is driven by the release of resources from local partners and declining census in shelter locations. This process includes:



Release of personnel and resources:

At the beginning of every new operational period the ESF8 Lead, along with the ESF8 Operations Manager and other appropriate ESF8 leadership, will make an assessment of the remaining response objectives and determine what response elements should be demobilized. Much of this decision is based on the release of resources from local partners, decline in support needed from ESF8 operational locations, or leadership decisions to scale back resources due to increased availability for local resources to be utilized. Discussions with local partners, operational incident management teams and North Carolina Emergency Management (NCEM) Emergency Services Group (ESG) should occur to determine anticipated resource need timeline as part of this decision-making process.

Communication to all parties involved with the resource (local partner, regional coordination center, incident management team, home agency etc.) should be engaged in the decision on the demobilization timeline to ensure no gap in operations and wrap around services occurs. Notes should be placed in the NCSPARTA WEBEOC resource request. Prior to demobilization of any resources ensure all mission assignment tasks and related documentation have been completed.

Track personnel back to home base:

Upon release of personnel and resources, the ESF8 Desk should ensure that tracking occurs back to home base to ensure safe arrival and ongoing support until completion of the mission. Notes should be added in NCSPARTA WEBEOC as applicable to update the status tracking. This includes contact when heading back to home base, midpoint check (if applicable) and safe arrival back. This can be accomplished via, text, phone, radio etc.

Coordinate the demobilization at operational field sites:

Each field operational site Incident Management Team (IMT) is responsible for ensuring that all assets and wrap around services in use at their sites are demobilized appropriately:

a. Make notes in the NCSPARTA WEBEOC resource request when an asset/wrap around service is able to be demobilized including the specific date and time agreed upon in the demobilization timeline.
b. Coordinate directly by phone or email for the release and return of contractual or borrowed assets and wrap around services. This may include physical pickup of assets (e.g. shower trailer) or notification that service can be stopped (e.g. waste management).
    i. If asset is owned by a SERT partner (e.g. HCC, NCDPH etc.) contact them directly to coordinate pickup or return
    ii. Majority of contractual items that need to be demobilized should be coordinated with NCEM Logistics
    iii. If NCOEMS owned asset, coordinate directly with ESF8 Operations Manager
c. Once all assets have been released/returned a final walk through of the operational site should occur and any potential damage that is noted should be documented, pictures taken and sent to the NCOEMS Support Cell.

Ensure proper policies are followed for response specific documentation:

During the course of the activation, response specific documentation will be generated at field operational sites, the SEOC ESF8 desk, and the NCOEMS Support Cell. The NCOEMS Support Cell is responsible for ensuring that all documents that are generated are properly collected and managed as outlined below:

a. Collect and secure documents with private health information (PHI) according to NC DHHS policies and manuals: https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security

b. Ensure completion of and collection of fiscal and administrative documents generated as part of the response. These documents should be placed in response specific folder on OwnCloud. These documents include expenditure reports, medical support shelter records, patient movement records, incident reports, activity logs, and rosters.
c. Collect any documentation and pictures from operational field site demobilization walk throughs and place in a separate file name by operational site on OwnCloud.

After-Action Report with a Corrective Action Plan:

Information for an After-Action Report (AAR) should be collected throughout a response while the incident actions are still fresh in responder's minds. This information is critical to improving future response performance and enhancing the morale of responders and their teammates. A ReadyOp form should be created for each new incident and the link to provide the feedback shared at the beginning of an event, throughout an event and at the end of an event.

Main purpose is to capture:
1. What went well?
2. What needs improvement or noted response gaps?
3. What lessons were learned?

After Action Report:

The following framework is suggested for the After-Action Report:
1. Report
    a. Accumulation of all incident documentation.
2. Discussion or Survey collection of information that needs to be included for the AAR.
    a. Significant events and actions taken
3. Analysis
    a. In-depth examination of successes and deficiencies: plan, operational, and organizational.
4. Follow-up
    a. Present recommendations to correct the identified deficiencies.
    b. Designation of required actions and responsible parties.

NCOEMS will complete an AAR within ninety days of incident closeout along with a corrective action plan. The completed report will be distributed to all NCOEMS staff, Healthcare Coalition staff, stakeholders, partners, and grantees. The report should be used to help prioritize future plans, trainings, exercises, grant purchases and strategic planning.

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX D: APPENDIX 7

Hospital Patient Movement Guideline

July 2021

Table of Contents

Purpose

The purpose of the North Carolina Hospital Patient Movement Guideline is to establish a standardized framework for patient movement that incorporates lessons learned from real events when the movement of patients involves placement into a hospital. This guideline identifies activation triggers, outlines procedures for triaging and placing patients in appropriate receiving facilities. This framework applies during instances when local assets require regional, state, or federal assistance to manage patient movement, including evacuation of existing healthcare facilities.

The triggers for hospital patient movement may vary for each healthcare facility based upon classification, physical location, available resources, and other factors; therefore, the decision is made by the individual facility. This framework is not intended to overrule existing Healthcare Facility Emergency Operations Plans but is designed to provide guidance when statewide activation and resources are needed, and the anticipated needs exceed what the healthcare facility and affiliated healthcare coalition can coordinate and/or provide.

Scope

This framework covers the regional and statewide hospital patient movement guidelines to include patient identification, placement, and overall coordination by the NCOEMS and Healthcare Coalitions (HCC), as well as the expected roles and responsibilities of other state and local emergency response organizations to meet its purpose. These guidelines were created to assist healthcare facilities plan and prepare for patient movement based upon impact to their facility from an event or incident; however, the basic framework can also be applied to a community-based event or incident when a local emergency manager requests assistance with patient movement resulting in patients being placed into a hospital or healthcare facility. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan, Annex D: Patient Movement, and Appendix 10 – Patient Transportation.

Definitions

- *1135 Waiver:* allows for federal waivers or modification of various requirements from section 1135 of the Social Security Act to include: Emergency Medical Treatment and Labor Act (EMTALA); screening, triage of patients at a location offsite from the hospital's campus; hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation; Preapproval Requirements; ability for healthcare facility(ies) to temporarily increase licensed bed capacity during a mass effect event to accommodate for a resulting influx in patients. A declaration of the Stafford Act or National Emergencies Act in addition toa public health emergency under Section 319 of the Public Health Services Act must precede state or healthcare facility request for an 1135 Waiver.
- *Decompression:* the identification and movement of admitted patients that are appropriate for discharge, downgrade, or lateral movement to another unit, to increase capacity to receive incoming patients. This is often a preparatory function of a receiving facility (as defined below).
- *De-risking:* the process by which a healthcare facility proactively relocates admitted patients in anticipation of an event that could trigger an emergent evacuation. This is often a preparatory function of a sending facility (as defined below).
- *Emergency Management:* Emergency Management programs prepare plans and procedures for responding to natural and manmade disasters in addition to other emergencies. These programs also help lead the response during and after emergencies, often in coordination with public safety officials, elected officials, nonprofit organizations, and governmental agencies.
- *Healthcare Preparedness Coalition Regions (HCCs):* geographical region aligning with a Level I or Level II trauma center that may include the full range of healthcare assets that provide "point of service" medical care and other medically related services during a mass casualty and/or mass effect incident for all healthcare provider types including hospitals, EMS systems, public health agencies, community health centers, integrated healthcare

systems, private physician offices, outpatient clinics, dialysis and other specialty treatment centers, and long-term care facilities.

- *Healthcare Facility Evacuation:* the emergent movement of admitted patients to an alternate internal or external location in response to a mass-effect event as a result of patient safety concerns (Note: the healthcare facility does NOT have to follow the same mandated evacuations of county and state officials).
- *Patient:* for the purpose of this framework, the term 'patient' will broadly include any person(s) who: are receiving in-patient medical care at a healthcare facility; are newly injured or ill due to an emergency incident/event or have existing medical conditions requiring the need to be moved to healthcare facility for treatment.
- *Patient Movement:* the physical relocation of a patient from one area to another to preserve their safety in anticipation of, or response to, a disaster or emergency situation where local resources have become overwhelmed and regional, state, or federal support for patient movement is required.
- *Patient Coordination Center Lead:* the incident/event-specific state-appointed healthcare facility that will help to facilitate planning and discussion amongst other pre-identified hospitals, healthcare facilities and Healthcare Coalitions (HCCs).
- *North Carolina Healthcare Association (NCHA)*- An alliance that unites hospitals, healthcare systems, and care providers across the state of North Carolina.
- *NCHA Mutual Aid Agreement:* an agreement that is activated in the event of a disaster and that allows for effective utilization of available hospital resources and the provision of timely and effective patient care.
- *North Carolina Office of Emergency Medical Services (NCOEMS):* provides technical assistance, support, and regulatory oversight to all local EMS systems in North Carolina and oversees the state trauma system. Serves as program oversight for the healthcare preparedness program (comprised of 8 healthcare coalitions). Serves as lead agency for Disaster Medical Services during activation of State Emergency Operations Plan within the State Emergency Response Team.
- *Receiving Facility* –a healthcare facility that may receive patients as part of a statewide patient movement plan activation. Note: There may be one or more receiving facilities based upon patient volume and acuity.
- *Sending Facility* – a healthcare facility that requests support to activate the statewide patient movement plan in anticipation of, or response to, a disaster that may/has impact(ed) patient care and hospital operations. Note: There may be one or more sending facilities based upon the magnitude of the impact.
- *Shelter-in-Place* – the process by which a healthcare organization hardens current infrastructure in order to provide safety and security measures for current inpatients in preparation of a potential mass effect event. This decision may be made as a result of a risk assessment which highlights that it is safer to remain in place than to relocate patients.
- *Statewide Patient Coordination Team* – a key point of contact and backup designee from each of the Transfer Center/Patient Flow Centers for the large healthcare systems in North Carolina to routinely meet and coordinate on the patient placement coordination within the state during disasters and emergency situations.
- *Transfer Center/Patient Flow Center* – the service unit within a healthcare organization that manages patient movement and flow during daily (normal) operations.
- *Triage* – the process of sorting and prioritizing patients' treatments based upon acuity.

Assumptions

- Decisions regarding when to move patients that are in a healthcare facility and who to move, are made within the hospital/healthcare system.
- A qualifying lead facility will have a transfer center and has been educated/trained to the state Patient Movement Annex and Hospital Patient Movement Guideline.
- Patients are often moved via ground and air ambulance through direct facility-to-facility transfer; however, competing transport resource requests may quickly overwhelm available resources during large incidents and should be avoided during statewide activation of the Patient Movement Guideline, except under the following circumstances:

    - Emergent patient transfers (STEMI, stroke, trauma, etc.). Standard procedures should ***not*** be bypassed during an activation of the Patient Movement Guideline to ensure safety of all patients.
    - Due to increased transportation demands, resources from the Hospital Patient Movement Guideline may need to be reallocated in order to ensure the safe and timely transfer of critical patients.
- A patient's health generally does not improve with relocation. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or in-route delays due to weather, accidents, or secondary events subsequent to the originating event/incident.
- Ideally, patients should be stabilized prior to being moved. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources, and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process, all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- All evacuations are subject to weather conditions and safety considerations.
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities and the responsibility for costs resulting from patient movement are primarily the obligation of the sending healthcare facility.

Triggers

The need for patient movement can originate from external or internal sources as described below:

- External – An event or incident, such as a hurricane, highly infectious disease/pandemic, fire, or hazardous plume that poses a risk to a healthcare facility that could compromise infrastructure, operations, or safety of patients/staff.
- Internal – An event or incident such as an explosion, fire, hazardous material release or major utility failure involving only the healthcare facility.

Note: In all scenarios, healthcare decision makers have made the determination that the risk of sheltering in place outweighs the risk of moving the patients to an alternate location.

The need for patient movement can be 'anticipated' or 'unexpected', as described below:

- Anticipated – greater than 48 hours to expected impact, allowing time to deliberately plan, identify, triage and link patients with appropriate facilities, including but not limited to:
    - Hurricanes
    - Highly Infectious Disease/Pandemic
    - Significant snow or ice storms
    - Storm Surges and Flooding
- Unexpected- the risk to life safety with immediate needs to relocate patients to an alternate healthcare facility, including but not limited to:
    - Power loss in the absence of a functioning generator
    - Tornado with direct impact
    - Other compromised infrastructure with significant impacts anticipated within 24 hours or less

Activation Framework

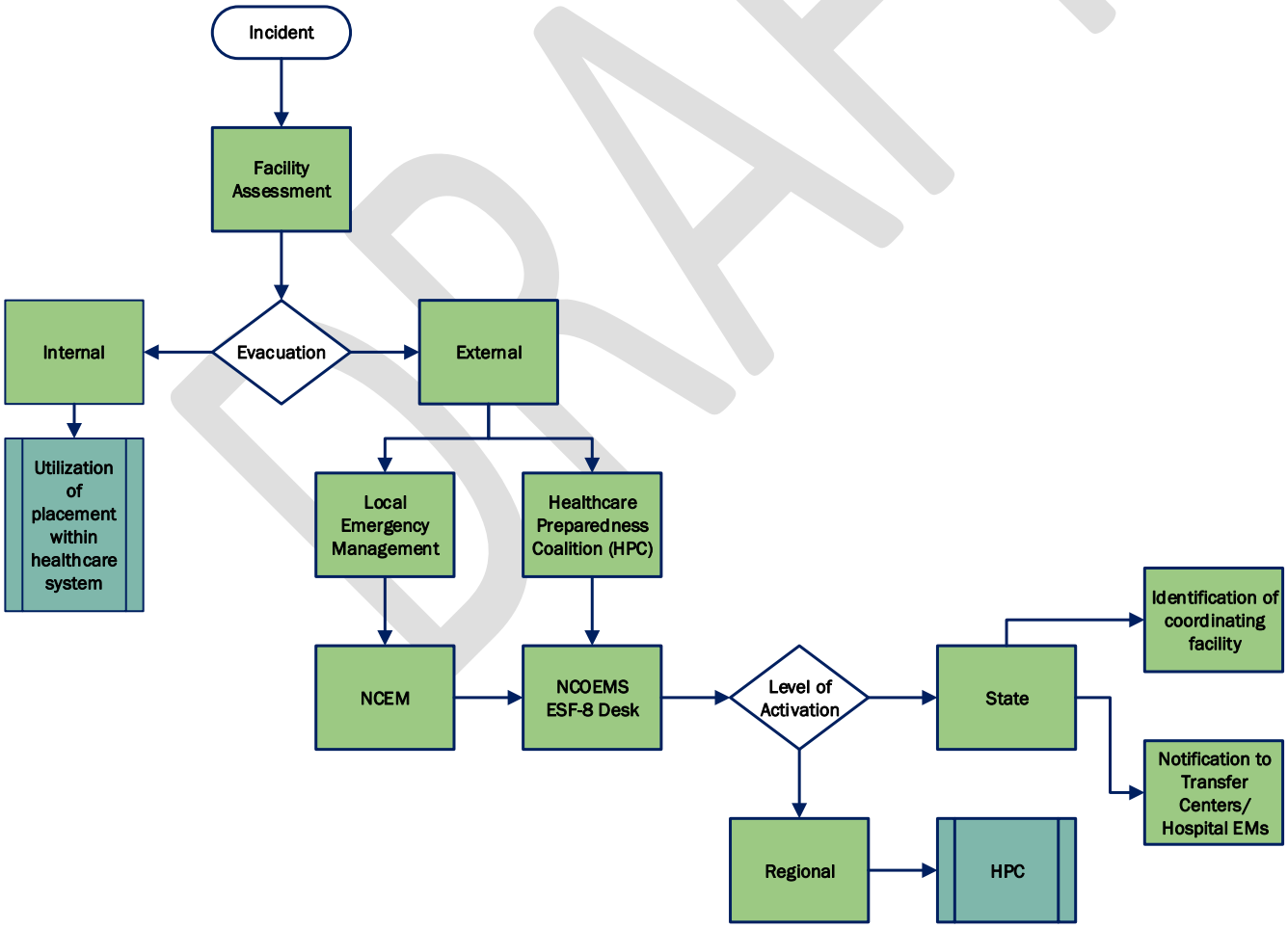
There is a three-tiered approach to facilitating hospital patient movement:

- **Healthcare system** – utilization of flagship entity and affiliate sites to absorb patients without Healthcare Preparedness Coalition or state support. Some agreements or standard partnerships between hospitals/healthcare systems may allow for the movement of low acuity and/or volumes of patients to respective facilities with no or minimal involvement of a Healthcare Preparedness Coalition.

- **Healthcare Preparedness Coalition (HCC) supported** – the state of North Carolina is divided into Regional Advisory Committees (RACs). Each HCC is led by a Level-I or Level-II trauma center. There are 8 healthcare coalitions in NC that align with each of the 8 RACs. The healthcare coalitions support all healthcare provider types within their region. Multiple coalitions may be involved in this type of event to absorb the patients, but it does not warrant a statewide activation.
- **Statewide activation** – requires collaboration between NCOEMS, all 8 HPCs, their respective transfer centers, and NCEM to facilitate movement, activate emergency contracts and implement mutual aid from other states, as necessary. If statewide activation occurs, ESF8 will assign a statewide Patient Movement Supervisor to oversee and coordinate all related operations. During an anticipated event it is expected that much of the decision to activate this guideline will be based on input from the Statewide Patient Coordination Team with the ultimate decision being made by ESF8 leadership.

Note: The escalation of activation from one tier to another can be attributed to the volume and/or acuity of the patients requiring temporary relocation. Additionally, when the Hospital Patient Movement Guideline is activated, and a healthcare facility is not impacted, the coordination begins in Tier II with the support of the Healthcare Preparedness Coalition.

Chart 1. Activation Flowchart of Patient Movement Guideline by Healthcare Facility



Procedure

Initiation

Event/Impact

- An incident or event impacts one or more healthcare facilities (or county if no healthcare facility involved), requiring some form of patient movement into a hospital and to support the healthcare system.
- The healthcare facility Emergency Manager performs an assessment and makes a recommendation for patient movement based upon internal protocols.

Notification of Event/Impact

- Upon the decision to request activation the Patient Movement Guideline:
    - Healthcare Emergency Management (EM) alerts County EM
        - County EM will notify their respective leaders & NCEM, as appropriate
    - Healthcare EM alerts Healthcare Preparedness Coalition
        - Healthcare Preparedness Coordinator alerts NCOEMS ESF-8 Desk
            - NC HPP Shift Duty Officer 919.855.4687
    - Notification provided to other stakeholders as identified within their respective EOPs
    - Patient Movement Planning Form should be completed by Healthcare Facility or designee (e.g., Healthcare Preparedness Coalition lead) to begin planning for potential patient movement resources. The link for the HIPAA Compliant ReadyOp Healthcare Facility Patient Movement Planning Form will be provided to stakeholders upon activation.
        - Key Elements needed for ReadyOp Healthcare Facility Patient Movement Planning Form:
            - Associated Healthcare Preparedness Coalition
            - Healthcare Facility Information (County, Full Name of Healthcare Facility, Name of Individual Requesting, 24/7 Contact Info)
            - Anticipated Patient Transportation Request Details (e.g., number of stretcher bound Advanced Life Support and Basic Life Support patients needing transport, number of non-ambulatory patients that could be moved via wheelchair, any patients requiring air ambulance transport)
            - Anticipated Patient Placement Bed Types (e.g., Adult, Pediatric, NICU for Medical/Surgical, OB/LND, Psychiatric, Critical: ICU, Critical: CCU, NICU/PICU etc.)

Activation Decision

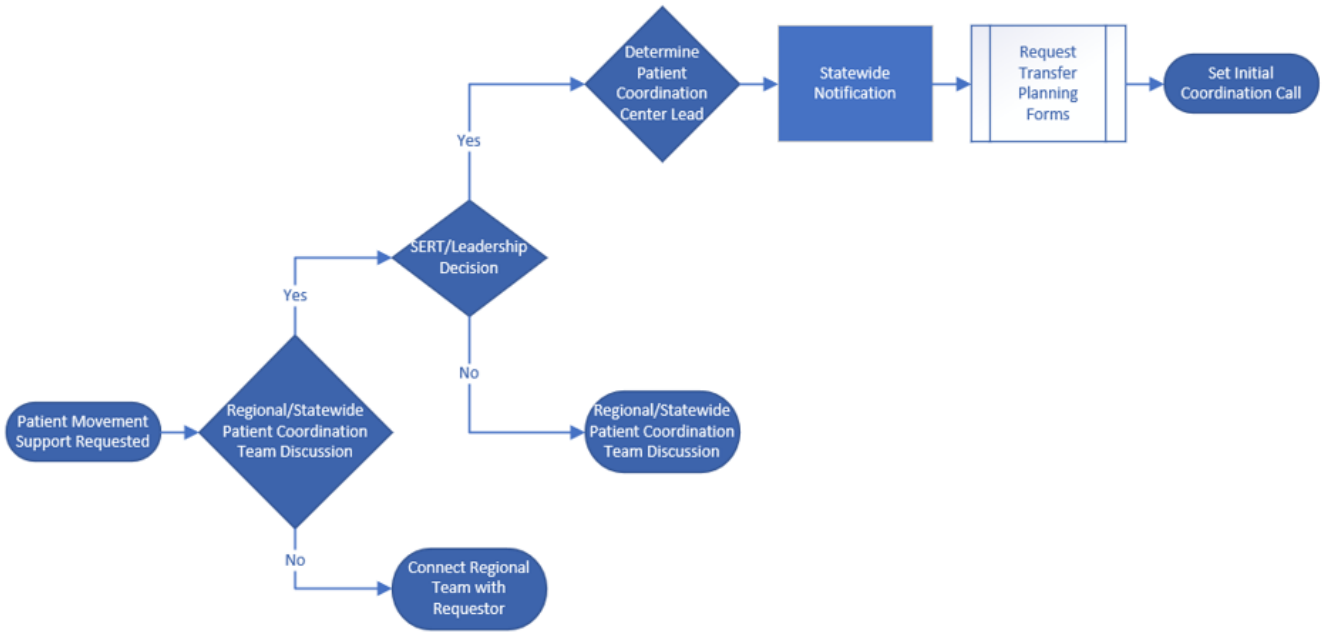
- Once the request is made to NCOEMS ESF8 Lead for patient movement support (from Healthcare Emergency Manager, County Emergency Manager, Healthcare Preparedness Coalition, or member of Statewide Patient Coordinator Team) a series of steps occurs to determine need for activation. Based on urgency of the need to activate statewide patient movement support, the request can be elevated immediately to State Emergency Response Team (SERT) for Leadership Decision and rapid activation of patient movement support.
    - Request for support from healthcare facility or impacted county
    - Optional: Discussion with the Regional Patient Coordination Representative or Statewide Patient Coordination Team to determine availability of resources for placement to support request for support within the region without state support
        - If Regional or Statewide Patient Coordination Team is able to support the healthcare facility or county with placement and no state support is indicated, then Regional Healthcare Coalition will connect requestor with their regional patient coordination team member
        - If Regional or Statewide Patient Coordination Team is unable to support the healthcare facility or county, then the ESF8 Lead should provide a situation report to the SERT Lead or designee for decision.

- Situation Report to SERT Lead for decision to activate patient movement guideline
- Once approved NCOEMS ESF8 lead will assign Patient Movement Supervisor and Determine Patient Coordination Center Lead

Notification of Activation

- Patient Movement Guideline activation notification
  - Healthcare System – Notification may or may not occur depending upon the scale of the incident/event
  - Regional – Healthcare Preparedness Coalition manages internal communications with regional hospitals
  - Statewide – NCOEMS activates communication trees (ReadyOp)

Chart 2: Approval Flowchart of Patient Movement Guideline by NCOEMS



Identification of Patient Coordination Center Lead

- NCOEMS will work with unaffected lead hospitals from active members in the Statewide Patient Coordination Team to determine an appropriate Patient Coordination Center Lead based upon impact and availability
- Notification of the Patient Coordination Center Lead will be provided in the initial activation communication

NC SPARTA/WEBEOC Event

- NCOEMS should request that a statewide event be created in NCSPARTA (if one does not already exist) to help manage the overall event
- Announcement of the statewide event should be included in the initial activation communications

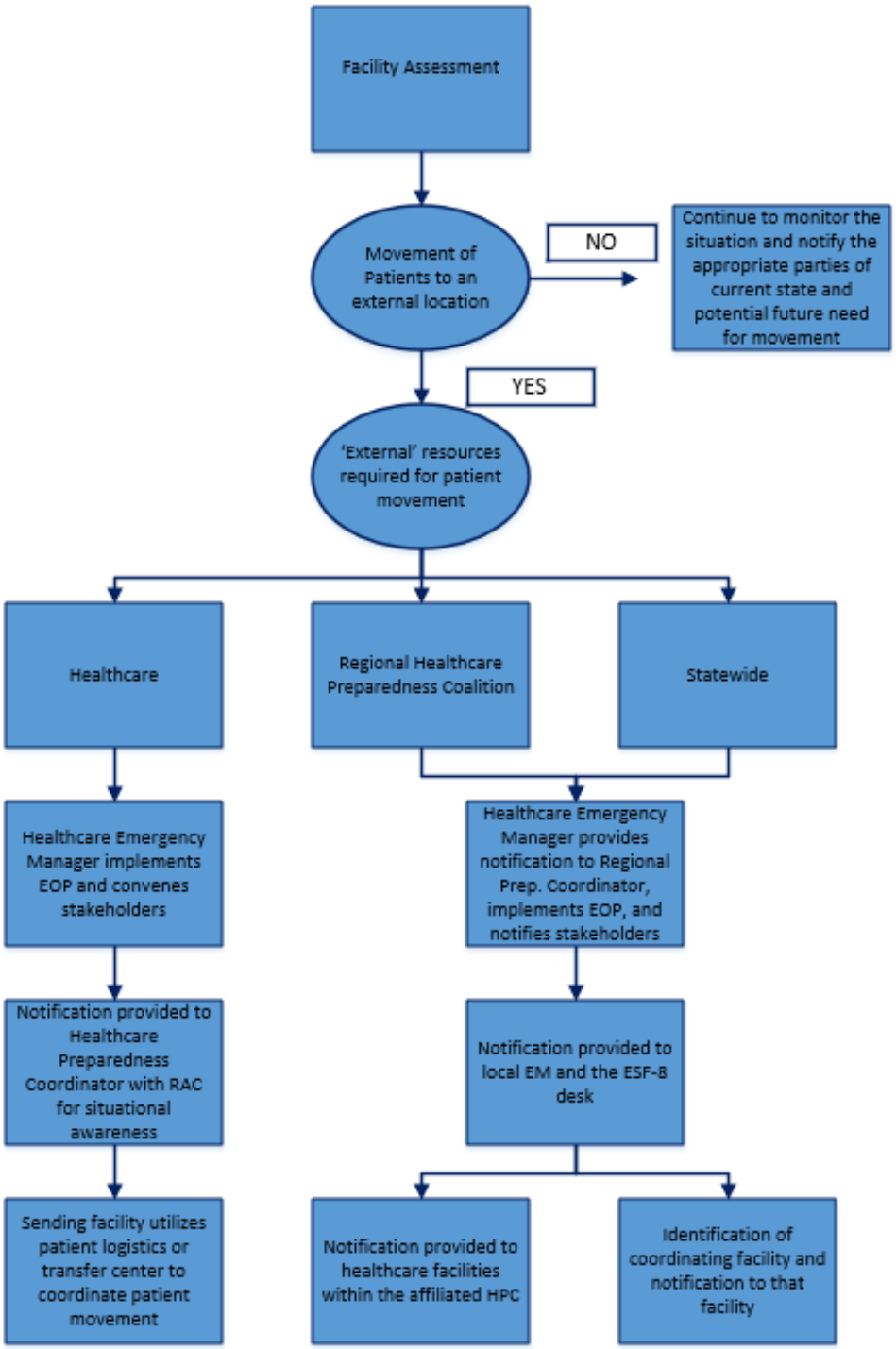
Patient Movement Coordination Activation

- NCOEMS will send activation email to NCEM SERT Emergency Services, Healthcare Coalitions, all hospital EMs & all Statewide Patient Coordination Team Members – this notification will include the initial

conference call line, Patient Coordination Center Lead, brief details of the situation, and ReadyOp Forms for patient movement

- An email notification will be distributed through the NCHA_EMC list serve to provide the information in the activation email from NCOEMS as a method of redundant communication

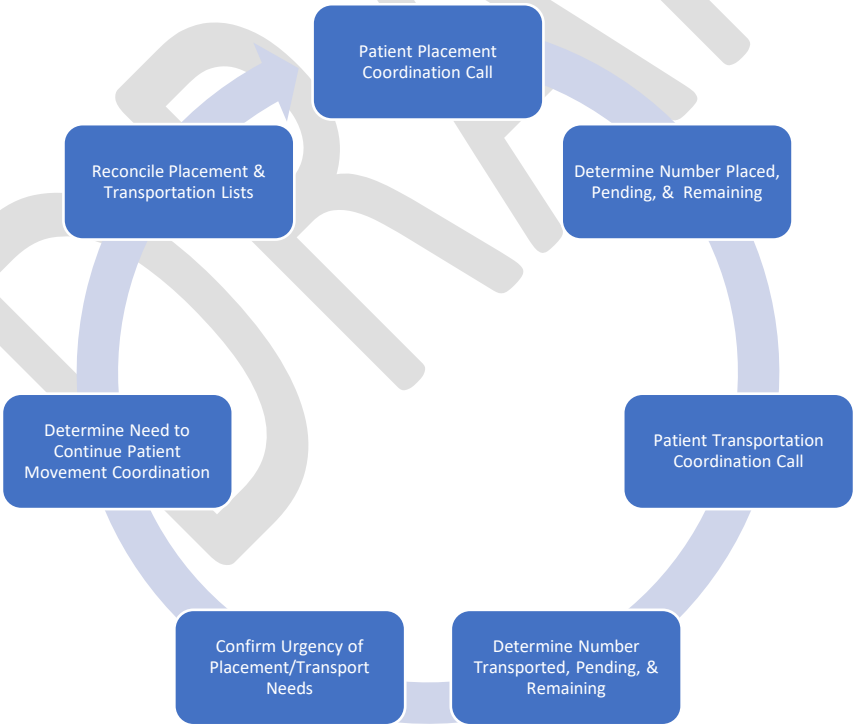
Chart 3. Healthcare Facility Patient Movement Assessment Flow Chart



Implementation

- The Patient Coordination Center Lead will facilitate the patient placement coordination conference call. NCOEMS will provide a Patient Placement Coordinator to record notes and provide overall support to the Patient Coordination Center Lead. In large scale events a Healthcare Facility Placement Unit maybe activated within ESF8 to support overall operations.
    - All participants will be contacted on their registered/Patient Transfer/Logistics Center phone numbers
    - Initial conference call agenda:
        - Roll Call (One spokesperson per entity/system)
        - Rules/expectations
            - Establish meeting cadence
        - Status Update (pertinent information)
            - Anticipated patient volumes and acuities
        - Patient Placement Update
            - Total number of patient placement needs identified
            - Total number of patients placed
            - Total number of patients pending placement
            - Total number of patient placements remaining
        - Challenges/Issues
        - Updates to process
        - Next call

Chart 4: Statewide Patient Movement Coordination Call Cycle



Patient Placement

- Patients are identified by the sending facility or facilities based upon their entity's Emergency Operations Plan and are submitted via the HIPAA Compliant ReadyOp Request Form provided in the activation email.

- Key Elements needed for ReadyOp Individual Patient Transfer Request Form:
  - Facility Details (Name, County, Contact Person, Title, Phone Number)
  - Patient Details (Name, Unit/Floor, Room Number, Unit Phone Number, Patient's Date of Birth, Veteran's Status)
  - Patient Condition (Primary Diagnosis, COVID Status, Patient Weight (Kgs), Oxygen Dependency, IV Access)
  - Any specialized equipment:
    - Arterial BP, Balloon Pump, Central Line, Chest Tube, Drains, IV Drips, Neuro Monitor, Pacer, PICC, Swan Cath, Traction, Umbilical Line, Ventilator, Other, None
  - Any specialty patient considerations:
    - Behavioral Health, Infection Control Precautions, OB Patient, Trauma Patient, Needs ECMO, Needs Dialysis, Other, N/A
  - Transportation Details:
    - Type of Transportation: Wheelchair Van - Driver Only (No Attendant), BLS - Basic EMTs (No Specialty Equipment), ALS - Paramedic (Limited Specialty Equipment), Specialty Care Transport - RN/Paramedic (Specialty Equipment), Other
    - Maximum transport time patient can tolerate (1-2 hours, 2-3 hours, 3-4 hours, 4-6 hours, <6 hours)
  - To attach any additional information you may have, such as medical history, medications, allergies, physician orders etc.

- The NCOEMS Patient Placement Coordinator or designee will receive via ReadyOp the Individual Patient Transfer Request Form(s) to review and approve requests, as appropriate
  - For bulk upload of patients, NCOEMS can provide an excel template and instructions for secure upload into ReadyOp to reduce the burden of multiple entries. Please note that all patients must be ready for placement at the time the form is uploaded.
- The Individual Patient Transfer Request Form(s) are provided to the Patient Coordination Center Lead
  - The Patient Coordination Center Lead will provide the initial and subsequent patient placement requests captured via Appriss Health Emergency Patient Movement Portal, HIPAA Compliant ReadyOp or via excel spreadsheet as tracked by NCOEMS Patient Placement Coordinator.
- Upon receipt of the patient placement requests, each hospital/health system will review the list to identify the appropriate placement of potential patients based off of current resources, specialties, and bed availability
- During the next scheduled Patient Placement coordination call, the Patient Coordination Center Lead will identify each patient by name and allow for participating hospitals to accept patients based upon appropriate level of care and resource availability
  - In some cases, two hospitals may each want to accept the same patient and a discussion will be had with all participants to determine the most appropriate placement
- The Appriss Health Emergency Patient Movement Portal, ReadyOp or excel spreadsheet will be updated during the coordination calls in real time by NCOEMS Patient Placement Coordinator.

Patient Tracking

- Patient Tracking will be utilized to monitor and track patients in real-time – patient tracking is the responsibility of the Patient Transportation Coordinator or designee. In large scale events a Patient Tracking Unit may be activated to handle this responsibility.
  - The Real time Tracking Board will include the following patient status categories:
    - Pending – patients pending the start of the patient movement process
    - Investigating – patients that are being investigated for possible placement

- Accepted – patients that have been accepted for placement but are awaiting transportation asset be assigned
- Pending Transport – patients that have a transportation asset assigned but haven't been picked up at the sending facility
- Transferring – patients that are enroute to the receiving facility
- Received – patients that have completed entire process

- Refer to Appendix 10: Patient Transportation Guideline for more details on patient tracking.

Sending Facility

The sending healthcare facilities should utilize the following checklist, built upon lessons learned from previous events, to help preplan and prepare for sending patients during regional/statewide patient movement event:

- ✓ Convene stakeholders (may include the Patient Logistics/Transfer Center, Nursing House Supervisors, Operational Executives, Emergency Management, Transportation, Medical Director, Care Management, etc.) to determine all patients that need to be moved
  - De-risking should be completed 120-148 hours before an anticipated incident (e.g., hurricane)
  - Ensure completion of Healthcare Facility Patient Movement Planning Form to inform planning factors as soon as possible
  - Patients that are submitted to NCOEMS ESF8 for placement are considered ready for placement and transfer (e.g., the patient, family & medical care team should be aware before submission to patient transfer center if applicable)
  - Patient placement location is dependent on the receiving healthcare facility and cannot be determined by sending facility if they are requesting support for regional or statewide patient movement
  - Evacuation decision should be no later than 96-120 hours before an anticipated incident (e.g., hurricane) to provide time for coordination and to ensure adequate transportation assets
  - Use of Regional or Statewide Hospital Patient Movement support for decompression should only occur after activation of a facilities internal surge plan and active steps to manage surge internally has occurred (EOC activated, decreased surgical load etc.)
  - Ensure proper waivers and regulatory notifications have been made
- ✓ Identify facility single point of contact for receiving information on the placement and acceptance of patients through the patient movement process
- ✓ Identify a hospital patient transportation coordinator to communicate, direct and support incoming transportation assets
- ✓ Ensure patient chart/documentation, belongings, and specialty equipment (when applicable) are ready to depart immediately upon arrival of transportation asset

Receiving Facility

The receiving healthcare facilities should utilize this checklist, built on lessons learned from previous events, to help preplan and prepare for receiving patients during regional/statewide patient movement

- ✓ Convene stakeholders (may include the patient logistics/transfer center, nursing house supervisors, operational executives, emergency management, transportation, medical director, care management, etc.)
- ✓ Identify facility single point of contact for receiving information and accepting patients
- ✓ Obtain common operating picture and current state of hospital
  - Evaluate capacity
  - Evaluate staffing
  - Evaluate critical supplies and equipment (and PPE)

- ✓ Identify patients that can be discharged, downgraded, or lateraled to increase receiving capacity
  - Determine and activate patient movement, as necessary
  - Patients can be discharged to State Medical Support Shelters if activated to help decompress facility to handle higher level of care patients.
- ✓ Engage affiliate sites, as appropriate
- ✓ Participate in coordination call
  - Review patient list compiled by the state and identify patients that may be an appropriate placement
  - Ensure appropriate clinicians and decision makers are present/available to assist with patient acceptance

Transportation: Information on the transportation coordination for patient movement can be found in Appendix 10 – Patient Transportation Guideline.

Patient Destination Arrival Verification

- At the start of each Patient Placement Coordination call, a review of accepted patients will occur in order to verify that the patient has arrived at the appropriate destination facility
- Patient Transport Coordinator or designee is responsible for monitoring and documenting patient's arrival at each destination in real-time throughout the incident
- Each case will be considered closed once verification of arrival has occurred

Demobilization

- The deactivation of the statewide Hospital Patient Movement Guideline will be determined in consultation with NCOEMS ESF8 Lead, and the Statewide Patient Coordination Team based on the current requests for patient movement and the statewide availability of resources
- The Patient Coordination Center Lead will facilitate one final coordination call in order to:
  - Verify the placement and arrival of all patients
  - Perform initial hot wash to gather after action reporting information (formal debrief and after action to be performed by NCOEMS)

Patient Movement Considerations for Managing Medical Surge During Statewide Event/Impact

This patient movement guideline can be utilized to support the entire healthcare system during a large statewide event/impact due to catastrophic disaster or highly infectious disease outbreak response/pandemic to balance the medical surge and avoid overwhelming the entire healthcare system.

Key differences during this type impact:

- Anticipate that majority/all healthcare facilities will be impacted by medical surge
- State assigned roles may need to provide higher level of support to Patient Coordination Center Lead due to competing demands from medical surge on their facility
- Primary goal of patient movement support will be to ensure patients are able to be cared for in most appropriate locations based on their conditions (e.g., ICU, Skilled Nursing Facilities, Alternate Care Sites etc.)
- Secondary goal of patient movement support will be to manage the medical surge needs of the entire healthcare system to optimize available space across each region and the entire state to balance the medical surge
- Statewide collaboration, communication and cooperation will be key parts of the patient movement coordination during this type of impact to ensure highest level of support across entire state
- Patient beds, appropriate staff and transportation assets will be extremely limited

- Patients may need to be transferred from tertiary/specialty care facilities to support decompression and facilitate placement of higher acuity patients within those facilities
- Additional facility types beyond just hospitals should be considered part of the patient movement coordination plan (e.g., Alternate Care Sites, Field Hospitals, Skilled Nursing Facilities as appropriate).
- Decision to activate hospital patient movement guideline will be based on request from Statewide Patient Coordination Team
- Timeframe for patient movement coordination may be extended due to length of the impact to healthcare system
- Statewide patient movement coordination may be activated, and demobilized multiple times as needed throughout impact

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX D: APPENDIX 8

SMSS Patient Movement Guideline

July 2021

Table of Contents

Purpose

The purpose of the State Medical Support Shelter (SMSS) Patient Movement Guideline is to establish a standardized framework for ESF8 SEOC and Support Cell staff to utilize upon activation of a SMSS. Staff must ensure that both the medical and transportation needs of patients are evaluated carefully when placing patients into a shelter.

Scope

This appendix covers specifics related to the movement of patients to/from the State Medical Support Shelters to include patient identification, patient placement, patient tracking, patient repatriation and overall coordination by North Carolina Office of Emergency Medical Services (NCOEMS) and Healthcare Coalitions (HCC). Additionally, it outlines the expected roles and responsibilities of other federal, state, and local organizations to ensure maximum efficiency and effectiveness during these operations. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan; Annex D: Patient Movement; and Appendix 10: Patient Transportation.

Guidelines

Patient Identification:

As outlined in the Patent Movement Annex, the identification of patients to be considered for placement within a State Medical Support Shelter is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.). This is to ensure pertinent information to determine the appropriateness of placement is known prior to acceptance of the patient into an SMSS.

SMSS Patients can be received from various locations:

- **General Population Shelter** - Citizens arriving at a general population shelter may be triaged and found to be more appropriately served at Medical Support Shelter. Request for placement into a SMSS from General Population Shelters should be initiated by the Healthcare Lead at the individual shelter and placed into the ReadyOp SMSS Individual Patient Placement Request Form. If telemedicine is in use at the general population shelter, then the patient may be referred directly by the physician supporting the shelter via telemedicine.
- **Healthcare Entity** – Hospitals, Long Term Care (LTC) Facilities, and other healthcare entities needing to de-risk, decompress, or evacuate, could potentially consider sending patients to a SMSS. Requests from Healthcare Entities requesting SMSS assistance should be routed through the healthcare emergency manager and placed into the ReadyOp SMSS Individual Patient Placement Request Form.
- **Home** – County entities (e.g. Social Services agencies, Emergency Management etc.) may identify individual residents in their communities who need to evacuate and require active monitoring/management. Requests for patients coming from home to be placed into the SMSS should be routed through local County Emergency Management and placed into the ReadyOp SMSS Individual Patient Placement Request Form.

The process for identifying patients appropriate for medical support shelters and those responsible for each step are outlined below.

1. Sending Entities (local emergency management agencies, healthcare facilities, EMS agencies, social services agencies, independent living facilities, etc.) considering the placement of patients who have or will be disrupted by the situation should evaluate individuals seeking SMSS placement based on the **Medical Support Shelter Placement Guidance (Figure 1.1).** Entities are encouraged to have a plan ahead of an emergency on how they will identify and transport individuals that will need to be placed in a medical support shelter. County emergency managers or designees are encouraged to complete a SMSS Patient Movement Planning Form upon activation of this plan to allow NCOEMS to begin preparing to handle the necessary patients that may require placement. This form is an early planning document to help inform need for size, number and location of medical support

shelters, potential transportation resources needed and staffing requirements. This should be completed at a minimum of 120 hours pre-land fall in the case of a potential hurricane.

a. SMSS Patient Movement Planning Form should be completed by the local county emergency manager, healthcare facility emergency manager or designee (e.g. county ESF8 lead or Healthcare Preparedness Coalition), the link for the form will be provided to stakeholders upon activation.
    i. Key Elements needed for ReadyOp SMSS Patient Movement Planning Form:
        1. Name of Organization
        2. Associated Healthcare Preparedness Coalition
        3. County Contact Information (24/7 Contact Info)
        4. Anticipated Patient Transportation Request Details (e.g. number of stretcher bound Advanced Life Support and Basic Life Support patients needing transport, number of non-ambulatory patients that could be moved via wheelchair, number of caretakers)

2. Identified Patients for placement in an SMSS, upon approval by the county emergency manager or designee, the SMSS Individual Patient Placement Request Form must be entered into the HIPAA Compliant ReadyOp platform. This form is an official request to have the patient accepted and placed in the medical support shelter and officially starts the process for patient placement. For counties that need to place multiple patients, NCOEMS can provide an excel template and instructions for secure upload into ReadyOp to reduce the burden of multiple entries. Please note that all patients must be ready for placement at the time the form is uploaded.
    a. Key Elements needed for ReadyOp SMSS Individual Patient Placement Request Form:
        i. Name of Organization (Name, County, Contact Person, Title, Phone Number)
        ii. Patient Details (Name, Address, Phone, Patient's Date of Birth, Veteran's Status, Weight (lbs))
        iii. Patient Condition (Primary Diagnosis, Infectious Disease Status)
        iv. Any specialty patient considerations:
            1. Alzheimer's/Dementia, Dialysis, Feeding Tube, IV Medications, Oxygen Dependency, Tracheostomy/Stoma, Ventilator, Wound Vac, Other
        v. Transportation Details:
            1. Type of Transportation: Wheelchair Van - Driver Only (No Attendant), BLS - Basic EMTs (No Specialty Equipment), ALS - Paramedic (Limited Specialty Equipment), Specialty Care Transport - RN/Paramedic (Specialty Equipment), Other
        vi. Notes/Attachments
            1. Feel free to attach any additional information you may have, such as medical history, medications, allergies, concerns about the residence, etc.

Patient Placement

NCOEMS will assign a Patient Placement Coordinator to oversee the placement of all patients into the SMSS. Depending on the size of the activation and patient movement needs there may be a specific Medical Support Shelter Unit assigned to oversee SMSS specific patient placement.

1. Receipt of SMSS Individual Patient Placement Request Form

The patient placement coordinator will monitor ReadyOp forms and OEMSSupportCell@dhhs.nc.gov for patient placement request forms. Within ReadyOp the patient placement status will be marked as **"Pending"** to indicate that the form has been received. The requestor should receive confirmation that NCOEMS is working on the patient placement form within 30 minutes upon entry into ReadyOp.

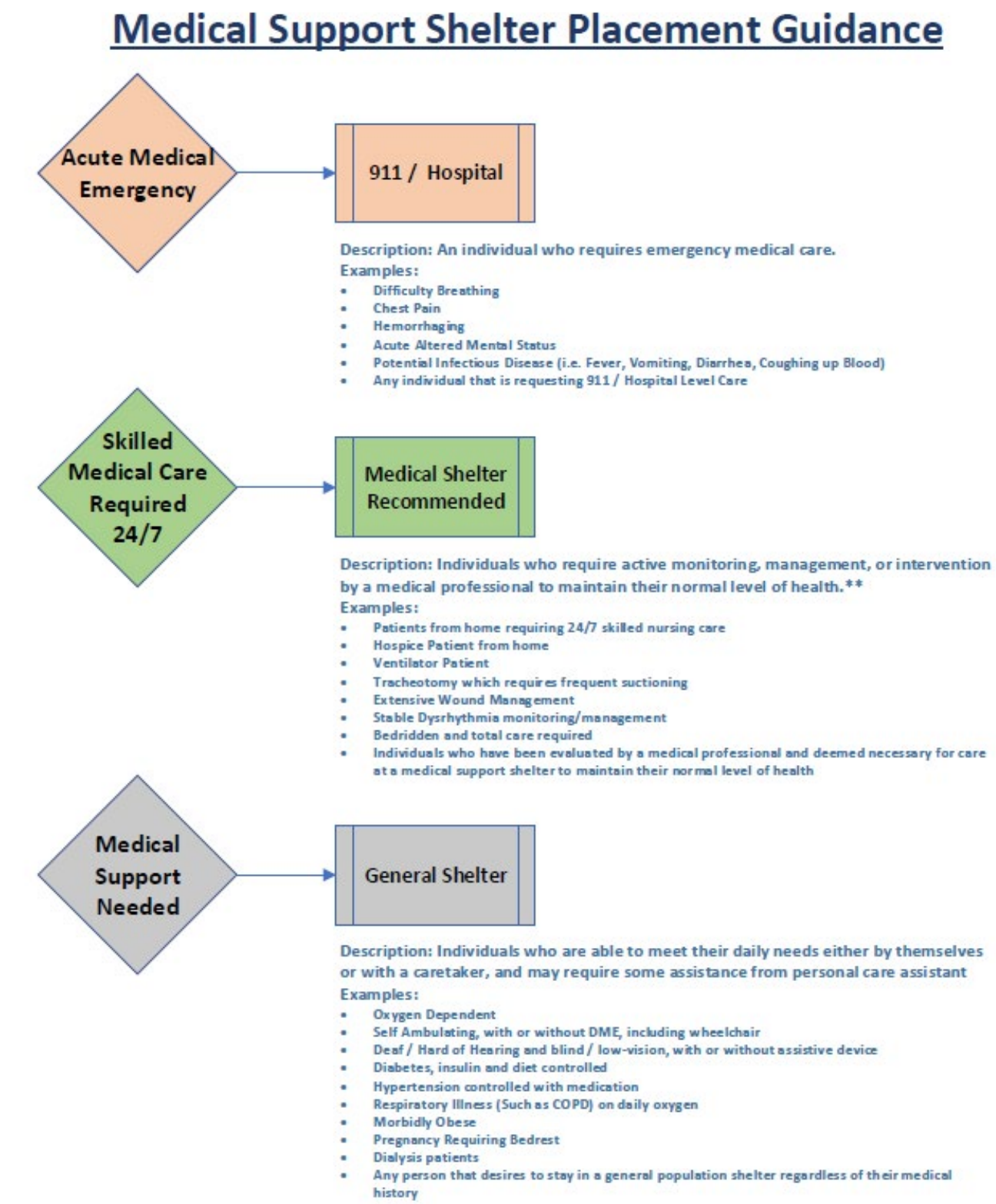
2. Review of SMSS Individual Patient Placement Request Form

a. The patient placement coordinator or designee will review each placement request form utilizing the SMSS Patient Guidance to determine/verify that the individual(s) submitted for placement into an SMSS is appropriate
b. Mark all individuals meeting the guidance for Skilled Medical Care placement as "**Accepted"** within ReadyOp Patient Placement Status section and note which SMSS facility (if multiple SMSS are open) the patient has been placed into along with the date and time patient was placed. If an individual meets the guidance for placement within an SMSS but one is not available, then the ReadyOp Patient Placement Status section should be "**Investigating,"** and the Patient Movement Supervisor made aware
c. Mark all individuals meeting the guidance for Medical Support placement (general population shelters) or Acute Medical Emergency (hospital) as **"Declined"** within ReadyOp Patient Placement Status section. Notes should be added to explain reason for declination.
d. Consultation with the assigned Medical Provider should occur to resolve concerns or questions about the appropriateness for placement
e. Once the SMSS Individual Patient Placement Request form has been resolved, the form should be provided to the Patient Transportation Coordinator for resolution and tracking

3. Resolution of SMSS Individual Patient Placement Request Form

a) The patient transportation coordinator is responsible to email the completed SMSS Individual Patient Placement Request Form with patient placement status and patient transportation status (if applicable) back to the submitting organization. The email should provide the SMSS location (if accepted) and SMSS IMT contact information. Email should request confirmation that the patient is still going to be placed in an SMSS, primary sending point-of contact information and estimated time of the patient's arrival (ETA) at the SMSS.
b) Once confirmation email has been received back from the requesting entity confirming that placement will occur and the ETA to SMSS, the form should be forwarded to the Patient Placement Lead and SMSS IMT.

Figure 1.1 Medical Support Shelter Placement Guidance:



North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX D: APPENDIX 9

Federal Coordinating Center Patient Movement Guideline

November 2021

Table of Contents

Purpose

The purpose of the North Carolina Federal Coordinating Center Patient Movement Guideline is to establish a standardized framework for patient movement that incorporates lessons learned from real events when the movement of patients is initiated by the activation of a Federal Coordinating Center (FCC). This guideline identifies activation triggers, outlines procedures for triaging and placing patients in appropriate receiving facilities.

Scope

This framework covers the FCC patient movement guidelines to include patient identification, placement, and overall coordination by the NCOEMS and Healthcare Coalitions (HCC), as well as the expected roles and responsibilities of other state and local emergency response organizations to meet its purpose. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan, Annex D: Patient Movement, and Appendix 10 – Patient Transportation.

Assumptions

- FCC Activation decision will be a joint decision between NCEM and NCOEMS with engagement from the Statewide Patient Coordination Team.
- A qualifying lead facility will have a transfer center and has been educated/trained to the state Patient Movement Annex and Hospital Patient Movement Guideline.
- A patient's health generally does not improve with relocation. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or in-route delays due to weather, accidents, or secondary events subsequent to the originating event/incident.
- Ideally, patients should be stabilized prior to being moved. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources, and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process, all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- All evacuations/patient movements are subject to weather conditions and safety considerations.

Triggers

- The triggers for FCC patient movement begin with an alert of the FCC site which is part of a joint decision between NCEM and NCOEMS. The statewide patient coordination team will be notified of a potential activation for their concurrence that an activation can be supported. It is anticipated that greater than 48 hours before the initial arrival of patients will allow time to deliberately plan, identify, triage and link patients with appropriate facilities.

Activation Framework

Statewide activation – requires collaboration between NCOEMS, all 8 HPCs, their respective transfer centers, and NCEM to facilitate movement, and activate emergency contracts. If statewide activation occurs, ESF8 will assign a statewide Patient Movement Supervisor to oversee and coordinate all related operations. It is expected that much of the decision to activate this guideline will be based on input from the Statewide Patient Coordination Team with the ultimate decision being made by ESF8 leadership and NCEM.

Procedure

Initiation

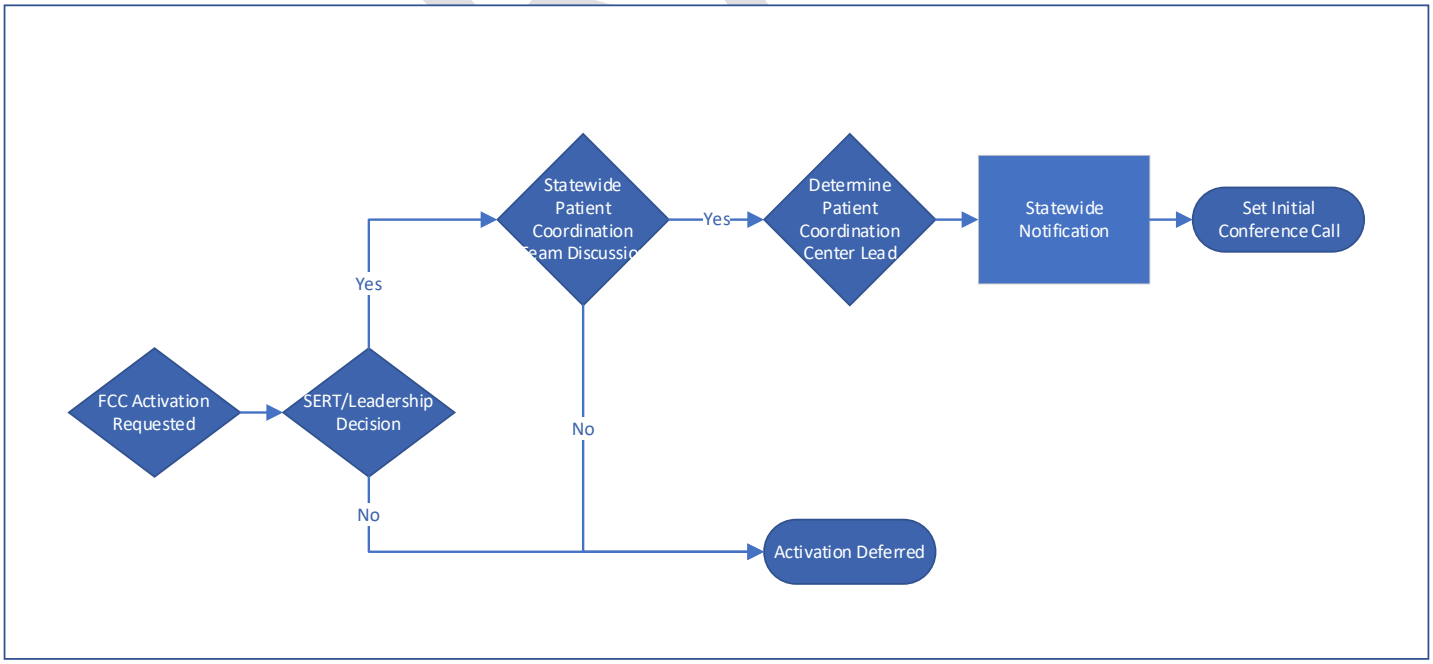
Event/Impact

- An incident or event impacts an area outside of North Carolina necessitating the need for patients to be evacuated from that state or territory.
- The Veterans Affairs Area Emergency Manager (VA AEM) requests activation of a North Carolina Federal Coordination Center to the NC ESF8 Shift Duty Officer or ESF8 Lead.
    - Note: North Carolina has two FCCs, one in Salisbury, NC which relies on the Charlotte-Douglas Airport and one in Durham, NC which relies on the Raleigh-Durham Airport.
- ESF8 Lead confers with NCEM Leadership and DHHS Leadership about the FCC Activation request. If concurrence to consider the FCC Activation is reached the Statewide Patient Coordination Team is notified for their input and concurrence.
- Once concurrence is reached the VA AEM is made aware that one or both FCCs are able to activate.
- Final decision to activate and receive patients will come from the VA AEM once the decision to use that FCC has been determined through their chain of command.

Notification of Activation

- Upon the decision to activate the FCC Patient Movement Guideline:
    - Notification will be made to the North Carolina Healthcare system via the Healthcare Coalitions and the North Carolina Healthcare Emergency Management Council (NCHEMC) list-serv for redundant communications that one of the NC FCCs has been activated.
    - Patient Movement Planning Form should be completed through receipt of information from the VA AEM to begin planning for potential patient movement resources. This information will be shared with the statewide patient coordination team as soon as received.

Chart 2: Approval Flowchart of FCC Activation Guideline by NCOEMS



Identification of Patient Coordination Center Lead

- NCOEMS will work with lead hospitals from active members in the Statewide Patient Coordination Team to determine an appropriate Patient Coordination Center Lead based upon impact and availability
- Notification of the Patient Coordination Center Lead will be provided in the initial activation communication

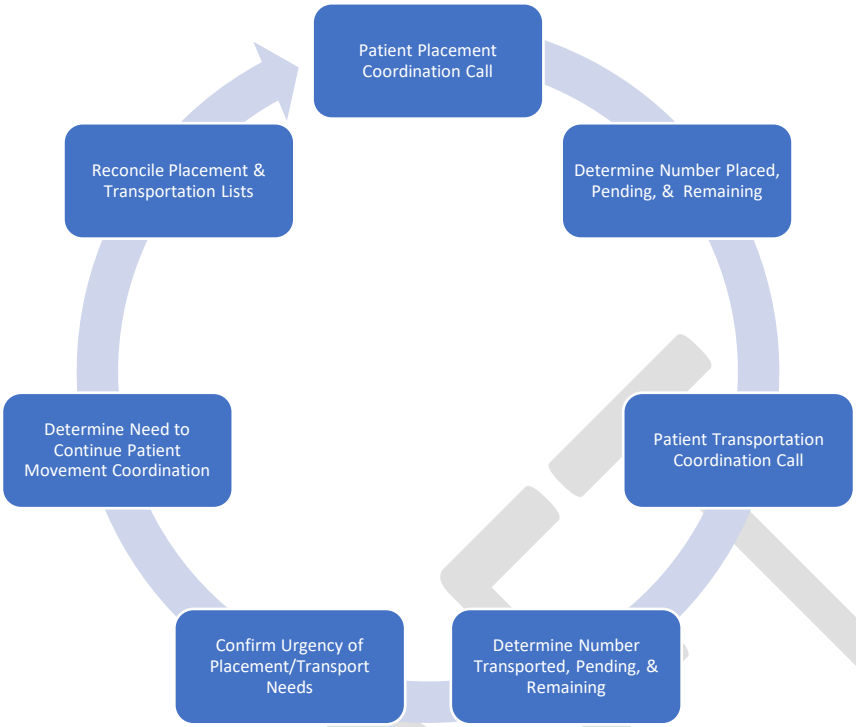
NC SPARTA/WEBEOC Event

- NCOEMS should request that a statewide event be created in NCSPARTA (if one does not already exist) to help manage the overall event
- Announcement of the statewide event should be included in the initial activation communications

Implementation

- Patient Bed Reporting – it is anticipated that NC will be asked to provide the VA AEM and ASPR REC the number of available beds by specific type (e.g. Adult, Pediatric, ICU, Med/Surgery, Psychiatry etc.). Currently bed reporting is completed via the APPRISS critical resource tracker and the Med-Surge Data Team is able to pull those bed numbers quickly to provide to VA AEM. NC does not track all the identified bed types so it will be limited to Acute Care (not including ICU) and ICU level beds for all ages.
- Receiving Patients - Patients will be sent from the sending facilities to one of the NC FCCs after a decision is made on placement by USTRANSCOM (the DoD patient evacuation agency responsible via the U.S. Air Force's Air Mobility Command team).
- Patient Placement Needs – USTRANSCOM should provide the patient manifest through the VA AEM and/or the ASPR REC. This will allow the patient coordination process to begin.
- The Patient Coordination Center Lead will facilitate the patient placement coordination conference call. NCOEMS will provide a Patient Placement Coordinator to record notes and provide overall support to the Patient Coordination Center Lead. In large scale events a Healthcare Facility Placement Unit maybe activated within ESF8 to support overall operations.
    - All participants will be contacted and provided WEBEX access for conference call.
    - Initial conference call agenda:
        - Roll Call (One spokesperson per entity/system)
        - Rules/expectations
            - Establish meeting cadence
        - Status Update (pertinent information)
            - Anticipated patient volumes and acuities
        - Patient Placement Update
            - Total number of patient placement needs identified
            - Total number of patients placed
            - Total number of patients pending placement
            - Total number of patient placements remaining
        - Challenges/Issues
        - Updates to process
        - Next call

Chart 4: Statewide Patient Movement Coordination Call Cycle



Patient Placement

- Patient transportation to an FCC is determined by USTRANSCOM and provided to the receiving state's ESF8 lead by way of a patient manifold. This manifold should provide details on each patient's condition prior to their arrival and should include the number of patients, patient diagnosis, specialized equipment, types of beds needed, etc.
- The NCOEMS Patient Placement Coordinator or designee will review the patient information and distribute appropriately.
- The Individual Patient Information is provided to the Patient Coordination Center Lead
  - The Patient Coordination Center Lead will provide the initial and subsequent patient placement requests captured via Appriss Health Emergency Patient Movement Portal, HIPAA Compliant ReadyOp or via excel spreadsheet as tracked by NCOEMS Patient Placement Coordinator.
- Upon receipt of the patient placement requests, each hospital/health system will review the list to identify the appropriate placement of potential patients based off of current resources, specialties, and bed availability
- During the next scheduled Patient Placement coordination call, the Patient Coordination Center Lead will identify each patient by name and allow for participating hospitals to accept patients based upon appropriate level of care and resource availability
  - In some cases, two hospitals may each want to accept the same patient and a discussion will be had with all participants to determine the most appropriate placement
- The Appriss Health Emergency Patient Movement Portal, ReadyOp or excel spreadsheet will be updated during the coordination calls in real time by NCOEMS Patient Placement Coordinator.

Patient Reception Site

- A patient reception site will be set up at the FCC location for the receipt, triage, emergency treatment, and transport of patients.
- Depending on the number of patients being received, available transportation assets and expected length of the FCC activation a State Medical Support Shelter may be setup to support the FCC

Operations. This decision is a joint decision between the ESF8 Lead and the Patient Movement Supervisor in consultation with NCEM.

- The patient reception site will have an Incident Management Team setup to coordinate and oversee operations onsite.
    - The patient movement roles identified in the Patient Movement Annex should be under the operations section with responsibility for the oversight of the roles outlined in that annex.

Patient Tracking

- Patient Tracking will be utilized to monitor and track patients in real-time – patient tracking is the responsibility of the Patient Transportation Coordinator or designee. In large scale events a Patient Tracking Unit may be activated to handle this responsibility.
    - The Real time Tracking Board will include the following patient status categories:
        - Pending – patients pending the start of the patient movement process
        - Investigating – patients that are being investigated for possible placement
        - Accepted – patients that have been accepted for placement but are awaiting transportation asset be assigned
        - Pending Transport – patients that have a transportation asset assigned but haven't been picked up at the sending facility
        - Transferring – patients that are enroute to the receiving facility
        - Received – patients that have completed entire process
    - Refer to Appendix 10: Patient Transportation Guideline for more details on patient tracking.

Receiving Facility

The receiving healthcare facilities should utilize this checklist, built on lessons learned from previous events, to help preplan and prepare for receiving patients during regional/statewide patient movement

- ✓ Convene stakeholders (may include the patient logistics/transfer center, nursing house supervisors, operational executives, emergency management, transportation, medical director, care management, etc.)
- ✓ Identify facility single point of contact for receiving information and accepting patients
- ✓ Obtain common operating picture and current state of hospital
    - Evaluate capacity
    - Evaluate staffing
    - Evaluate critical supplies and equipment (and PPE)
- ✓ Identify patients that can be discharged, downgraded, or lateraled to increase receiving capacity
    - Determine and activate patient movement, as necessary
    - Patients can be discharged to State Medical Support Shelters if activated to help decompress facility to handle higher level of care patients.
- ✓ Engage affiliate sites, as appropriate
- ✓ Participate in coordination call
    - Review patient list compiled by the state and identify patients that may be an appropriate placement
    - Ensure appropriate clinicians and decision makers are present/available to assist with patient acceptance

Transportation: Information on the transportation coordination for patient movement can be found in Appendix 10 – Patient Transportation Guideline.

Patient Destination Arrival Verification

- At the start of each Patient Placement Coordination call, a review of accepted patients will occur in order to verify that the patient has arrived at the appropriate destination facility
- Patient Transport Coordinator or designee is responsible for monitoring and documenting patient's arrival at each destination in real-time throughout the incident
- Each case will be considered closed once verification of arrival has occurred

Demobilization

- The deactivation of the FCC Patient Movement Guideline will be determined in consultation with NCOEMS ESF8 Lead, and the Statewide Patient Coordination Team based on the current requests for patient movement and the statewide availability of resources
- The Patient Coordination Center Lead will facilitate one final coordination call in order to:
  - Verify the placement and arrival of all patients
  - Perform initial hot wash to gather after action reporting information (formal debrief and after action to be performed by NCOEMS)

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX D: APPENDIX 10

Patient Transportation Guideline

July 2021

Table of Contents

Purpose

The purpose of the Patient Transportation Guideline is to set forth a standard framework for the coordination of transportation for patients. Additionally, it will allow maximum efficiency for the movement of patients during an emergency or disaster by having a central point of coordination for all patient transportations.

Scope

This guideline covers state coordinated patient transportation efforts as part of the larger annex for patient movement.

Assumptions

- This appendix should be used in conjunction with the NCOEMS Annex D: Patient Movement.
- Medical Resources and EMS Mutual Aid, as referred to in this framework, often involve private and public EMS resources that will require reimbursement or payment for services rendered.
- All patient transportations are subject to weather conditions and safety considerations.
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities and the responsibility for costs resulting from patient movement are primarily the obligation of the sending healthcare facility.

Guidelines

The sending entity is ultimately responsible for providing transportation from the patient's origin to their destination (healthcare facility, medical support shelter etc.). However, it is anticipated that during a large-scale incident there will not be enough local transportation assets to complete patient movement activities without state coordinated transportation support. Early notification when transportation support is anticipated is critical to ensuring enough assets can be coordinated. The NCOEMS assigned statewide patient transportation coordination is ultimately responsible for all transportation requests. Depending on the number of operational sites and volume of patient movement requests, a Transportation Unit and a Tracking Unit may be activated.

- Statewide Patient Transportation Coordinator: NCOEMS ESF-8 desk will assign a statewide patient transportation coordinator to oversee all patient transportation activities (with exception of standard procedures for emergent patient transfer from a healthcare facility). All patient transportation requiring state support from healthcare facilities and/or counties during the statewide activation of patient movement should be coordinated through the patient transportation coordinator or designee. The Patient Transportation Coordinator will facilitate the patient transportation coordination conference call.
- Roles and Responsibilities for the Statewide Patient Transportation Coordinator includes:
    - Receives individual patient movement request form from the Patient Placement Coordinator and reviews for transportation needs
        - If the patient has been waitlisted for patient placement and/or declined placement, it is the patient transportation coordinators or designee's job to notify the requesting entity of the status of the patient within 30 minutes of receiving the patient movement form.
    - Contacts submitting organization to verify the need for transport and collects information necessary for the creation of a transportation mission (e.g. type of transport needed, time, place, point-of-contact, etc.)

- Consult with Medical Provider to resolve questions about appropriate type of transport for patients if necessary
- Provide transportation mission information to SEOC ESF8 Desk representative or Transportation Unit if activated, requests transportation mission, and requests notification when transport has been tasked
- Oversee tracking unit to ensure proper status updates are entered into the individual patient movement request form in ReadyOp
- Provides final resolution and status back to the Patient Movement Coordinator and the sending entity point of contact
- It is anticipated that coordination with multiple transportation coordinators/EMS Systems may be required to ensure efficiency and strong communication during large-scale events. In this circumstance it may require a transportation coordination call to discuss potential asset needs and receiving ongoing updates on total patient numbers for transportation. Below outlines the process and agenda for a transportation coordination call if required:
    - All participants will be contacted on their registered Communications Center phone numbers
    - Initial conference call agenda:
        - Roll Call (One spokesperson per entity/system)
        - Rules/expectations
            - Establish meeting cadence
        - Status Update (pertinent information)
            - Anticipated patient volumes and acuities
        - Patient Transportation Update
            - Total number of patients pending transportation
            - Total number of patients currently transferring
            - Total number of patients received
        - Challenges/Issues
        - Updates to process
        - Next call

- Statewide Communication Channel: NCOEMS ESF-8 desk will request a statewide communication channel for transportation assets to utilize for direct communications between the transportation coordinator and the sending/receiving facilities and all transportation assets

- Sending Facilities Transportation Coordinator: Sending facilities should identify a patient transportation coordinator to serve as the main point of contact at the facility to support patient transportation assets with access, direction, and coordination on site. This individual should have access to the statewide communications channel.

- Resource Tracking: Transportation assets from Public, Private, Mutual Aid, EMAC, federal resources will be identified and tracked in SERT Inventory within WEBEOC.

- Specialty Care Transport (SCT) should be utilized to the extent possible when patient movement involves two healthcare facilities unless it is anticipated that there will not be enough SCT resources to manage all the patient movements in a timely manner. Resource allocation decisions should be made based on the individual patient transfer request forms as determined by patient transportation coordination team. Ideal hierarchy of available resources is outlined below:

- Sending facility Specialty Care Transport entities should be utilized first when available in an acceptable timeframe to complete patient transports to receiving facilities
- Receiving facility Specialty Care Transport entities should be utilized second when available in an acceptable timeframe to complete patient transports from sending facilities
- Any available Specialty Care Transport entity should be utilized third when available in an acceptable timeframe to complete patient transports between sending/receiving facilities
- Non-Emergency Transportation entity should be utilized fourth when available in an acceptable timeframe to complete patient transports between sending/receiving facilities
- 911 EMS System assets should only be utilized when no additional transportation resources are available in an acceptable timeframe to complete patient transports between sending/receiving facilities

- 911 EMS System assets should be utilized when patient movement is from a non-healthcare facility (such as a scene or large-scale community incident). Ambulance Strike Teams and Ambulance Buses are also commonly utilized as an effective way to move patients during an emergency or disaster. This can include healthcare facility transports (as outlined above) and medical support shelter transportations.

- Incident Specific Transportation Assets: When transportation assets have been obtained specifically for the incident, (Emergency Transportation Contracts, State Ambulance Strike Teams (ASTs), Emergency Management Assistance Compact (EMAC), Federal Ambulance Contracts etc.) as commonly seen during an anticipated activation, these assets should be used first and foremost to decrease the impact on the daily operational assets. The available transportation asset(s) will be updated and monitored in the SERT Inventory resource board in WEBEOC to ensure visibility of available assets throughout the activation.

- Patient Tracking: The patient tracking unit is responsible for ensuring that all patient movement activities are tracked throughout entire process. The primary location for this tracking is on the patient tracking board in Appriss Health or via ReadyOp. The patient tracking unit should be able to provide real-time updates on all patient positions/statuses.

    - The Real time Tracking Board in Appriss Health or ReadyOp will include the following patient status categories:
        - Pending – patients pending the start of the patient movement process
        - Investigating – patients that are being investigated for possible placement
        - Accepted – patients that have been accepted for placement but are awaiting transportation asset be assigned
        - Declined – patients that are not able to be moved based on ESF8 lead decision
        - Pending Transport – patients that have a transportation asset assigned but haven't been picked up at the sending facility
        - Transferring – patients that are enroute to the receiving facility
        - Received – patients that have completed entire process

- Refueling will be the responsibility of the transportation asset – if assistance is required or fueling locations are unavailable in an affected area, coordination should occur between the transportation coordinator and NCEM to ensure refueling locations can be made available

- Anticipating Resources: It is important to anticipate when/if additional resources may be required for ongoing patient movement activities. This can be driven by the patient movement planning forms

and/or awareness of patients in healthcare facilities or medical support shelters that will need repatriation. Identifying additional resources and receiving them in staging can take 24-72 hours depending on where the resources are coming from so the earlier this can be anticipated and requested the more successful the patient movement operation. Discussion should be had with the Patient Movement Supervisor and the ESF8 lead to advise on need for additional resources.

North Carolina OEMS Emergency Operations Plan (NCOEMS EOP)
ANNEX F: APPENDIX 11

Situation Reports

November 2021

Table of Contents

Purpose

The purpose of the Situation Report Appendix is to provide standard formatting for gathering of information and the sending of situation reports during an activation of the NCOEMS EOP.

Assumptions

- This appendix should be used in conjunction with the NCOEMS Annex F: Situational Awareness & Information Sharing.
- Activation of personnel for the State Emergency Operations Center (SEOC) and/or the ESF8 Support Cell will require a situation report
- Staff working in the SEOC and/or the ESF8 Support cell will gather the necessary information for the situation reports.

Guidelines

The below information is considered a guideline to completion and dissemination of situation reports during an activation of the NCOEMS EOP. The ESF8 Lead has ultimate oversight of the situation report to include the frequency, content, and distribution list. This may change depending on the cause of the EOP activation.

- ### Collection of information:

  A situation report is required for all operational areas (e.g. Support Cell, MDH, SMSS etc.). The SEOC ESF8 Desk Manager has the responsibility of collecting the information from operational areas, and pertinent partners (e.g. HCCs) to compile the full situation report and present to the ESF8 lead or designee for approval.

  ReadyOp is the primary system used to collect the information necessary for the completion of the situation report.

  The following items are considered the minimum information to gather for a situation report:

  1. Name of person completing the form
  2. Operational Period Date & Time
  3. Number of Staff Activated
  4. Overall Status (e.g. No Change, Improving, Worsening)
  5. Mission Assigned
  6. Total number of patients impacted by mission (e.g. number of patients moved, number of patients sheltered, number of patients treated etc.)
  7. Current Operations Summary
  8. Critical Issues / Needs

- ### Essential Elements of Information:

  Specific Essential Elements of Information (EEI) above and beyond the list above are often required by DHHS Leadership, ASPR Regional Emergency Coordinators, NCEM etc. and should be considered part of the situation report when required to be collected. Typically EEI requirements involve a survey to healthcare facilities to determine the following:

  1. Census
  2. Number of Beds (different types depending on facility type i.e. inpatient vs. outpatient)
  3. Patient Treatment Status

4. Structural Damage
5. Evacuation Type
6. Evacuation Status
7. Reentry Status
8. Power Status
9. Generator Fuel Status
10. Generator Fuel Type
11. HVAC Status
12. Water Supply Status
13. Dialysis Status (if applicable)
14. Sewer Status
15. Immediate Needs

- ## Distribution of Information:

Once the situation report has been complied and approved it should be shared with the following groups:

1. NCOEMS Staff
2. Regional Healthcare Preparedness Coalition Staff
3. NCEM Operations Section (via the Emergency Services Lead) and Plans Section
4. Primary Stakeholders and Partners (as identified in the ReadyOp Partner Contacts Group)

North Carolina Emergency Operations Plan (NCOEMS EOP)
ANNEX G: APPENDIX 12

State Medical Support Shelter (SMSS) Plan

January 2020

Record of Changes

Date	Change	Section/Page	Updated By
11/3/2021	Updated to incorporate new SMSS Patient Movement Guideline (7/2021) and reorganize appendices.	Concept of Ops, page 10 & all Appedices	J. Comello

Table of Contents

Introduction

Over the past decade, North Carolina has experienced natural disasters that resulted in the need for local and state government to provide shelter for residents that evacuated or were displaced from their homes. Many of these displaced individuals have medical needs that require ongoing skilled medical care to assist them in maintaining their usual level of health and avoid hospitalization.

Future disaster incidents will stress the existing healthcare delivery system due to several factors: an increasing number of patients receiving advanced medical care at home; an expanding number of individuals with chronic medical conditions; and minimal hospital surge capacity during normal conditions. Based on this identified risk, North Carolina utilizes State Medical Support Shelters to ensure the safety of all evacuees while attempting to minimize the surge on the healthcare system.

Purpose, Scope, Situation and Assumptions

Purpose: To provide direction for the establishment and operation of State Medical Support Shelters (SMSS) so the continuity of healthcare is maintained for individuals with medical conditions requiring active monitoring and management by a credentialed medical professional during incidents that result in medical surge.

Scope: This plan covers the selection, staffing, activation, operation, and management of SMSS by the North Carolina Office of Emergency Medical Services, Healthcare Preparedness Program (NCOEMS-HPP) and Healthcare Coalitions (HCC), as well as the expected roles and responsibilities of other state and local emergency response organizations to meet its purpose. It should be used in conjunction with the NCOEMS-HPP Emergency Operations Plan.

Situation Overview: The situations listed below were considered in the development of this plan.

- Each day the health care delivery system (e.g. home healthcare, clinics, hospice, medical offices, skilled nursing facilities, and hospitals) provide a comprehensive range of medical care to the residents of North Carolina. However, during a disaster there can be a temporary loss of capacity or capability to provide needed healthcare services.

- Temporary loss of community healthcare supports (e.g. home healthcare, clinics, hospice, and medical offices) result in a medical surge on the already stressed in-patient health care delivery system (e.g. skilled nursing facilities and hospitals).

- In many cases individuals can maintain their usual level of health in a temporary residence (e.g. hotel, shelter, and relatives' home) with minimal healthcare support required. However, some individuals will require a specialized level of medical care to maintain their usual level of health and avoid hospitalization.

Planning Assumptions: The following assumptions and historical situations were considered in guiding this plan.

- An organized response within the State Medical Response System (SMRS) framework and Incident Command System (ICS) is superior to an unorganized response.

- Depending on the size and scope of disaster, the initial SMSS Incident Management Team (SMSS IMT) and SMSS personnel may not receive support (e.g. equipment, supplies, and personnel) for up to 72 hours.

- SMSS operations require local and state support coordination and may need up to 72 hours of preparation time prior to opening.

- Health and medical staffing are dependent on volunteerism of SMAT/MRC healthcare providers.

- Access to comprehensive information regarding the patient's conditions and needs may be limited.

Concept of Operations

Authority**:** Pursuant to Chapter 166A, North Carolina Emergency Management Act, the North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency responsible for Disaster Medical Services and is managed through the Healthcare Preparedness Program (HPP). NCOEMS has primary responsibility for the coordination of these services during disasters.

North Carolina Emergency Operations Plan (NCEOP) specifically tasks NCOEMS with the coordination of medical sheltering.

Mission and Goals**:** To provide shelter for individuals requiring specialized healthcare attention due to a disruption in their community healthcare support system. This includes individuals:

- Evacuating from their homes due to the disaster, and are affected with non-acute/non-infectious health conditions requiring a higher level of medical skill or resource than can be provided in a general population shelter;
- Being moved from a general population shelter and have a reasonable expectation of requiring a higher level of medical care to maintain their usual level of health after evaluation by a medical professional (e.g. telehealth or EMS); or
- Discharged from an in-patient healthcare facility after receiving stabilizing medical care and a medical provider is requiring a higher level of medical skill or resource than can be provided in a general population shelter.

Key goals in support of this mission require the establishment of SMSS:

- In close geographic proximity to the affected area, but in an area that remains out of harm's way;
- In communities with the necessary infrastructure and a willingness to support the operation; and
- Ability to begin receiving patients by the time requested to be operational

Managing the SMSS is a joint responsibility shared by NCOEMS and North Carolina Emergency Management (NCEM). Potential SMSS facilities should be identified, inspected, and approved by an NCOEMS evaluation team. Refer to **Appendix 1: SMSS Checklists** for additional information about site-specific criteria for SMSS establishment.

SMSS Types and Capacities**:** Configuration of an SMSS is flexible and tailored to accommodate up to 150 patients, based on the scope of incident and needs of the local jurisdiction. The three defined types of SMSS:

- Type III Shelter; 0 - 50 patients
- Type II Shelter; 51 – 100 patients
- Type I Shelter; 101 – 150 patients

SMSS may be established up to three days prior to impact of weather-related events, such as hurricanes and/or tropical storms, or as requested for local incidents that require evacuations or relocation. SMSS are designed to be self-supporting and on-scene for up to 72 hours after receipt of first patient. Refer to **Appendix 2: Mission-Ready Packages** for additional information about these specific assets.

Activation and Deployment: Processes for the activation and deployment of SMSS assets differ depending on whether the incident is a notice (e.g. hurricane) or no-notice (e.g. radiological release).

- For no-notice incidents the process begins with a request for support from a local jurisdiction through the State Emergency Operations Center (SEOC), and to the SDO/ESF8 Desk and appropriate Healthcare Coalition(s) for mission fulfillment.
- For notice incidents, to meet the mission safely and effectively, the initial planning and placement of SMSS should be determined in anticipation of potentially affected areas.

Initial Planning and Placement**:** Guidance for the initial planning and placement of SMSS:

- The emergency (e.g. likely storm track and affected areas);
- Factors that support the key mission goals (e.g. safe proximity from affected area, infrastructure to support, and operational within the requested time); and
- Location of adequate available facilities (Appendix 1: SMSS Checklists).

NCOEMS-HPP, with input from NCEM-Operations, and regional Healthcare Preparedness Coordinators (HPC) will determine locations for SMSS placement. Facilities adequate to support SMSS operations are pre-identified by NCOEMS-HPP, NCEM, and HPC.

General Population Shelters*:* Coordination with NCEM-Operations should include confirmation through Human Services (ESF6) that separate "general population" sheltering operations are established to serve the affected area(s), location(s) and associated contact information.

Refer to **Appendix 4: SMSS Locations** for current approved facilities and to **Appendix 1: SMSS Checklists** for site-specific criteria for SMSS establishment.

Asset Selection, Staffing, and Support**:** Concurrent with the determination of locations for SMSS operations, NCOEMS-HPP staff must secure the staffing and support necessary to establish and maintain SMSS operations.

Staffing and Support*:* Organized into three functional areas:

- Overhead (i.e. SMSS IMT leadership);
- Personnel (i.e. medical staff); and
- Logistics (e.g. logistics staff, equipment, and supplies).

Overhead function is filled through NCOEMS as part of the non-medical staffing component while the personnel and logistics functions are filled through one or more HCC as part of the medical and non-medical staffing components respectively.

NCOEMS-HPP staff assign NCOEMS staff as a liaison on the Incident Management Team (IMT) for each SMSS location and ensure fulfillment of an IMT for each SMSS.

HPC identify the personnel, and logistics assets within their HCC available to staff and materially support the identified SMSS locations.

Assignment of these HCC assets will be affected by the situation, readiness of personnel and equipment, and the type of SMSS being established. Based on real world operations, the following breakdown of responsibilities is expected to meet operational goals:

- Type III Shelter: Two HCC (one responsible for providing personnel and one responsible for providing logistics);
- Type II Shelter: Four HCC (two responsible for providing personnel and two responsible for providing logistics); or
- Type I Shelter: Six HCC (three responsible for providing personnel and three responsible for providing logistics).

Refer to **Appendix 5: SMSS Staffing Levels, Roles, and Responsibilities,** and **Appendix 6: SMSS Assignment Chart** for specific staffing requirements and guide to SMSS assignment.

Community Support*:* Support from communities is essential to SMSS operations. The extent of that support will vary depending on the characteristics of the selected facility, local support for SMSS operations developed through the pre-identification process, and the effect of the situation on that support. To determine what support is needed per SMSS location and mobilize those resources NCOEMS-HPP staff will:

- Contact identified SMSS host facility owners to activate existing Memoranda of Agreement (MOAs) and verify space and services available.
- Coordinate with local and state Emergency Management:
    - To identify the locations of "general population" sheltering operations established to serve the affected area(s). General shelters outside an affected county (state-supported) may satisfy this need; and
    - Secure law enforcement, fire safety, and other "wrap-around" logistical support that is not provided by the facility and cannot be provided otherwise.
- Coordinate with Division of Public Health (NCDPH) to verify and/or establish for available support for environmental health and mortuary services.
- Coordinate with appropriate patient transport resources (e.g. local EMS, hospital, public transportation, and AST) to verify and/or establish medical and non-medical patient transportation capability.
- Coordinate with local healthcare organizations (e.g. ESRD and Behavioral Health) to verify and/or establish access to patient care services. However, during large scale incidents with multiple SMSS open, NCOEMS HPP staff will request that existing care-specific coordinating organizations (e.g. IPRO ESRD Network 6) take on this role.

Refer to **Appendix 7: SMSS Site Requirements and Support Services** and **Appendix 1: SMSS Checklists** for specific support service requirements.

Placement of Patients in SMSS*:* To ensure that medical capabilities are adequate to care for individuals directed to SMSS, potential patients' medical support needs must be evaluated prior to transport. The SMSS Patient Movement Guideline (Appendix 8, Annex D: Patient Movement, NCOEMS EOP) details the process of patient movement to SMSS locations. The process is summarized here:

- Organizations considering the placement of patients who have or will be disrupted are expected to evaluate individuals seeking SMSS placement based on Medical Support Shelter Placement Guidance, see **Appendix 9: SMSS Placement Guidance and Patient Flow.**
- Organizations submit completed SMSS Individual Patient Placement Request Forms into ReadyOp for all patients that meet the guidance for SMSS placement.

- The assigned NCOEMS-HPP Patient Placement Coordinator monitors ReadyOp and OEMSSupportCell@dhhs.nc.gov for patient placement request forms, marks them as received, and confirms receipt of the forms with the sending organizations within 30 minutes
- Patient Placement Coordinator, in consultation with the assigned Medical Provider, reviews the forms to verify that SMSS placement is appropriate and updates the status of each request as **Accepted** (verified and SMSS facility is available), **Investigating** (verified but SMSS facility is not available), or **Declined** (request not verified). Request forms marked Accepted are forwarded to the assigned Patient Transportation Coordinator for resolution and tracking
- Patient Transportation Coordinator confirms patient placement and transportation status (including location and SMSS IMT contact information) with sending organizations via email and, in turn, requests confirmation from them that patients are still ready for SMSS placement (including organization point-of contact and patient ETA information)
- Upon receipt of sending organization confirmation emails, the Patient Transportation Coordinator forwards resolved SMSS Individual Patient Placement Request Forms to the SMSS IMT

SMSS Site Operations

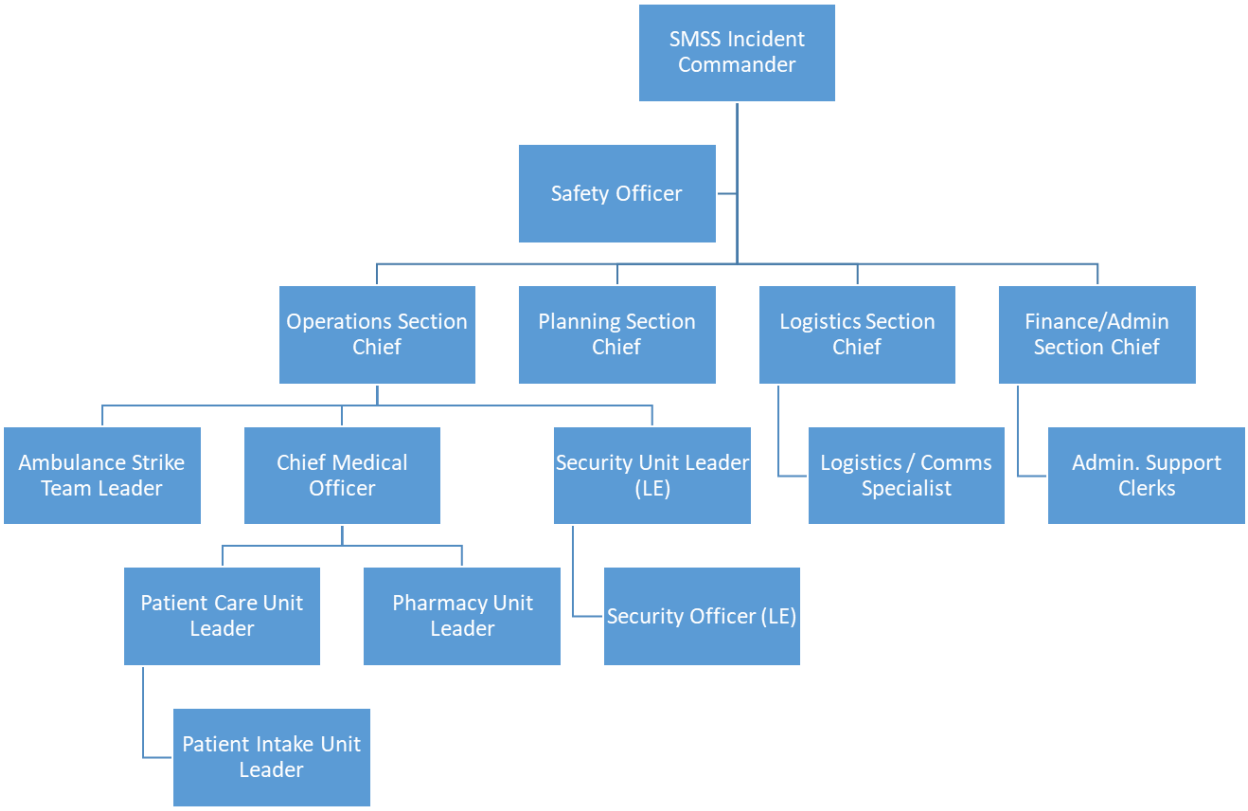
Facility Pre-Operation Survey/Inspection: Upon arrival at the activated SMSS, the SMSS IMT Leader and the Host Facility Liaison will conduct a joint inspection of the areas of the facility that will be utilized for the SMSS operations. The purpose of the survey is to:

- Document the initial condition of the facility and facility equipment designated for SMSS use, and ensure they are ready or identify necessary corrections prior to use.
- Ensure that the facility can be properly secured against weather and unauthorized entry, and that areas that are not to be used for SMSS operations are secured and clearly identified as off limits.
- Identify and verify the locations in the facility where the various medical and logistical units and areas will be set-up to ensure they are conducive to efficient patient flow.

Area/Unit Staffing and Set-Up: Following the pre-operation survey/inspection, the SMSS IMT Leader will identify staff to fill available medical and logistical areas and unit leader positions, work with area and unit leaders to fill available staff positions, and brief available staff on the chain of command and current situation.

The numbers of personnel needed in each area and unit will fluctuate over time with the arrival and flow of patients. For example, when receiving patients, staff assigned to patient care activities may need to assist staff assigned to patient intake. Once patients have been processed, staff assigned to patient intake activities may need to assist staff assigned to patient care.

The initial set-up of the SMSS is very labor-intensive and assistance from local fire and EMS agencies may not be available. For that reason, Healthcare Coalitions (HCC) tasked with providing the Logistics Team must ensure that adequate numbers of staff are activated and deployed for this purpose. Once set-up is completed, these team members may be demobilized back to the HCC unless they have also been tasked to work in the SMSS. Details covering staffing for set-up can be found in **Appendix 5: SMSS Staffing Levels, Roles, and Responsibilities.**



Once staffing is complete, all SMSS area and unit leaders and staff should begin setting up their various functional areas and medical units as planned to include proper exterior and interior signage. Standard SMSS functional areas and medical units are listed under SMSS Medical Operations below. To guide set up, SMSS unit and area leaders and staff should refer to:

- **Appendix 9: SMSS Placement Guidance and Patient Flow** for initial patient flow into the SMSS;
- **Appendix 10: SMSS Site Set-Up Considerations** for area-specific operation guidelines;
- **Appendix 11: SMSS Forms** for forms utilized throughout the SMSS; and
- **Appendix 12: SMSS Job Action Sheets** for the specific job duties of each position in the SMSS.

Arrival of Patients: Security personnel should direct all incoming potential patients to the Waiting Area. Assigned Patient Intake staff will register patients in the patient tracking system, evaluate their condition, and determine appropriate placement within the SMSS patient care area.

Buses should be directed to the SMSS Drop-off Area near the SMSS main entrance if possible. Individuals in private cars who need assistance should be allowed to unload at the Drop-off Area. Non-medical volunteers should be utilized when possible to assist with parking cars in designated areas.

SMSS Medical Operations

General: Medical operations in the SMSS encompass the following functional units and areas:

- Patient Intake (e.g. waiting, initial, triage and registration);

- Patient Care (e.g. care, crash and isolation); and
- Pharmacy

Functional descriptions of these areas are provided in **Appendix 10: SMSS Site Set-Up Considerations** and specific staffing requirements are provided in to **Appendix 5: SMSS Staffing Levels, Roles, and Responsibilities**.

Medical Direction: Once the SMSS becomes operational, it shall be the duty of the Chief Medical Officer (CMO) to maintain a shelter census, to evaluate the conditions of patients, and to recommend health and medical staffing level adjustments as appropriate to the Unit Charge Nurse. The CMO directs medical operations providing treatment orders and approving medical procedures.

Unit Charge Nurse: Each SMSS unit will have a charge nurse who is responsible for the overall operation of their unit including staffing adjustments. Qualified medical personnel, as determined by the SMSS IMT, will serve this role in the Patient Intake Unit Leader (PIUL) and Patient Care Unit Leader (PCUL). Paramedics with supervisory experience and Registered Nurses (RN) with emergency department/intensive care unit and supervisory experience are considered good candidates for the PIUL and PCUL positions respectively.

Caregivers: Caregivers include RNs and Paramedics not in supervisory positions as well as CNAs, certified home health aides, home health aides, EMTs, personal care attendants, nursing aides. These individuals will be assigned an area to work in and may work under the supervision of an RN/Paramedic as appropriate.

Pharmacist/Pharmacy: The SMSS will deploy with SMAT-II Drug Go Packs. The assigned Pharmacy Unit Leader and pharmacy technicians will be responsible for the proper storage, security, and distribution of pharmaceuticals in the SMSS. Patients will bring some or all their prescribed medications however, new medications may be ordered while at the SMSS.

Social Service/Discharge Planning: When a SMSS is activated, it is mandatory to have a medical social worker or case manager on staff. This is required to allow efficient referrals and placement of the patients. These individuals must understand the SMSS operations and disaster medicine.

Medical Specialists: There may be a need for onsite or on call specialist such as Hospice workers, Dietitian, Mental Health specialist, and others.

Patient Transportation: At a minimum, at least one fully staffed ambulance will be at the SMSS location and available 24/7 to support at the SMSS operations.

Organization and Assignment of Responsibilities

The successful establishment, maintenance, and operation of SMSS requires close coordination and planning between NCOEMS-HPP, HPCs, NCEM, SMSS facility owners, local emergency management, local healthcare, and many other organizations. To facilitate these efforts, planned roles and responsibilities for these organizations have been identified and listed below and identified by phase in the emergency management process as applicable: Preparedness, Response, Recovery, and Mitigation.

Internal Support Organizations:

NCOEMS-HPP:

- Preparedness
  - Support the identification of facilities suitable for SMSS operations through the Healthcare Coalitions (HCC).
  - Establish Memoranda of Agreement (MOA) with facilities (SMSS Facilities) identified as suitable for SMSS operations.
  - Develop and maintain plans for SMSS operations.
  - Establish and maintain personnel to provide SMSS IMT support.
  - Coordinate with NCEM for the provision of logistical support necessary to establish and maintain SMSS operations.
  - Coordinate with the IPRO ESRD Network 6 for the provision of dialysis services for SMSS patients.
  - Coordinate with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) for the provision of behavioral health support for SMSS personnel and patients.
  - Support SMSS/SMSS IMT training for NCOEMS/HCC personnel through the Healthcare Coalitions.
- Response
  - Provide strategic and tactical oversight and support of SMSS operations through the:
    - Planned activation of SMSS appropriate to the situation;
    - Deployment of personnel to establish SMSS IMTs; and
    - Deployment of Ambulance Strike Teams, Ambulance Buses, and other EMS resources for medical transportation.
  - Coordinate with local Emergency Management agencies through the SMSS IMT or SEOC ESF8 Desk concerning:
    - Location(s) of general population shelters;
    - Vetting of evacuees prior to transport to SMSS facilities to ensure available SMSS services are appropriate; and
    - Availability and provision of public transportation resources to assist with SMSS patient access to non-emergency health services.
  - Coordinate with partner agencies through the SMSS IMT or SEOC ESF8 Desk to provide necessary support services to the SMSS (e.g. fire/safety inspection, sanitary inspection (e.g. food, environmental, laundry), food service, waste management, and janitorial services).
  - Support and coordinate, as necessary, the resupply of medical and non-medical supplies to active SMSS operations
  - Coordinate with response partners to meet the immediate operational needs of activated SMSSs (e.g. NCEM for logistical support, IPRO ESRD Network 6 for dialysis services, DMHDDSAS for behavioral health services).
- Recovery
  - Conduct Hot Wash/After Action Reviews of SMSS operations with SMSS IMT to gather information on strengths, opportunities for improvement, and recommendations for future SMSS operations.
- Mitigation

- Conduct or support activities addressing identified opportunities for improvement of SMSS operations (e.g. installation of transfer switches to ensure uninterrupted power supply, etc.)

External Support Organizations:

Healthcare Coalitions (HCC):

- Preparedness
  - Coordinate with local emergency management agencies within region to identify facilities suitable for SMSS operations, facilitate communication with local services (EMS, Fire, Police), and identify services that may be available to support the SMSS when opened
  - Coordinate with local health and medical agencies (Public Health, hospitals) within region on the location(s) of facilities suitable for SMSS operations and identify services that may be available to support the SMSS when opened
  - Establish and maintain personnel to support initial SMSS set-up, staff SMSS medical or logistics support teams, and support the SMSS IMT.
  - Participate in the development of the SMSS Operations Plan and ensure that personnel are familiar with it.
  - Establish and maintain SMSS Logistics Package, including pharmaceutical cache.
  - Establish plans for and provide resupply of medical and non-medical supplies to active SMSS operations through Lead Hospitals, Healthcare Coalitions, NCOEMS-HPP, and ESF8.
  - Provide SMSS and SMSS IMT training for NCOEMS and HCC personnel.
- Response
  - Provide medical or logistics teams to support SMSS operations
  - Provide personnel to support initial SMSS set-up and SMSS IMT staffing
  - Provide initial SMSS Logistics Package, including pharmaceutical cache
  - Support and execute resupply of medical and non-medical supplies to active SMSS operations through Lead Hospitals, other Healthcare Coalitions, NCOEMS-HPP, and ESF8
- Recovery
  - Participate in Hot Wash/After Action Reviews of SMSS operations with SMSS IMT to gather information on strengths, opportunities for improvement, and recommendations for future SMSS operations.
- Mitigation
  - Conduct or support activities addressing identified opportunities for improvement of SMSS operations (e.g. improvement of patient tracking systems, upgrade of patient care equipment and supplies, etc.)

SMSS Facilities:

- Preparedness
  - Maintain close coordination with HCC on the on-going maintenance, changes in structure or function, and operational readiness of facilities identified for SMSS operations.
  - Maintain designated shelter areas and services so they remain adequate in the area and function as planned:
    - Patient and medical treatment areas;

        - Utilities (e.g. electric, water, and sewer);
        - Common areas (e.g. restrooms, storage areas, and meeting rooms);
        - Other areas, if provided (e.g. sleeping areas, loading and dock areas, shower facilities, laundry facilities, and kitchen and dining areas);
- Response
    - Upon notification of activation, make notifications to facility support staff and initiate actions to prepare the facility for use as an SMSS as per the SMSS Site Operations Plan and MOA (e.g. inspect, remove, and/or relocate facility equipment and/or supplies).

NCEM:

- Preparedness
    - Participate in the development of the SMSS Operations Plan
    - Assist with the establishment and support of SMSS facilities through coordination with NCOEMS-HPP and local Emergency Management agencies
- Response
    - Support the establishment and operation of identified SMSS facilities through the provision of logistical support that may include but not limited to:
        - Food services (e.g. K&W) and staff lodging and billeting;
        - Shower/bathroom facilities/trailers
        - Power generation/back-up (e.g. generators);
        - Medical and non-medical equipment and supplies (e.g. Hill-Rom);
        - Security services (e.g. ALE, DOI, and State Parks);
        - Environmental (e.g. janitorial) services;
        - Laundry and linen services;
        - Waste management services (e.g. trash and medical waste pickup)

Direction, Control, Coordination

General**:** Activation of this plan will be the responsibility of NCOEMS-HPP. Once SMSS resources have been deployed the designated SMSS Incident Management Team (SMSS IMT) will provide the primary direction, control, and coordination function for established SMSS operations. NCOEMS-HPP staff, acting from the State EOC or NCOEMS Support Cell as part of the State Emergency Response Team (SERT), will provide strategic planning and support to those operations.

Chain of Command: A clearly defined chain of command is necessary to ensure continuity of operations. The chain of command should be based on the knowledge, skills, and abilities of individuals and the established disaster response structure. The planned chain of command for SMSS operations will follow the established ICS structure with an Incident Commander, Operations Chief, and Planning Chief.

SMSS IMT**:** All members of the established SMSS IMT report through the chain of command up to the SMSS Incident Commander. In coordination with the SMSS Incident Commander (SMSS IC) SMSS IMT members will manage their assigned functional areas and, as necessary, will as assist the SMSS IC with opening and closing of the SMSS, external reporting, personnel staffing decisions, the receipt, storage, and disbursement of equipment and supplies, and the establishment of site security.

Operational Schedule & Situation Reporting: All SMSS IMTs will follow the operational schedule provided below for operational activity and situation reporting. This schedule details personnel work shifts and times when briefings and conference calls will occur and when Situation Reports will be produced. The SMSS Planning Section Chief will manage the operational schedule.

SMSS Operational Activity/Reporting Schedule **Shift 1: 0700 – 1900 - Shift 2: 1900 – 0700**	
0700	SMSS Situation Report due to SERT ESF8 Desk Rep. or HPP Support Cell (if active). Start Shift 1, end Shift 2.
1100	NCOEMS-HPP Conference Call with SERT ESF8 Desk Representative, NCOEMS regional staff, Healthcare Preparedness Coordinators, SMRS Incident Management Teams, and other essential ESF8 partners as the incident situation requires (optional).
1500	SMSS Situation Report update due. SMSS IMT reports activity since 0700 per WebEOC.
1900	SMSS Situation Report due to SERT ESF8 Desk Rep. or HPP Support Cell (if active). Start Shift 2, end Shift 1.

Internal situation reporting should be utilized to develop an Incident Action Plan (IAP) for the SMSS every operational period. This IAP should be provided to the SERT ESF8 Desk and shared with all SMSS staff. The SMSS IMT should participate in NCOEMS coordinating calls and submit situation reports (ICS-209, or equivalent form) to the SERT ESF8 Desk according to the established schedule for inclusion in the State Incident Action Plan. NCSPARTA WebEOC or ReadyOp may be utilized for situation reporting when available and appropriate.

Patient Tracking and Census**:** SMSS operations will utilize the SMRS Patient Tracking System (DMS FirstTrak). The patient tracking staff in the Patient Intake Unit are responsible for maintaining a count of the number of patients who are admitted and being cared for in the SMSS. These numbers will require the patient tracking personnel to receive a twelve-hour unit census report from each patient care unit in the SMSS. The patient tracking staff will provide the CMO and SMSS Planning Section Chief a report of the number of patients in the SMSS on a 12-hour basis and report to the SMSS Planning Section Chief when the capacity of the SMSS is 80% full.

The registration team is responsible for updating SMSS census records once the major influx of patients has ceased. An accurate census of how many patients and caregivers are in the SMSS needs to be maintained to ensure that the proper supplies/staff are available to continue operations.

Patient Medical Records**:** All medical records of patients are considered confidential information and shall be safeguarded by the SMSS staff. SMSS staff will utilize standard SMSS patient care forms and appropriate medical update forms to create and update patients' medical records as needed. Upon demobilization all patient records will be collected by the SMSS IMT and provided to NCOEMS-HPP leadership for maintenance and storage. Refer to **Appendix 11: SMSS Forms**.

Equipment/Supply Management and Resupply Operations**:** SMSS operations will utilize the SMRS Inventory Control and Asset Management system (iCAM) for the management and reporting of equipment and supplies utilized during SMSS operations. Overall SMSS logistics and resupply operations will be conducted in accordance with the SMRS iCAM Resupply Standard Operating Guidance (iCAM Resupply SOG).

Security, Safety, and Management of Non-SMSS Personnel: It is the responsibility of the SMSS IMT through the Safety Officer and Security Unit Leader to ensure that the areas and units in and around SMSS operations are safe and secure. To meet these goals, the SMSS Security SOG and Safety Policies (Appendix 13) have been developed to assist these individuals and the SMSS IMT with the development of SMSS site-specific security plans.

General Security Notifications:

- Situations involving the potential for violence or other actions taken by staff, patients, or visitors which may be harmful to them, others, or disrupt SMSS operations should be reported to SMSS IMT and security personnel immediately. In turn, the SMSS IMT should make notification to the SERT ESF8 Desk as soon as possible. These actions will not be tolerated and may result in removal from the SMSS by security personnel. Under no circumstances should SMSS staff attempt to diffuse potential violent situations
- Other emergency situations (e.g. fire, flood, loss of power, loss of HVAC, etc.) or situations which escalate to an emergency (e.g. partial loss of power/HVAC) should be reported by the SMSS IMT to the SERT ESF8 Desk as soon as they are recognized

Electronic Devices and Privacy: The use of cell phones, tablets, laptops, and personal gaming systems are permitted in an SMSS. However, when using devices, SMSS staff, patients, and visitors are expected to alert others before taking pictures and/or video in the event they do not want to be in the photo and/or video and not to post any pictures and/or videos that include other individuals without those individuals' written consent.

Weapons*:* Weapons are not allowed in SMSSs. Individuals with weapons will be asked by SMSS Security Officers to secure them in the individual's vehicle. If that is not an option, Security Officers may secure the weapons in their law enforcement vehicle.

Visitors: Access to the SMSS by visitors and the media is allowed but may be restricted or cancelled by the SMSS IMT or Chief Medical Officer if deemed to be detrimental to SMSS operations or the health outcomes of patients. Upon arrival all visitors must sign in at the SMSS Registration Desk to provide identification, explain the reason for their visit, and await appropriate escort if necessary. Once visitors are approved for entry, Registration Desk staff will inform the SMSS IMT. Visitors will be given a visitor pass which allows them access to specific designated areas only. If visitors require escort, the SMSS IMT will assign staff for escort duty. During their visit, all visitors will be treated in a kind and courteous manner. However, actions taken by visitors which disrupt SMSS operations will not be tolerated and may result in removal. The visitor Waiting Area should not interfere with SMSS operations.

Types of Visitors:

- Family and Friends of Patients: Family and friends are allowed access to visit once the visit is approved by the patient and the CMO. Depending on the condition of the patient, the CMO may restrict or not allow patient visits. Once the visitors have been identified, Registration Desk staff will confirm approval through the CMO. Visits should be limited to avoid disrupting ongoing SMSS medical operations while being respectful of all who may want to visit. For that reason, no more than 2 visitors will be allowed per visit and visits will be time-limited at the discretion of the CMO.

- Host Facility Personnel: These are individuals that may work in or otherwise utilize areas of the Host Facility that are not being utilized for SMSS operations. These individuals must check-in at the SMSS Registration Desk and should only be allowed into operational SMSS areas and units if it is related to their work or they must pass through to get to their part of the Host Facility. Registration Desk staff will assign an escort in coordination with the SMSS IMT.
- Volunteer Organizations: These are individuals representing organizations that may want to provide support to some aspect, medical or non-medical, of SMSS operations. They must be vetted and approved by staff at the SERT ESF8 Desk or Support Cell prior to arrival and should arrive in duty uniform, with appropriate and current identification. If not, they should not be allowed access until they have been approved. Once approved, Registration Desk staff will direct them to their assigned work area or unit as provided by the SMSS IMT. They should not require escort.
- VIPS and Media: Visits by these individuals must be vetted and approved by staff at the SERT ESF8 Desk or Support Cell prior to arrival. They should present with appropriate and current identification. If not, they should not be allowed access until they have been approved. Once approved, Registration Desk staff will assign an escort in coordination with the SMSS IMT. Visits should be limited to avoid disrupting ongoing SMSS medical operations while being respectful of all who may want to visit. For that reason, no more than 2 visitors will be allowed per visit and visits will be time-limited to no more than 30 minutes at a time.

Media: The management of media coverage at SMSS operations and interaction with SMSS staff will be coordinated through the NC DHHS Office of Communications in conjunction with the ESF8 Desk or NCOEMS Support Cell. The ESF8 Desk or NCOEMS Support Cell should coordinate and communicate media requests directly with the SMSS IMT. Media visits may be further restricted or cancelled at any time at the discretion of the SMSS Incident Commander and/or the Chief Medical Officer due to patient privacy and patient safety. All personnel present in a SMSS should sign the DHHS Media Release Form prior to allowing media to enter the operational area according to policy. If media presents directly to an SMSS site and has not coordinated through the ESF8 Desk or NCOEMS Support Cell and/or the NC DHHS Office of Communications, the SMSS IMT should immediately contact the ESF8 Desk or NCOEMS Support Cell for guidance and direction.

- Security personnel will escort media members to and from designated parking areas and notify the SMSS ICP that media are on campus. SMSS IMT staff will notify the SERT ESF8 Desk of the visit.
- Media members will be asked to sign in at the SMSS Information Area and wait for escort in an area that does not interfere with the SMSS operations. If the weather or conditions permit, the media may be asked to wait outside.
- The privacy rights of the staff and patients in the SMSS are to be observed, and media personnel should only be allowed to access areas of the SMSS that do not interfere with anyone's rights or with the SMSS operations. If the media wish to interview patients or staff in the SMSS, the SMSS IMT may ask for volunteers but no one is required to provide an interview.
- All media releases must be approved by SERT ESF8 Desk in conjunction with DHHS Communications prior to release.
- Media visit information will be included in the SMSS situation reports to the SERT ESF8 Desk.

Refer to **Appendix 13: SMSS Security SOG and Safety Policies** for more information.

Communications

Communications and Information Management: Telephone, computer-based, and radio communication systems available for SMSS operations and assigned by NCOEMS-HPP are provided to ensure that the SMSS IMT have the capability to maintain situational awareness, report essential elements of information, and coordinate the arrival and departure of ESF8 personnel and resources at the SMSS.

Telephone communication systems (e.g. telephone, FAX, and Smart phones) will be utilized for all communications purposes as needed.

Computer-based communication systems (e.g. Continuum, MHTD, NCSPARTA, DHHS, organization e-mail, ReadyOp, and NC TERMS) will be utilized to:

- Access health and medical facility contact information;
- Gain situational awareness of SMRS and SMSS and healthcare organization operations;
- Report status; and
- Message and coordinate mission information with NCOEMS-HPP and SMRS and SMSS staff.

Radio Communication Systems (VIPER Medical Network (VMN)): Can be utilized as a backup for all purposes as needed to monitor and communicate with SERT ESF8 Desk, NCOEMS Support Cell, other, SMRS organizations, all hospitals and community health centers in North Carolina, and other organizations utilizing VIPER (Voice Interoperability Plan for Emergency Responders) radio system. VMN radio channels, talk group, and use guidance can be found in the VIPER Medical Network (VMN) Reference Guide at: https://www2.ncdhhs.gov/dhsr/EMS/pdf/dtmfref.pdf

SMSS Radio Communications Plan (ICS-205): Upon establishing operations he SMSS IMT will submit any information necessary for the development and update of the established ICS-205 to the NCOEMS-HPP Communications Director. The SMSS IT will utilize the established ICS-205 for radio communications.

Training

SMSS Training Requirements

Operations: Successful establishment and operation of SMSS depends on adequate facilities, equipment and supplies, and trained personnel. The following areas of training are identified as essential for personnel assigned to SMSS operations:

- SMSS plans and procedures including security standards;
- SMSS functional positions: IMT, medical, and logistics positions; and
- SMRS Information Management Systems: WebEOC, iCAM, DMS FirstTrak, EMR, HIE, and Telemedicine.

SMSS Training Recommendations

Orientation: Support and proper utilization of SMSS facilities by local response organizations within a jurisdiction depends on the understanding of SMSS operations. SMSS Orientation training

covering this plan and SMSS site-specific plans should be developed and provided to leadership and management of these organizations in the form of seminars and/or workshops. NCOEMS-HPP and HPC will coordinate on the development and delivery of this training to SMRS personnel and other response organizations.

Appendices

Appendix 1: SMSS Checklists
Appendix 2: Mission-Ready Packages
Appendix 3: Levels of Care
Appendix 4: SMSS Locations - RESERVED FOR FUTURE USE
Appendix 5: SMSS Staffing Levels, Roles, and Responsibilities
Appendix 6: SMSS Assignment Chart - RESERVED FOR FUTURE USE
Appendix 7: SMSS Site Requirements and Support Services
Appendix 8: SMSS Operations Timeline - RESERVED FOR FUTURE USE
Appendix 9: SMSS Placement Guidance and Patient Flow
Appendix 10: SMSS Site Set-Up Considerations
Appendix 11: SMSS Forms
Appendix 12: SMSS Job Action Sheets
Appendix 13: SMSS Security SOG and Safety Policies

Appendix 1: SMSS Checklists (available as separate PDF documents)

Appendix 2: Mission-Ready Packages (available as separate PDF documents)

Appendix 3: Levels of Care

The following is a list of reasonable expectations for the levels of care being provided for at an SMSS including possible exceptions to this level of care. Individuals should agree with placement in an SMSS and should never be sent against their will even if their condition is outlined below.

1. Individuals who require active monitoring, management, or intervention by a medical professional to maintain their normal level of health.
    a. Patients from home requiring 24/7 skilled nursing care
    b. Hospice Patients from home
    c. Ventilator Patient
    d. Tracheotomy which requires suctioning
    e. Extensive Wound Management
    f. Stable Dysrhythmia monitoring/management
    g. Bedridden and total care required
    h. Individuals who have been evaluated by a medical professional and deemed necessary for care at a medical support shelter to maintain their normal level of health

2. The level of care provided at an SMSS should not exceed the level of staff skills and resources available.

3. Medical Providers that are assigned to an SMSS are operating in an emergency situation and should exercise reasonable care and judgment to assure patient safety.

4. Care provided at a medical shelter is not intended to replace all services provided across the healthcare system continuum

5. Any person who presents or develops the need for a level of care beyond that which can be provided at a medical shelter should be transported to an appropriate medical facility or the care/resource required should be requested from NCOEMS so that care can continue at the SMSS.

Appendix 4: SMSS Locations - RESERVED

RESERVED FOR FUTURE USE

Appendix 5: SMSS Staffing Levels, Roles, and Responsibilities

General Guidelines
Non-Medical Staffing
Medical Staffing
Initial Set-Up Staffing

General Guidelines:

Staff Preparedness: All activated staff should ensure their families and property are prepared prior to deployment. Appropriate pre-deployment preparedness activities include:

- Securing their home;
- Making arrangements for family members/pets during their activation;
- Locating the personal supplies that should be needed during the activation;
- Ensuring that they have supplied up to date emergency contact numbers to their agency or the person who should be notifying them;
- Ensuring that any vehicles and/or equipment they should need are operational and that any supplies they may need during the event are on hand.
- Reviewing the SMSS Operations Plan so they are familiar with their roles and responsibilities.

Report for Duty: All assigned staff should report for duty, in duty uniform, with appropriate and current identification, and ready to work. Upon arrival at the SMSS, all staff will report to the Staff Registration Desk for check-in and assignment to their work area/unit.

Work Hours: SMSS staff members should not be scheduled to work for more than 12 consecutive hours in a 24-hour period.

*Standards***:** Medical/health professionals should only perform those duties consistent with their level of expertise and only according to North Carolina professional licensure laws, regulations, and protocols.

Staffing Reports: The SMSS IMT must estimate the SMSS patient load and report the staffing requirements above their on-site capabilities to the SERT ESF8 Desk in accordance with the established operational schedule.

Staffing Levels: The staffing levels should be adjusted based on the actual patient numbers and needs. Specific information addressing non-medical staffing, medical staffing, and staffing for the initial set-up of the SMSS are provided below.

Staff Rotation: Persons who staff a shelter should be rotated every five to seven days on a regular basis. However, rotations should be staggered or phased to prevent the complete turnover of operational staff at one time**.** The Chief Medical Officer is responsible for developing and managing the staffing plan and should keep the Incident Commander and Operations Section Chief informed of staffing plans, and unmet needs.

Non-Medical Staffing:

Staffing Levels:

Incident Management Team (IMT) will vary depending on the number of patients supported:

- 0 - 49 patients: Partial IMT with some staff positions combined, total staff #: **6**
    - Incident Commander (IC) and Ops = 1 day & 1 night
    - Plans and Finance/Admin = 1 day & 1 night
    - Safety and OEMS Liaison/PIO = 1 day & 1 night
- 50+ patients: Full IMT required, total staff #: **17**
    - Incident Commander = 1 day & 1 night
    - Operations Chief = 1 day & 1 night
        - Chief Medical Officer/Chief Nursing Officer report under Operations
    - Plans Chief = 1 day & 1 night
    - Safety Officer = 1 day & 1 night
    - Communications Day/Night = 1 day & 1 night
        - Comm-L (Communications Unit Leader, 24 hours for first few days and then only 12 hours/day, day shift)
    - Logistics Chief = 1 day & 1 night
    - Finance/Admin Chief = 1 day & 1 night

Non-Medical Support Staffing:

- 0 - 49 patients: Partial IMT with some staff positions combined, total staff #:
    - Logistics Specialist = 1 day (in addition to LSC)
    - Administrative Support Clerk = 1 day
    - Case Worker = 2 day only
- 50+ patients: Full IMT required, total staff #:
    - Logistics Specialists = 1 day & 1 night (in addition to LSC)
    - Administrative Support Clerks = 2 day & 1 night
    - Communications Specialist = 1 day & 1 night
    - Case Worker = 4 day only

Roles and Responsibilities:

- Incident Commander
- Safety Officer
- Operations Section Chief
- Plans Section Chief
- Logistics Section Chief
    - Communications/Logs Spec.
- Finance/Admin Section Chief
    - Admin. Support Clerks
    - Case Workers

For more detailed information covering specific job duties refer to **Appendix 12: SMSS Job Action Sheets.**

Medical Staffing:

Staffing Levels:

- 0-50+ patients: total staff # = **65** (non-medical staff are extra)
    - MD = 1 day

- PA / NP = 1 day & 1 night
- Respiratory Therapist = 1 day & 1 night
- Pharmacist = 1 day & 1 night
- CMO = 1 day & 1 night
- RNs = 6 day & 6 night
- Paramedics = 6 day & 6 night
- Support Staff (CMA, CNA, RN, Medic, MD, PA, NP) = 16 day & 16 night

Roles and Responsibilities:

- Chief Medical Officer
- Patient Care Unit Leader
- Patient Intake Unit Leader
- Nursing Staff
- Paramedic-EMT
- Respiratory Therapist
- Pharmacist
- Behavioral Health Specialist

For more detailed information covering specific job duties refer to **Appendix 12: SMSS Job Action Sheets.**

Initial Set-Up Staffing:

This guidance is based on the following planning assumptions that have been validated through SMSS deployment history:

1. Medical Team staffing will always lag well behind the Logistics Team due to staffing processes and will likely not be available for initial set-up; and
2. Even though set up assistance may be available during some events from local EMS/Fire SMSS plans cannot and should not count on them as a resource

Planning options for addressing staffing for the initial set-up of SMSSs may vary depending on whether or not the facilities have been reviewed and "pre-diagramed" (set-up locations for equipment and supplies have been established through prior facility reviews or training events).

The preferred option, in both cases, is for the HCC assigned to the Logistics mission to provide an SMSS Logistics Team consisting of **12-14 personnel** broken down as follows:

- **2 – Logistics personnel** (Logistics Lead and Logistics Specialist) who would work at the trailers and on iCAM. When initial set-up has been completed these individuals become part of the SMSS IMT
- **10-12 – Other personnel** (MRC or SMAT) who would off-load and move stuff to the treatment areas, set up cots, etc. These personnel are called to duty to deploy within the same timeframe of the logistics personnel however, when initial set-up has been completed these individuals return to their home HCC

The secondary option for facilities that have not been "pre-diagramed" or have been reviewed but never used before is for the HCC assigned to the Logistics mission to provide an SMSS Logistics Team

consisting of **10-12 personnel** while the HCC assigned to the Medical mission to provides an "Advance Team" of **2-3 personnel.** The complete team, **12-15 personnel**, is broken down as follows:

- **2 – Logistics personnel** (Logistics Lead and Logistics Specialist) who would work at the trailers and on iCAM. When initial set-up has been completed these individuals become part of the SMSS IMT
- **8-10 – Other personnel** (MRC or SMAT) who would off-load and move stuff to the treatment areas, set up cots, etc. These personnel are called to duty to deploy within the same timeframe of the logistics personnel however, when initial set-up has been completed these individuals return to their home HCC
- **2-3 - Medical clinicians** (e.g. RN and Paramedic) who would go over the carts, put batteries in everything, and ensure that equipment and supplies are right in the treatment area(s). When initial set-up has been completed these individuals become part of the SMSS IMT or SMSS staff

Appendix 6: SMSS Assignment Chart – RESERVED

RESERVED FOR FUTURE USE

Appendix 7: SMSS Site Requirements and Support Services

The following listing is meant to assist planners and understand the key physical requirements and services for successful SMSS operations and, subsequently, identify needs that should be considered in the development of any Memorandum of Agreement (MOA) with prospective host facilities.

Geography/Area Infrastructure:

- Outside flood plains
- Easy access to major transportation routes

Site Attributes/Configuration:

- **Requirements (must provide):**
  - Facility is ADA compliant (as close as possible)
  - Patient area adequate to accommodate at least 50 patients at 70-100 sq. ft. per patient (3500 – 5000 sq. ft.)
  - Areas adequate to conduct the following medical functions:
    - Patient Intake (for initial holding, triage, and registration)
    - Patient Care (for care and crash/isolation if necessary)
    - Pharmacy (for pharmaceutical storage and distribution)
  - Electric power service with back-up power source (generator or transfer switch)
    - Adequate power distribution system (multiple, working electrical outlets in all areas)
  - Water service (hot and cold running)
    - Adequate water distribution system (multiple, working sinks in all areas)
  - Sewer service (with hookups for shower trailers if no showers in facility)
  - Restrooms (1 toilet per 8 patients)
  - Command and Control area (for overhead management of SMSS)
  - Logistics area adequate for unloading and the secure (lockable) storage of supplies, equipment and meds needed for immediate operations)

- **Recommendations (may provide):**
  - Facility on single floor
  - Separate rooms for:
    - Crash (for patients needing emergency care/resuscitation)
    - Isolation (for septic patients or those with infectious disease)
    - Mortuary (for deceased patients (hospice/DNR)
  - Area adequate to accommodate staff billeting (away from patients if possible)
  - Logistics area adequate for unloading and storage of **all equipment and supplies from trailers**
  - Shower facilities (1 shower per 15 patients)
  - Laundry facility (for staff only)
  - Kitchen or food prep area for meals, including cold storage for food
  - Loading dock
  - Internet connectivity (network)
  - Phone service and SAT link

Site Support Services and Supplies:

- **Medical/Patient Support:**

- Ambulance Strike Team / Ambulance Bus (critical to getting patients to/from dialysis, hospitals, discharges etc.)
- Public transportation support (in addition to AST/Ambus)
- Behavioral Health support (request through Human Services DMH representative in SEOC)
- Mortuary Services w/ plan (area to isolate body for pick-up or delivery to collection point)
- Discharge Planning support

- **Medical/Patient Supplies and Internal Logistics Support:**
  - M8 Trailer configured for staff billeting (if not provided in facility, can also augment Overhead Team/Command & Control function)
  - Refer to SMSS Minimum Supply & Equipment List maintained by the SMRS Logistics Action Team

- **External Logistics Support:**
  - Forklift (must be onsite before or arrive with SMSS trailers)
  - Food Services
  - Site Food Cache (i.e. tuna fish in can, cans of vegetables, Ensure, etc. for patients in case food service is not delivered initially or supply breaks down during operations; 48-72hr supply)
  - Security Services (24/7, ALE or Dept. of Insurance agents preferred)
  - Laundry Services with contract for laundering patient clothes/bedding
  - Environmental (janitorial) services
  - Waste management services (including containers and removal of medical and regular waste)
  - Fuel Services w/ delivery plan
  - Consider capability for EMR / HIE, and/or Telemedicine
  - Consider large TVs/video screens that can be used for status boards etc.

Appendix 8: State Medical Support Shelter (SMSS) Operations Timeline - RESERVED

RESERVED FOR FUTURE USE

Appendix 9: SMSS Placement Guidance and Patient Flow (available as separate PDF documents)

Appendix 10: SMSS Site Set-Up Considerations

Medical Areas

Patient Intake Area (for initial holding, triage, and registration)

- Waiting Area
- Initial Triage & Patient Registration

Patient Area (for general and emergent care if necessary)

- Patient Care & Registration Follow-Up
- Emergent Care/Isolation

Pharmacy (for pharmaceutical storage and distribution)

PATIENT INTAKE AREA

WAITING AREA

Functional Description:
Covered area adjacent to the SMSS drop-off/arrival area large enough to hold multiple patients (~30+ patients) and allow for them to undergo initial triage without interfering with the patient registration or other SMSS operational areas.

Tasks: See Initial Triage & Patient Registration

INITIAL TRIAGE & PATIENT REGISTRATION

Functional Description:
Adjacent to or set-up in a portion of the Waiting Area. Activities are focused on the initial, rapid, sorting and registration of patients, identification of patients requiring higher levels of care, and the movement of patients to appropriate sections of the Patient Area. Activities include:

- Assisting with the unloading of patients at the SMSS patient drop off point
- Greeting arrivals, explaining the SMSS's function
- Collecting patients' basic registration information in the SMSS Patient Tracking System (DMS FirstTrak)
- Evaluating patient initial information to determine the level of care required
- Assigning patients to a bed in the Patient Area if they meet SMSS criteria for care or arranging transfer to appropriate healthcare or shelter facilities if they do not

PATIENT AREA

PATIENT CARE

Functional Description:
Set-up dictated per facility, but typically consists of a single area for care and sheltering located adjacent to the Patient Intake Area. Nursing stations serving this area should be centrally located with space for charting and tables for medical supplies and equipment. Patients should have access to their belongings from this area. Activities are focused on providing basic care to patients arriving at the SMSS and include:

- Receiving patients from the Patient Intake Area and escorting them to their assigned bed

- Completing the patient's Patient Care Record and making any necessary adjustments to care or placement
- Providing basic patient care as necessary and updating and maintaining patient records accordingly

Patient Care:

EMERGENT CARE/ISOLATION AREA

Functional Description:
An area dedicated for the care of patients which are temporarily unstable and need emergency care or are affected with a disease or condition that warrants isolation from other patients. The area should be separated from the other areas by at least twenty (20) feet. O2, suction, ECG, and BP monitoring in the area but not at each bed. Must have Blood borne PPE and hand washing capability. Note: If the CMO makes the determination that the patient probably does have a transmittable disease the patient will be transferred to a hospital however, these patients should only be moved if stable.

Tasks: Same as for Patient Care

Non-Medical Areas
Command and Control Area (Incident Command Post)
Staff Registration Desk
Logistics/Supply Area
Food Service Area
Staff Billeting Area
Communications Area
Security Area

COMMAND AND CONTROL AREA

Functional Description: This area serves as the Incident Command Post (ICP) for the SMSS and houses a minimum of six staff and a briefing room that will accommodate at least twelve persons for meetings. It must have internet connectivity, telephones, and electrical outlets.

Location and Space Requirements: Space is also required for tables and chairs. Preferably the ICP should be located near an outside entrance and a parking lot. Space requirements; 400- 600 sq.ft.

STAFF REGISTRATION DESK

Functional Description: Activities in this area focus on the registration of incoming/outgoing SMSS personnel, direction to their assigned work area, and management of personnel sign-in/sign-out. Staff assigned here provide the SMSS IMT Planning Section Chief with daily summaries of available medical and non-medical staff.

- Badging: The deployed HCC responsible for logistics SMAT should provide badging equipment to accommodate personnel without appropriate/current identification badges. SMSS personnel should have/receive an SMAT ID Badge which covers the anticipated duration of the event plus ten (10) days before expiring.

Location and Space Requirements: This area should be placed close to the main entrance of the SMSS or other entrance designated for the entry of personnel. Typically, it is co-located with Patient Registration in the Patient Intake Area. It must have space for a table and several chairs, easy access to electrical outlets, and a black/white board where updates, emergency/service information, and SMSS rules can be posted. Space requirements are approximately 150 sq. ft.

LOGISTICS/SUPPLY AREA

Functional Description: This unit is designed to receive, sort, and dispense all disposable medical supplies to the SMSS upon receiving properly documented request. All supply management tasks should be performed in accordance with the iCAM Resupply Standard Operating Guidance.

Location and Space Requirements: This unit must be located near an outside entrance and preferable a loading dock for delivery trucks. It must have work tables and space for storage shelves and boxes to store large quantities of medical supplies. Space requirements are approximately 400 sq. ft.

FOOD SERVICE AREA

Functional Description: Areas designated for the service and storage of food to SMSS personnel, patients, and supporting staff. These areas must be identified, prepared for use, and include kitchen, serving, dining, and storage areas. Facilities should have standard kitchen commercial equipment or be connected to an outside entry for catering or a field kitchen. NCEM has contracts with food service vendors to provide food services for the SMSS personnel, patients, and supporting staff, including those with required special diets. The SMSS IMT/SERT ESF8 Desk/Support Cell will coordinate with local/state Public Health to provide required food service inspections and ensue safe food handling practices in accordance with the North Carolina Food Code Manual.

Location and Space Requirements: The kitchen and serving area should have a minimum of 800 sq. ft. The dining area should be capable of serving at least 70 at a time (half of minimum census for 50-bed SMSS (~140 total)) approximately 12 tables with 6 chairs each and 1,600 sq. ft. of space. Total inside space = 2, 400 sq. ft. Outside space must be available for a standard refrigerated trailer and/or parking for catering vans.

STAFF BILLITING AREA

Location and Space Requirements: This area should be in a quiet area of the SMSS, preferably away from the main traffic. The ideal area is one where there is limited or no natural light to allow people to sleep during the day. There must be bathrooms and showers available or set up in the area from the SMAT basic load.

COMMUNICATION AREA

Functional Description: Activities in this area should focus on providing interoperable and redundant communications within the SMSS operation and with the SERT ESF8 Desk/Support Cell, Healthcare

Coalitions, local Emergency Management, and other local and regional response partner organizations via phone, internet, radio, and satellite radio.

Location and Space Requirements: This area should be co-located with the SMSS ICP. The location must have connectivity to outside walls/windows for antenna connections, multiple electrical outlets and IT connections. Space requirements: 200 sq. ft.

SECURITY AREA

Functional Description: Activities in this area should focus on the coordination of security services within the SMSS operation and in the area surrounding the SMSS location.
These services are critical to safe operation of an SMSS and must be instituted when the SMRS is activated.

Location and Space Requirements: This area should be co-located with the SMSS ICP.

Appendix 11: SMSS Forms

- SMSS Site Security Assessment Form
- SMSS Unusual Event Form
- State Medical Support Shelter Rules
- SMSS General Supply Order Form
- SMRS Patient Care Report (available as separate PDF document)
- SMSS Discharge Planning Checklist
- Refusal of Care/AMA Form
- SMSS Patient Admission Request Form (available as separate Excel spreadsheet)
- SMSS Staff Registration Form
- SMSS Controlled Substances Accountability Record
- SMSS Patient Intake Form
- SMSS Patient Transfer Form

SMSS Site Security Assessment Form

Purpose: The purpose of the site security assessment is to:

- Identify security or safety hazards that can be mitigated or corrected and assign actions to do so
- Confirm area perimeters for SMSS operations, staff billeting, and recreational activities
    - Identify conditions for the modification of these areas (e.g.
    - Produce a simple diagram or map depicting the areas graphically for staff, patients, and visitors
- Identify and establish necessary exterior and interior security measures
    - Produce site-specific security plan

Conducted by: Operations Section Chief and/or Safety Officer with the Security Unit Leader

SMSS Site Security Assessment			
		Key: Y – Yes; **N** – No; **U** - Unknown	
Exterior Security			**Y/N/U**
1	Traffic control plans for vehicles and foot traffic have been established and do not create safety/security hazards		
	a	Traffic routes/drop-off areas for vehicles and pedestrians have been clearly marked	
2	Primary entrance for patients, visitors, has been established and is free of hazards to safety or security		
3	Secondary entrance for equipment and supplies has been established and is free of hazards to safety or security		
4	All other exterior entrances have been secured from outside entry and emergency exits are not blocked		
5	Registration areas for patients, staff, and visitors have been established within the primary entrance and can be secured easily.		
	a	Check-in/check-out procedures for patients, visitors, and staff, vehicles, and keys have been established	
6	Security Officer(s) are available to post at the primary entrance 24/7		
	a	Schedule for external security patrols has been established	
7	Check-in times for patient and staff accountability at the beginning of Quiet Hours (established by SMSS IMT) have been established		
8	Plan for facility lock-down due to disturbances (e.g. demonstrations, civil disobedience, gang activity, etc.) has been established.		
	a	Plan includes procedures for the rapid securing of exterior entrances and establishment of a single point of entry/exit	
	b	Activation of the plan does not create hazards to the safety or security of patients, staff, or visitors	
9	**Note all other exterior security or safety issues that need to be addressed:**		
Interior Security			**Y/N/U**
1	Interior areas not used by the SMSS have been secured and clearly identified as off-limits		
2	Information identifying areas approved for access and defining acceptable conduct have been posted		
	a	Diagram/simple map showing the layout of the SMSS (areas for work, living, and recreation)	

	b SMSS Shelter Rules	
3	Facility fire suppression systems have been inspected and are operational	
4	Potential fire hazards have been identified and removed or mitigated	
5	Emergency evacuation routes have been clearly identified and are clear of obstructions	
6	Schedule for internal patrols has been established	
7	Controls and policies for media access and personnel have been established as specified in the SMSS plan	
8	Plan for facility evacuation due to internal hazards (e.g. fire, etc.) has been established in accordance with SMSS security policies.	
9	SMSS policies covering weapons, the use of force, missing person, and fire have been reviewed	
10	**Note all other interior security or safety issues that need to be addressed:**	

Conducted by (name):	**OSC:**	**SO:**	**SUL:**
Date conducted:		**Time conducted:**	

NORTH CAROLINA STATE MEDICAL SUPPORT SHELTER
UNUSUAL EVENT FORM

OCCURRENCE:

_____
_____
_____
_____
_____

Reported by: _____Title: _____
Date: _____ Time: _____

Persons involved: Use, Position, or function, **NOT INDIVIDUALS NAME:**

_____
_____
_____
_____
_____

Describe in chronological order: A) Details of the occurrence, B) Immediate action taken, C) Outcome, D) Expected Outcome.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
____

Submitted by: _____ Title:
_____
Date: _____ Time: _____

Reviewers Comments:

_____
_____
_____
_____
_____
_____
_____

Reviewed by: _____ Title: _____
Date: _____ Time: _____
Follow-up indicated: Yes _____ No _____ Due _____

NORTH CAROLINA
STATE MEDICAL SUPPORT SHELTER RULES

1. **Staff, volunteers, and other visitors must sign in at the Staff Registration Desk upon entry into the shelter. Upon leaving the shelter, for any period of time, everyone must sign out and sign back in at return**

2. **All patients must be registered through the Patient Intake Area**

3. **No drugs, alcohol, weapons, or pets are permitted**

4. **Smoking is permitted only in designated areas**

5. **Cell phones, tablets, laptops and, personal gaming systems are permitted unless they disrupt patient care operations or are used in a way which violates the privacy of others. Office phones are for emergency staff communications only**

6. **Sleeping areas are quiet areas at all times of the day and night. Quiet hours with lights out are enforced in the sleeping areas between: _____and_____.**

7. **Food and drinks, other than water, are not allowed in sleeping areas**

8. **Be respectful and courteous to others at all times. Loud or disruptive behavior is not permitted**

9. **Immediately report all health or safety concerns to shelter staff**

10. **Meals will be served at:**

    Breakfast: _____

    Lunch: _____

    Dinner: _____

11. **Please help keep your area and the center clean.**

NORTH CAROLINA STATE MEDICAL SUPPORT SHELTER
GENERAL SUPPLY - ORDER FORM

Unit/Area: _____
Date: _____ **Time:** _____
Name_____

Type of Supply	Quantity NEEDED	Quantity DELIVERED

SMRS PATIENT CARE REPORT – (available as separate PDF document)

Adobe Acrobat Document

SMSS DISCHARGE PLANNING CHECKLIST

SMSS Facility Name: _____

Date/Time: _____

Patient Name: _____
Patient DOB: _____
Patient Emergency Contact: _____

ITEM	CONFIRMATION BY: P=Patient F= Family S=Staff				NOTES
Wants to go home?					
Baseline home care available?					
Family aware patient going home?					
Home: 1. Food available? 2. Oxygen Available? 3. Electricity? 4. Road Access? 5. Building Intact? 6. Risk of flooding after d/c?					
Ambulatory Status / devices?					
Copy of Chart / meds needed?					
Meds from Pharmacy and nursing cabinet?					
Pt belongings collected?					
Mental capacity and competency?					
Discharge flood warning to family and patient?					
Discharge Summary w new active diagnosis explained?					
Mode of Transport?	Type: BLS	ALS	Wheelchair van	POV	
Main Obstacle for disposition?					

Date / Time of Transport if known:

_____

Location Patient transferred to:

_____

Patient Signature for Belongings:

_____

Staff Name and Signature:

_____

REFUSAL OF CARE/AGAINST MEDICAL ADVICE (AMA)

Patient Name (print name):

_____

I am refusing:

- □ the following medical treatment:
  _____
  _____
  _____
  or the provision of stabilizing treatment for my emergency condition.
- □ a medical screening examination to determine if I have an emergency medical condition;
- □ admission to the hospital
- □ continuing hospitalization; and/or
- □ a medically appropriate transfer to another medical facility

The reason for my refusal is:

_____
_____
_____

A facility staff member and/or physician has informed me of the risks and benefits of receiving the recommended examination, treatment or transfer, as well as the risks and dangers in my choosing not to follow the recommendation at this time. I fully understand the risks of this decision. I assume all responsibility for any complications or dangers that may result from my decision. I hereby release NC SMRS and any and all of its divisions, affiliates, and subsidiaries, and their respective agents, servants, employees, Medical Officers, officers, successors, and assigns and all doctor(s) from any responsibilities whatsoever for any complications or dangers that may result from my decision. I understand that I may change my mind at any time, and I will notify facility staff if I do so. I have the capacity to make and communicate my own healthcare decisions. By signing here, I fully understand the contents of this document. I understand that any rights and obligations that relate to my care apply only to the SMRS facility in which I am being treated.

_____

Patient Signature Date/Time

This patient does not have the capacity to make and communicate healthcare decisions and I am authorized to speak on the patient's behalf.

_____ _____

Signature of Authorized Person Relationship to the patient

Date/Time

- □ Refused to sign
- □ Unable to Locate – UTL (Patient left after exam, but before or during treatment without notifying hospital staff or doctor.)
- □ Elopement

_____ _____

Witness Signature Date/Time

If limited English proficient or hearing impaired, offer interpreter:

☐ Interpreter Accepted _____ □ Interpreter Refused
(Name/Number of Person/Services Chosen/Used)

SMSS PATIENT ADMISSION REQUEST FORM – (available as separate EXCEL Spreadsheet)

SMSS Patient
Admission Request Fc

SMSS STAFF REGISTRATION FORM (ICS 211)

CHECK-IN LIST	1. INCIDENT NAME	2. CHECK-IN LOCATION _____ _____ _____ _____ ☐ BASE ☐ CAMP _____ ☐ STAGING AREA ☐ ICP RESOURCES ☐ HELIBASE	3. DATE/TIME

CHECK-IN INFORMATION

4. List Personnel (Overhead) by Agency & Name - or- List Equipment by the Following Format:					5.	6.	7.	8.	9.		10.	11.	12.	13.	14.	15.	16.
Agency	Single T/F S/T	Kind	Type	I.D. No./Name	Order/ Request Number	Date/Time Check-in	Leader's Name	Total No. Personnel	Manifest Yes	No	Crew Weight or Individual Weight	Home Base	Departure Point	Method of Travel	Incident Assignment	Other Qualification	Sent To Resources Time/Int.

17. Page ___1___ of __2___ 253/ICS 211	18. Prepared By (Name and Position) Use back for remarks or comments

SMSS CONTROLLED SUBSTANCES ACCOUNTABILITY RECORD

State Medical Support Shelter Controlled Substance Accountability Record

Patient's Name: | **Room / Bed Number**

Medication Name:

Ln #	Quantity Received (+)	Quantity Removed (-)	Balance Forward	Time-Date	Nurse Signature (req'd for med removal)	Charge / Pharmacist Signature
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

State Medical Support Shelter Patient Intake Form

Date: _____ Time: _____

Patient Name: _____

Responsible Party: _____

Referring Hospital/Facility: _____

Contact Name: _____

Phone Number: _____

Referring or Treating Dr. (if applicable): _____

Phone Number: _____

Current Diagnosis: _____

Age: _____ Sex: _____ Weight: _____ Height: _____

Triaged By: _____

C/C at time of admission: _____

_____

DNR: Y / N Is there a copy with the patient: Y / N

Current Medication List: _____

_____

Oxygen Needs: _____

DME with the patient: _____

_____

DME Needs: _____

State Medical Support Shelter Patient Transfer Form

Date: _____

SMSS Facility Name: _____

SMSS Facility Phone: _____

Patient Name: _____ DOB: _____

Patient Home Address: _____

Patient Telephone: _____

Chief Complaint: _____

_____

Medications: _____

_____

Allergies: _____

Patient requires transfer to: _____

Reason for Transfer: _____

_____

_____

Name of Transferring Provider: _____

Signature of Transferring Provider: _____

Name of Receiving Provider: _____

Time Receiving Provider Contacted: _____

Time of Patient Transfer: _____

Appendix 12: SMSS Job Action Sheets

- **SMSS INCIDENT COMMANDER**
- **OPERATIONS SECTION CHIEF**
- **PLANNING SECTION CHIEF**
- **LOGISTICS SECTION CHIEF**
- **FINANCE/ADMINISTRATION SECTION CHIEF**
- **CHIEF MEDICAL OFFICER**
- **SAFETY OFFICER**
- **ADMINISTRATION SUPPORT CLERKS**
- **PATIENT CARE UNIT LEADER**
- **PATIENT INTAKE UNIT LEADER**
- **PATIENT INTAKE UNIT JAS (consolidated)**
- **PATIENT CARE UNIT JAS (consolidated)**
- **COMMUNICATIONS/LOGISTICS SPECIALIST**
- **PHARMACY UNIT LEADER**
- **SECURITY UNIT LEADER**
- **SECURITY OFFICER**
- **HOSPICE SPECIALIST**
- **CASE MANAGER/DISCHARGE PLANNER**
- **BEHAVIORAL HEALTH SPECIALIST**
- **HOST FACILITY LIAISON**

SMSS INCIDENT COMMANDER

Selected by OEMS ESF8 Lead

Supervised by: ESF8 Lead

Responsible for the overall operation of the SMSS. Operates from the SMSS Incident Command Post (ICP). Duties include, but are not limited to:

- Receives briefing from the ESF8 Lead and works with the ESF8 Lead to identify staff to fill the SMSS Incident Management Team (SMSS IMT)
- Briefs all staff assigned to the SMSS IMT and executes the SMSS Operational Plan:
    - Establishes the operational periods, schedules, communicates the time for the SMSS IMT briefings
    - Leads all SMSS IMT briefings, develops and presents incident objectives (Incident Briefing (ICS-201)), and approves the Incident Action Plan (IAP)
    - Briefs or reports back to the SERT ESF8 Desk in accordance with the operational schedule
- Meets with Host Facility Liaison and leads inspection of SMSS facility with the SMSS IMT to:
    - Identify operational areas and any issues or conditions requiring correction in support of SMSS operations
    - Identify available host support for SMSS operations
    - Establish communications between the ICP and Host Facility management
- Directs the organization and set-up of the ICP, oversees SMSS IMT direction of SMSS staff in set up and operation of the facility and the correction of identified issues, and notifies the ESF8 Lead when the SMSS is operational and ready to open
- Oversees the Safety Officer to ensure that safety hazards are identified, communicated to SMSS staff, patients, and visitors, and corrected or mitigated as planned
- Oversees the Operations Section Chief to ensure that:
    - All actions necessary for opening operations of the SMSS are completed including the provision of adequate security
    - Staff have been designated to serve in appropriate positions
    - All operational records, including patient records are collected
    - All staff, patients, and visitors are registered upon arrival
    - Patient discharge and transfer plans are properly communicated to all staff and carried out in a safe manner
- Oversees the Planning Section Chief to ensure the:
    - Development and dissemination of Incident Action Plans, situation/patient census reports, and demobilization plans
- Oversees the Logistics Section Chief to ensure the:
    - Appropriate inventory and resupply of SMSS equipment and supplies
    - Provision of adequate and safe food supplies for patients, personal caregivers
    - Establishment of cleaning and waste management services necessary to maintain maintenance and upkeep of the SMSS area
    - All requests pertaining to ordering or releasing of resources are submitted to for review and approval
- Oversees the Finance/Administration Section Chief to ensure the:
    - Documentation of activities, expenses, and emergency actions.
- Conducts or designates the appropriate staff member to escort and briefs all VIP visits.

- Holds overall responsibility for demobilization of the SMSS

OPERATIONS SECTION CHIEF

Selected by SMSS Incident Commander

Supervised by: SMSS Incident Commander

Responsible for specific SMSS operations including operation of the Medical Transportation Unit (AST), Patient Care/Intake Unit, and Security Unit. Duties include, but are not limited to:

- Receives briefing from the SMSS Incident Commander
- Wears Identification Badge at all times while on site
- Assists the SMSS Incident Commander when requested and acts as the SMSS IC in their absence
- Provides situation briefing and tour of SMSS facilities to assigned Unit Leaders. Tour should cover: SMSS facility layout, planned points of facility entry/exit, planned traffic patterns (drop-off/pick-up area, parking area), shift and duty assignments, chain of command, internal communication plan, and SMSS IMT reporting requirements
- Coordinates with Safety Officer and Security Unit Leader on the development of a site-specific security plan.
- Participates in inspection of SMSS operations areas and:
    - Coordinates plan for set-up of equipment and supplies with Logistics Section Chief
    - Coordinates with the Patient Care Unit Leader to identify staff to fill available positions in accordance with the SMSS Operations Plan
    - Notifies the SMSS Incident Commander when the SMSS is operational and ready to open
- Attends all IMT briefings and reports out on operational status and needs
    - Develops the Assignment List (ICS 204) with input from the IMT for inclusion in the IAP
    - Develops and submits Operational Planning Worksheet (ICS 215) to the IC for approval. Submits approved ICS 215 to the Planning Section Chief
- Briefs and oversees all staff assigned to the Operations Section
    - Coordinates with the Patient Care Unit Leader on issues affecting patient care and intake
    - Coordinates with the Chief Medical Officer on oversite of SMSS medical operations
    - Coordinates with the Security Unit Leader on oversite of SMSS area and building security
    - Coordinates with the Pharmacy Unit Leader on oversite of SMSS pharmacy operations
- Oversees demobilization of the SMSS

PLANNING SECTION CHIEF

Selected by SMSS Incident Commander

Supervised by: SMSS Incident Commander

Responsible for the overall planning and information management within the SMSS. Duties include, but are not limited to:

- Receives briefing from the SMSS Incident Commander.
- Wears Identification Badge at all times while on site
- Participates in inspection of SMSS operations areas
- Organizes, collects necessary reports, and conducts all IMT briefings
    - Develops the IAPs (ICS 202 and 203) with input from the IMT
    - Presents the SMSS Incident Action Plan (IAP) and ensures that copies of the IAP are accessible to all SMSS staff
    - Develops and submits Situation Reports (ICS 209) to the IC for approval. Submits approved situation reports to the SERT ESF8 Desk in accordance with the SMSS reporting schedule
- Briefs and oversees all staff assigned to the Planning Section
- Obtains rosters of deploying SMRS teams from the SERT ESF8 Desk
- Coordinates with the Patient Intake Unit Leader to verify current patient and staff status.
- Collects Patient Records from Patient Care Unit Leader upon demobilization of SMSS
- Ensures that all forms necessary for SMSS operation are available and addresses questions if requested by staff members
- Develops action plans (e.g. evacuation, demobilization, etc.) in consultation with the IC and IMT

LOGISTICS SECTION CHIEF

Position is selected from Healthcare Coalition Logistics Leads or other staff member with overall responsibility for logistics of the deployed SMSS

Supervised by: SMSS Incident Commander

Responsible for ensuring that all logistical needs at the SMSS are met (e.g. cots, blankets, beds, signage, communications, water, power, computer access, ADA accommodations, janitorial, etc.). Duties include, but are not limited to:

- Receives briefing from the SMSS Incident Commander
- Wears Identification Badge at all times while on site
- Participates in inspection of SMSS operations areas
    - Coordinates plan for set-up of equipment and supplies with Operations Section Chief and Unit Leaders and briefs the IMT
    - Establishes unloading and parking locations for incoming SMRS vehicles
    - Post signs that designate the facility as an SMSS
    - Notifies the SMSS Incident Commander when the logistical set up of the SMSS is complete
- Briefs and oversees all staff assigned to the Logistics Section including any assigned Communications staff
- Attends all IMT briefings and briefs out on status of logistical support and needs
    - Coordinates the development of the Communications Plan (ICS 205) and Medical Pan (ICS 206) and provides to the Planning Section Chief for inclusion in the IAP
- Maintains inventory of all equipment and supplies and oversees their receipt, storage, and deployment
- Develops, reviews, and submits resource requests as needed to the SERT ESF8 Desk
- Reviews all submitted supply packing slip receipts and submits them to the Administrative/Finance Section Chief
- Collects and documents information concerning any lost, damaged, or stolen SMSS or Host Facility property
- Develops the Logistics portion of the Demobilization Plan and provides to the Planning Section Chief
- Coordinates demobilization and inventory of equipment/supplies including: packing, movement and placing items in the proper trailer (each item has the owner and location for return).

FINANCE/ADMINISTRATION SECTION CHIEF

Selected by SMSS IC

Supervised by: SMSS Incident Commander

Responsible for ensuring that all costs associated with medical shelter are documented and submitted to the IC. Duties include, but are not limited to:

- Receives briefing from the SMSS Incident Commander
- Wears Identification Badge at all times while on site
- Participates in inspection of SMSS operations areas
- Attends all IMT briefings and briefs out on duty time record keeping and cost issues
- Develops and manages the system of record keeping for the SMSS
- Documents all SMSS assigned staff duty time sheets (who will need to be paid by any agency)
- Documents all expenses incurred by the Host Facility and contracted vendors due to SMSS operations
    - Collects all supply requests after approval by appropriate ICP command staff.
    - Collects all received supply packing slips after approval by appropriate unit leader.
- Collects and secures all administrative records on demobilization.
- Coordinates with the Operations Section Chief to collect and secure all patient information and records on demobilization.

CHIEF MEDICAL OFFICER

Position is selected from the SMSS IMT or an SMAT team physician, PA, NP, or RN with supervisory experience.

Supervised by: Operations Section Chief

Responsible for overseeing patient care operations of the SMSS, including the opening and closing procedures. Duties include, but are not limited to:

- Reports to the SMSS IMT (in the SMSS ICP) and receives briefing from the Operations Section Chief
- Wears Identification Badge at all times while on site
- Attends all IMT briefings and reports
- Notifies the ME on all deaths at the SMSS.
- Assess the health care needs of the SMSS patients
- Answers “Code Blue” facility calls when available
- Monitors potential for infectious disease transmission
- Coordinates patient care briefings

SAFETY OFFICER

Position is selected by SMSS IC

Supervised by: SMSS Incident Commander

Responsible for ensuring that SMSS operations are conducted in a way that guarantees the safety of the SMSS staff and patients. Duties include, but are not limited to:

- Receives briefing from the SMSS Incident Commander
- Wears Identification Badge at all times while on site
- Participates in inspection of SMSS operations areas
- Participates in a site security assessment with the Security Unit Leader (SUL) and works with the SUL to develop a site-specific security plan in accordance with the SMSS Security SOG
- Attends all IMT briefings and briefs out on any identified safety issues
- Provides information (ICS 208 and safety message for the ICS 202) to the Planning Section Chief for inclusion in the IAP
- Monitors local weather forecasts and SMSS operational areas to identify any potential hazards or safety concerns
- Discusses potential safety issues with the Security Unit Leader
- Briefs all SMSS staff regarding safety concerns and coordinates the establishment of area “safety officers” to monitor operations for safety issues
- Responds to and attempts to resolve all reported accidents, injuries, lost person notifications, etc.
- Reviews and completes Unusual Incident Reports as necessary
- Collects all Unusual Incident Reports and gives to the Planning Section on demobilization

ADMINISTRATIVE SUPPORT STAFF

Should be selected from OEMS staff or the SMRS roster

Supervised by: Applicable Section Chief/Unit Leader

Clerical/non-medical volunteers work under the direction of the assigned Section Chief/Unit Leader. They provide administrative and general support services to the SMSS. Duties include, but are not limited to:

- Completes the SMSS Check-In List and is interviewed to determine work capabilities, hours/days available.
- Wears Identification Badge at all times while on site
- Reports to the ICP and is orientated to the expected tasks and the staff.
- Performs clerical duties as assigned including:
    - Answering telephone calls
    - Collecting and delivering forms to the required locations
    - Obtaining and delivering equipment and supplies
    - Maintaining paperwork as requested
    - Maintaining clean area
- Supports general SMSS operations
    - Assists in setting-up the SMSS;
    - Helps patients find the right location
    - Assists in distribution of food;
- Attends shift briefings as scheduled
- Reports any problems to the assigned Section Chief/Unit Leader.

PATIENT CARE UNIT LEADER

Position selected from a deployed lead SMAT-II RN with ED or ICU and management experience.

Supervised by: Operations Section Chief

Responsible for managing staffing and operations in the Patient Intake and Patient Care areas of the SMSS. Duties include, but are not limited to:

- Receives briefing from the Operations Section Chief
- Wears ID Badge at all times
- Briefs Patient Care Unit (PCU) staff on the situation and set-up/functions of the Patient Area
- Supervises the Patient Intake Unit Leader (PIUL) and all staff assigned to the PCU
    - Assigns staff to roles (emergent/patient care) within the PCU
    - Coordinates set-up of the PIU area with the PIUL
- Oversees the delivery of patient care and assistance
- Evaluates the patients and determines patient placement within the SMSS or if transfer to other healthcare facilities is appropriate
- Oversees the administration and documentation of all medications administered/adverse reactions and the maintenance of Patient Care Records by PCU staff
- Provides Patient Care Records to Planning Section Chief upon demobilization
- Assures that PCU staff adhere to standard precautions and infection control practices
- Instructs the staff on supply requests and signs off on all supply requests
- Leads the shift reports at shift change
- Coordinates with the Chief Medical Officer on patient care assessments and patient transfers outside the SMSS
- Coordinates with the Patient Intake Unit Leader on patient transfers within the SMSS
- Coordinates with the Operations Section Chief on matters affecting the PIU and PCU operations
- Oversees demobilization of the PCU

PATIENT INTAKE UNIT LEADER

Position filled by a SMAT- II or III Paramedic with supervisory experience.

Supervised by: Patient Care Unit Leader

Responsible for operations involving the reception, initial triage and registration of patients and the check-in/out of SMSS staff and visitors. Duties include, but are not limited to:

- Receives briefing from the Patient Care Unit Leader
- Wears ID Badge at all times.
- Briefs staff on the situation, PIU set-up/functions, and supervises all staff assigned to the Patient Intake Unit (PIU)
    - Assigns staff to roles (triage, registration/check-in, support) within the PIU
    - Coordinates set-up of the PIU area in accordance with direction provided by the Patient Care Unit Leader
- Ensures that staff understand the SMART Triage System, proper techniques for lifting patients and handling of wheelchairs/stretchers, how to utilize DMS FirstTrak for patient tracking and provide training on these subjects if necessary
- Ensures that all patients, staff, and visitors are registered/checked-in upon arrival and maintains current census of patients and staff in the SMSS
- Ensures that all patients are properly triaged, assigned a bed, and transferred to the Patient Area
- Coordinates with the Patient Care Unit Leader on patient transfers
- Coordinates with the Planning Section Chief on patient and staff census
- Oversees demobilization of the PIU

Patient Intake Unit (PIU) Job Action Sheet

Positions selected from available SMRS volunteers with the following backgrounds:

- Emergency Medical Technicians (Basic through Paramedic)
- Registered Nurses (with Triage or Patient Registration experience)
- EMTs/RNs trained on the NCOEMS-HPP patient tracking system (DMS FirstTrak)

Supervised by: Patient Intake Unit Leader

Responsible for: Reception, initial triage and registration of patients and the check-in/out of SMSS staff and visitors.

Job Functions	Assigned Tasks	Best Staffed By
Triage	• Assess the physical condition of incoming patients and collect basic personal information utilizing SMSS Patient Intake Form, Initial Treatment/Triage page of Patient Care Record or equivalent • Identify patients with emergent needs or infectious conditions and inform PIUL • Tag durable medical equipment (DME), medications, and personal bag with patient's name	Paramedic
Registration	• Review Patient Intake Form, Initial Treatment/Triage page of Patient Care Record or equivalent • Register patients as they arrive at the SMSS and begin SMSS Patient Care Record or equivalent and provide patient identification band • Assure that all medications and DMEs are labeled with patient's name • Enter patients into Patient Tracking System (DMS FirstTrak) • Determine where patients should be placed and assign to available beds in the Patient Area • Transfer patient with Patient Care Record to Patient Area in coordination with Patient Care Unit staff • Organize all patient registration materials and provide patient information to PIUL upon request • Provide information about the SMSS to patients and visitors and notifies SMSS IMT of arrival of visitors • Check-in/out SMSS staff and visitors utilizing the SMSS Staff Registration Form (modified ICS 211)	RNs and EMT-B
Common	• Receive situation and unit orientation briefings from the Patient Intake Unit Leader (PIUL) • Wear ID Badge at all times • Set up the PIU area in accordance with PIUL direction • Assist with unloading of patients and their personal items, DME, & medications • Maintain cleanliness of PIU • Demobilize the PIU	All staff assigned to the PIU

Patient Care Unit (PCU) Job Action Sheet

Positions selected from available SMRS volunteers with the following backgrounds:

- Physician
- Physician Assistant
- Nurse Practitioner
- Registered Nurses (with Emergency Department or ICU experience)
- Emergency Medical Technicians (Paramedic to Basic)
- Nursing Assistant

Supervised by: Patient Care Unit Leader

Responsible for: Assessment of admitted patients, monitoring of their medical needs, delivery of medical care within the capabilities of the SMSS, transfer of patients with medical needs outside SMSS capabilities, and discharge of patients to home or other appropriate living facilities following a disaster.

Job Functions	Assigned Tasks	Best Staffed By
Patient Care	• Provides medical care for those admitted to the PCU • Completes Patient Care Record on patients examined and treated • Reviews patient dispositions and coordinates with the PCUL on necessary changes to patient placement • Responds to Codes in the PCU if available • Reviews all radiological studies • Assists PCUL with work up on admitted patients • Supervises mid-level providers (PAs/NPs) assigned to the PCU **(Physician only)**	**Physicians & Mid-Level Practitioners** (Physician Assistants and Nurse Practitioners)
Patient Care	• Receives patients admitted by the PIU, confirms bed for patient and moves patient to it • Completes evaluation of patients utilizing the Patient Care Record or equivalent patient record document • Monitors the physical condition of the patients on an on-going basis and makes referral to Respiratory Therapist if problems occur with patients receiving oxygen • Delivers care and assistance to patients as required within their scope of practice and following approved protocols, procedures, and guidelines. • Administers and documents all medications administered and any adverse reactions • Maintains the patient's Patient Care Record and advises the PCUL of any adverse change in the condition of a patient • Inventories all received supplies and check against the order request or unit inventory list. • Supervises all nursing assistants, nursing students, EMTs, assigned to the area **(Lead Nurse only, if staffed)** • Determines where patients should be placed in the PCU and notifies the PCUL if other facilities may be more appropriate for patient care **(Lead Nurse only, if staffed)**	**Registered Nurses & Paramedic** (RNs include Lead Nurse and Staff Nurses)
Patient Care Assistance	• Delivers care and assistance to patients as required following approved protocols, procedures, and guidelines	EMT-B

	• Assists other PCU staff with:
	  ○ Moving patients to assigned beds
	  ○ Completing Patient Care Records
	  ○ Patient care and monitoring patient conditions for changes
	  ○ Bed changing
	  ○ Inventory, ordering and distribution of medical supplies	

Patient Care Assistance	• Works within their skills and abilities and takes direction from the licensed staff person in charge of the area in which they are working
	• Assists PCU licensed medical staff with:
	  ○ Moving patients to assigned beds
	  ○ Patient care and monitoring patient conditions for changes
	  ○ Bed changing
	  ○ Inventory, ordering and distribution of medical supplies
		Nursing Assistant

Common	• Receive situation and unit orientation briefings from the Patient Care Unit Leader (PCUL) • Wear ID Badge at all times • Set up the PCU area in accordance with PCUL direction • Participate in the shift reports at shift change • Assist with inventory of supplies, packing and returning supplies and equipment to the SMRS trailers • Submit supply requests to PCUL for review • Adhere to standard precautions and infection control practices • Maintain cleanliness of PCU • Observe PCU staff, patients, and family members for stress and assist as needed • Demobilize the PCU	All staff assigned to the PCU

COMMUNICATIONS/LOGISTICS SPECIALIST

Position is selected from the roster of SMAT-II volunteers with logistics and communications systems experience.

Supervised by: Logistics Section Chief

Responsible for the set up and operation of radio and other communication systems available to the established SMSS operation in accordance with guidance provided by the SMSS IMT. Duties include, but are not limited to:

- Receives briefing from Logistics Section Chief
- Wears Identification Badge at all times
- Assists the Logistics Section Chief with the development and update of the SMSS Incident Radio Communications Plan (ICS-205)
- Assists Logistics Section Chief with inventory of supplies, packing and returning supplies and equipment to the SMSS and SMAT trailers (ownership marked on all items)
- Assists the SMSS IMT in resolving technical issues that may limit the effectiveness or usability of internal and external communication systems
- Reviews communication systems in each functional area of the SMSS at least once per shift to ensure proper internal communication is in place and that internal communication protocols established by the SMSS IMT are followed
- Participates in daily shift briefings.

PHARMACY UNIT LEADER

SMAT-II Pharmacist with knowledge of the SMRS pharmacy program and management skills

Supervised by: Operations Section Chief

Responsible for maintaining pharmaceutical supplies in the SMSS and providing or supervising the delivery of pharmaceutical services to patients. Duties include, but are not limited to:

- Receives briefing from Operations Section Chief
- Wears Identification Badge at all times
- Sets up and organizes the Pharmacy Unit area
- Orients any assigned staff to the set-up and operation of the Pharmacy Unit
- Maintains the inventory of controlled substances, pharmaceuticals, supplies, equipment, and reports status to the Operations Section Chief upon request
- Oversees requests for medications following approved protocols and standards of practice
- Provides pharmaceutical consultations when requester or indicated.
- Adheres to standard precautions and infection control practices
- Approves and submits orders for additional medications to the Logistics Section Chief
- Coordinates with the Operations Section Chief on matters affecting Pharmacy Unit operations
- Provides shift reports to the Operations Section Chief at shift change
- Demobilizes the Pharmacy Unit including the inventory, packing, and return of controlled substances, pharmaceuticals, and other supplies and equipment.

SECURITY UNIT LEADER

Position selected from sworn officers of state or local law enforcement agencies (e.g. ALE, DOI, local LE provided through jurisdiction hosting SMSS)

Supervised by: Operations Section Chief

Responsible for providing and supervising security services necessary to ensure the safety of SMSS staff, patients, and visitors. Duties include, but are not limited to:

- Receives briefing and tour of SMSS facilities from the Operations Section Chief to familiarize SUL with:
    - SMSS facility layout
    - Planned points of facility entry/exit
    - Planned traffic patterns, drop-off/pick-up area, parking area
    - Planned duty assignments
    - Security Officer shift and duty assignments and chain of command
    - Roles and responsibilities of in-house security personnel if provided by the host facility
    - Internal communication plan
    - SMSS IMT reporting requirements
- Completes a site security assessment with input from the Operations Section Chief and Safety Officer following initial situation briefing and facility tour.
- Provides input from the site security assessment to the SMSS IMT (Operations and Safety Officer) for the development of a site-specific security plan in accordance with the SMSS Security SOG
- Coordinates with SMSS IMT and local Emergency Management representative to confirm process for requesting and obtaining assistance from local law enforcement if necessary
- Briefs Security Officers on the established site security plan
- Leads security efforts in support of SMSS Safety Guidelines (Appendix 13) as they relate to fire, use of force, missing person, and evacuation
- Attends all SMSS IMT briefings unless an emergency prevents attending
- Monitors all radio transmissions and respond to assist when indicated
- Completes a daily security report to the Operations Section Chief covering:
    - Summary of security activities and actions taken
    - Recommendations to improve security/safety issues encountered
- Briefs security report at the SMSS IMT briefing
- Coordinates with the SMSS IMT on maintaining security during demobilization of the SMSS and the demobilization of all assigned security duty areas
- Briefs Security Officers on the SMSS demobilization plan and oversees their demobilization as planned

SECURITY OFFICER

Position selected from sworn officers of state or local law enforcement agencies (e.g. ALE, DOI, local LE provided through jurisdiction hosting SMSS)

Supervised by: Security Unit Leader

Responsible for providing security services necessary to ensure the safety of SMSS staff, patients, and visitors. Duties include, but are not limited to:

- Receives briefing and tour of SMSS facilities from the Security Unit Leader to become familiar with:
    - SMSS facility layout
    - Planned points of facility entry/exit
    - Planned traffic patterns, drop-off/pick-up area, parking area
    - Planned duty assignments
        - Security at vehicle entrance
        - Traffic control at drop-off/pick-up and parking areas
        - Interior SMSS security (e.g. Waiting/Registration area)
        - Exterior SMSS security (e.g. periodic area patrolling)
- Performs assigned security roles and responsibilities in coordination with in-house security personnel as instructed by the SUL
- Performs calls for assistance to local law enforcement jurisdictions as instructed by the SUL
- Performs duties in accordance with the established SMSS site security plan
- Performs actions in support of SMSS Security SOG and Safety Policies (Appendix 13) as they relate to fire, use of force, missing person, and evacuation
- Monitors radio transmissions and respond to assist when indicated
- Provides activity reports to the SUL as requested
- Participates in the demobilization of SMSS and assigned security areas as instructed by the SUL

HOSPICE SPECIALIST

Assigned to SMSS duties by state or local Hospice Agency**.**

Supervised by: Patient Care Unit Leader

Responsible for providing support to hospice patients in the SMSS. Duties include, but are not limited to:

- Receives briefing from Patient Care Unit Leader
- Wears ID Badge at all times
- Works day shifts, on call at nights for emergencies
- Provides case management for hospice patients as needed during their stay in the SMSS
- Plans and coordinates services leading up to patient discharge or transfer
- Advises staff and family members on end of life and terminal patient care issues

CASE MANAGER/DISCHARGE PLANNER

Position assigned to SMSS duties by state or local Social Service Office**.**

Supervised by: Patient Intake Unit Leader

Responsible for providing case management services to patients in the SMSS. Duties include, but are not limited to:

- Receives briefing from Patient Intake Unit Leader
- Wears ID Badge at all times.
- Works day shifts, on call at nights for emergencies.
- Plans and coordinates services leading up to patient discharge or transfer
    - Expedites the proper placement of patients to transition from temporary shelter to medium to long term care facilities or home
    - Identifies healthcare resources that are best suited to the patient's medical and financial situation
    - Determines viable plans for alternative housing if patients are unable to return to their pre-event residence. Plans will ensure the continuity of care and access to transportation, medical services, and medical care, availability of food, water, power, sewer, fire protection, and law enforcement
    - Ensures that patients have transportation that will accommodate the them and ensure the safe transport of any medical equipment or supplies. If necessary, works with the SMSS IMT to arrange transportation
- Coordinates patient and child locator services for unaccompanied minors and parents who have lost children or family members.
- Documents minors, patients with competency concerns, and shelter patients moved to higher level of care.

BEHAVIORAL HEALTH SPECIALIST

Position assigned to SMSS duties by state or local agency.

Supervised by: Patient Care Unit Leader

Responsible for providing behavioral health services to patients in the SMSS. Duties include, but are not limited to:

- Receives briefing from Patient Care Unit Leader
- Wears ID Badge at all times
- Works day shifts, on call at nights for emergencies
- Makes rounds watching for signs of agitation, depression, confusion, etc. and resolving potential problems
- Assists the staff in promoting diversions and activities, conversation, time orientation, etc.
- Works with the patients who are experiencing mental health problems and guides the staff on how to be most therapeutic in the situation
- Reports current problems and potential problems that may need additional intervention to the Patient Care Unit Leader
- Provides counseling services according to need and within the scope of licensure
- Provides onsite referrals for additional services as needed
- Assists in the coordination of patient services upon discharge from the facility
- Plans for debriefing of staff before they leave the shelter
- Determines the efficacy of holding a debriefing session a week or two after the evacuation experience
- Participates in the health/medical briefings at shift change

HOST FACILITY LIAISON

Position is provided by the host facility organization from staff with property management experience.

Supervised by: Host Facility Management

Responsible for managing host facility operations in support of SMSS operations as agreed to with the NCOEMS-HPP. Duties include, but are not limited to:

- Coordinates with SMSS Incident Commander or designee on SMSS operations and support issues
- Wears Facility Identification Badge at all times while on site
- Provides tour of facility with SMSS IC and IMT
- Serves as the official spokesperson for the Host Facility
- Provides SMSS IMT with 24-hour contact numbers
- Attends shift briefings
- Communicates and coordinates with the SMSS IC on the:
    - Inspection of SMSS areas of the host facility before, during, and after operations
    - Reporting and resolution of issues and needed repairs
    - Cleaning of all SMSS areas, notification of damage to facility, and return of furniture and non-medical equipment to the proper storage
- Submits any payment /reimbursement requests from Host Facility to the SMSS Administrative/Finance Section

State Medical Support Shelter Security Standard Operating Guidance

1. **Purpose:** To maintain a safe environment for medical shelter staff, patients, and visitors

2. **General Security Requirements:**
    a. Medical shelters are particularly vulnerable to security hazards and threats due to the circumstances of their establishment:
        i. Disrupted services/infrastructure due to ongoing or recent disaster
        ii. Large population of medically-fragile patients
        iii. Presence of pharmaceuticals and other valuable equipment and supplies
    b. Security must be established and maintained at State Medical Support Shelter (SMSS) facilities 24 hours a day and 7 days a week from the time SMSS Incident Management Teams (SMSS IMT) first arrive to establish the shelters until demobilization of the shelters are complete. The level of security required will depend on the emergency and location of the medical shelter site.
    c. Security includes, at a minimum:
        i. The physical presence of trained, sworn Law Enforcement officers (local, state, etc.) with jurisdiction to enforce the law, in adequate number to meet the purpose of this SOG (see Security Roles and Staffing Levels) and in order to perform or assist the SMSS IMT with achieving the following security priorities:
            1. Conducting an initial site security assessment and developing an operational security plan
            2. Establishing control of access outside the SMSS including traffic control, external presence/patrols, and escort activities
            3. Establishing control of access inside the SMSS including internal presence/patrols and enforcement of shelter rules and policies
            4. Coordinating SMSS security activities, including requests for additional assistance, with local law enforcement
        ii. The active support of the SMSS IMT and all SMSS staff for the development of the security plan and enforcement of SMSS rules and policies, especially as they related to security and safety

3. **Security Roles and Staffing Levels:**
    a. SMSS IMT: Provides direction and coordination of plans, policies, and actions related to on-site security and safety through the SMSS Operations Section Chief and Safety Officer positions. Specific responsibilities of individuals assigned to these positions are covered in their Job Actions Sheets (see, Appendix 12).

    b. Law Enforcement
        iii. Roles: Provides sworn law officers to fill Security Unit Leader (SUL) and Security Officer (SO) positions within the SMSS Incident Command Structure.

1. SULs are supervised by and report to the SMSS Operations Section Chief, coordinate their actions with the SMSS Safety Officer, and provide direction to all assigned Security Officers.
2. SOs are supervised by, report to, and perform their duties based on direction from the SUL.
3. The specific responsibilities of law officers assigned to these positions are covered in their Job Actions Sheets (see, Appendix 12).

iv. Staffing Levels: The number of SUL and SO positions adequate to meet the purpose of this SOG will be determined prior to the deployment of SMSS resources by the ESF8 Lead (Disaster Medical), in coordination with the SMSS Incident Commander, ESF13 Lead (Law Enforcement), and the Emergency Services Group Supervisor or their designees. However, initially, at least four (4) law enforcement officers should be provided to meet SMSS security needs over each 24-hour period (2 – day, 2 – night).

4. **Security Priorities and Best Practice Guidelines:**

a. Site Security Assessment and Operational Security Plan Development: Assessment completed by SUL with input from the Operations Section Chief and Safety Officer following initial situation briefing and facility tour. SUL and Safety Officer work together to develop site-specific plan. Assessment and plan should:

i. Identify hazards for mitigation and associated corrective actions
ii. Set initial area perimeters for work, living, and recreational activities, identify conditions for their modification, and include a simple diagram or map depicting them graphically for staff, patients, and visitors
iii. Address the establishment of exterior and interior security measures
iv. Support shelter rules established by the SMSS IMT regarding personal conduct, pharmaceutical storage, etc. and incorporate existing SMSS Safety Policies (Appendix 13) covering Fire, Use of Force, Missing Persons, and Evacuation
v. Address the coordination of SMSS security activities with local emergency management and law enforcement

b. Control of access outside the SMSS: Directed by the SMSS IMT, in accordance with the results of the initial security assessment and maintained by the SUL and assigned SOs upon their arrival to the SMSS.

i. Establish traffic control plans for vehicles and foot traffic
    1. Provide escort for vehicles entering/exiting premises, if necessary
ii. Establish primary entrance for patients, visitors, and staff and secondary entrance for equipment and supplies
iii. Secure exterior doors to areas in use that are not being used as entrances from outside entry, however:
    1. DO NOT KEEP OUTSIDE DOORS PROPPED OPEN
    2. DO NOT BLOCK EMERGENCY EXITS
iv. Establish Patient Intake/Staff Registration desk(s) at the primary entrance. Include check-in/check-out procedures for patients, visitors, and staff, vehicles, and keys
v. Post security personnel at the primary entrance 24/7 and establish schedule for external patrols

vi. Establish an evening check-in time (e.g. 2200 check-in to Branch Directors and report to SMSS IMT Section Chiefs no later than 2210)
vii. Establish a plan for facility lock-down to restrict access into and out of the SMSS due to disturbances (e.g. demonstrations, civil disobedience, gang activity, etc.). Plan should include procedures for the rapid securing of exterior entrances and establishment of a single point of entry/exit

c. Control of access inside the SMSS: Directed by the SMSS IMT and CMO/CNO, in accordance with the results of the initial security assessment. Maintained by the SUL and assigned SOs upon their arrival to the SMSS (Note: Signage and posting of signage is the responsibility of the Logistics Section Chief.)

i. Secure unused areas and clearly identify them as off-limits by posting "Do Not Enter" signs and/or use of colored safety tape
ii. Post signage identifying service areas and defining acceptable conduct (Shelter Rules). Rules should be displayed prominently where they can be easily seen by patients, staff, and visitors
iii. Ensure that emergency evacuation routes are clearly identified
iv. Establish schedule for internal patrols by security personnel
v. Enforce established controls and policies for media access and personnel as specified in the SMSS plan

d. Coordination of SMSS security activities: Processes for requesting and obtaining assistance from local law enforcement will be based on agreements established between SEOC (ESF8 Desk, Public Safety (ESF13), and NCEM Emergency Services) and local Emergency Management representatives prior to SMSS deployment. Once deployed, SMSS IMT will manage these processes in accordance with agreements and utilize the SUL and assigned SOs for direct coordination with local law enforcement.

State Medical Support Shelter
Safety Policies

Fire
Use of Force
Missing Person
Evacuation

Fire

PURPOSE: To provide guidelines in responding to fires and define responsibilities of the SMSS IMT and staff in the activation of this policy.

DESCRIPTION OF THE THREAT: Fires are extremely destructive and have the potential to spread and rapidly become a hazard to life and property. If a fire develops, smoke production is the first and greatest hazard to patients, staff, and visitors.

PERSONNEL: This policy applies to all SMSS patients, staff, and visitors

EQUIPMENT: Fire extinguishers

RESPONSIBILITY: SMSS Incident Commander and Incident Management Team are responsible for managing all mitigation, preparedness, and response activities related to fire/threat of fire in an SMSS (see SMSS IC/IMT sections under **RESPONSE** below).

MITIGATION/PREPAREDNESS:

- The SMSS IC will ensure that the SMSS facility receives a fire inspection for local/state fire authorities with jurisdiction over the facility prior to opening
- Fire safety issues will be included as part of the SMSS Site Security Assessment
- The Safety Officer will be responsible for the resolution of any fire hazard issues noted during the inspection and ensure that:
    - All fire extinguishers provided by the SMSS are properly placed
    - Staff are aware of the locations of all available fire extinguishers and Fire Alarm Pull Boxes and how to utilize them
    - SMSS staff are familiar with this policy especially as it pertains to response and Fire Safety Guidelines

Fire Safety Guidelines:

- **"Code Red"** will be the signal word for verbal notification of a fire in progress:
    - **"Attention, Attention, Code Red and (location)"** will be used for notification over the radio of a fire in progress to all SMSS work areas. This notification may be made by any SMSS staff
    - **"Attention, Attention Code Red All Clear!"** will be used for notification over the radio that a fire in progress has been extinguished and it is safe to return to SMSS work areas. This notification may only be made by the SMSS Incident Commander or the Safety Officer
- Firefighting: SMSS staff will not fight a fire unless:
    - The fire can be fought effectively with portable extinguishers
    - They have knowledge or training on using a portable fire extinguisher
    - They can safely fight the fire in normal work clothing
- Operating a Fire Extinguisher:
    - Pull the pin on the fire extinguisher
    - Aim the fire extinguisher nozzle at the base of the fire
    - Squeeze the handle trigger
    - Sweep the extinguisher from side to side at the base of the fire
- Checking Work Areas: If doors are closed, feel the door and the doorknob before entering. If either is hot, DO NOT open the door. If the door and the doorknob are cool, stand to the side of the door and open the door slowly.

RESPONSE:

SMSS Staff: Staff responsibilities will vary depending on whether they are working in an area affected by a fire or not. Responsibilities, in these situations, are as follows:

Directly Involved in a Fire:

1. Call out the fire signal **"Code Red!"**
    a. All other area staff will relay that call and ensure that their Unit Leaders are notified
2. Extinguish the fire

a. If the fire is small enough to be put out by a fire extinguisher, staff will use a fire extinguisher, or other available fire suppression equipment to put out the fire immediately.
b. If the fire cannot be extinguished immediately or is too large to be put out by a fire extinguisher, staff will activate of the facility fire system by pulling down on the nearest fire alarm pull box

3. Evacuate any person(s) in immediate danger (if it can be done safely)
4. Contain the fire (close doors to patient rooms, offices, hallway closets, smoke doors, fire doors, windows, etc.)

Not Directly Involved in the Fire:

1. Proceed to your area of responsibility; if you do not have an assignment outside your unit, remain in your work area for instructions
2. Close doors to patient rooms, offices, hallway closets, smoke doors, fire doors, windows, etc.
3. Leave the lights on
4. Clear hallways of equipment, carts, etc. If equipment and carts cannot be removed from hallways, move them along the wall opposite any fire stairwells to create the widest possible space for movement of patients
5. Request that all visitors report to a waiting area or remain in the patient's area until the "All Clear" is announced
6. Remain in your area of responsibility until notified of the all clear

SMSS Unit Leaders: In areas directly involved with a fire, Unit Leaders are responsible for the following until relieved by the Safety Officer, other designated member of the SMSS IMT, or a member of the local Fire or Police Department:

1. Initial assessment of the fire and situation reporting to the SMSS ICP
2. Directing fire suppression
3. Directing internal patient movement
4. If necessary, requesting authority to shut off medical gas valves in the Patient Care Area from the CMO, the Charge Nurse, or their designee.

The Unit Leaders in areas not involved with a fire are responsible for securing their area and continuing normal activities until called for possible assignment.

SMSS IC: When notified of a fire or potential fire event, the SMSS IC will take the following actions to maintain direction and control over SMSS operations and the health and safety of patients, staff, and visitors:

1. Direct the Logistics Section Chief or Communication Specialist to broadcast notification of the fire (**"Attention, Attention, Code Red and (location)"**) over radio to all SMSS areas, if not already done.
    a. If radio communications are down, direct the LSC and Finance/Admin. Section Chief to assign runners from available non-medical support staff to communicate with Unit Leaders in other SMSS areas
2. Dispatch the Safety Officer, Operations Section Chief, and other members of the SMSS IMT as designated to the affected area
3. Contact the SEOC ESF8 Desk to report the event, provide current status, and request any necessary support needs

4. Upon confirmation of fire and the need for external fire support, direct the Security Unit Leader to call 911, report the situation, and coordinate local fire department support
5. Direct the Logistics Section Chief or Communication Specialist to broadcast notification of all clear (**"Attention, Attention Code Red All Clear!"**) over radio, to all SMSS areas, once the fire has been extinguished.

SMSS IMT: The Safety Officer, Operations Section Chief, and other members of the SMSS IMT designated by the SMSS IC will respond to the affected area in order to:

1. Establish communications between the affected area and the SMSS ICP, if not already established
2. Verify the assessment of the fire, support suppression efforts, and support internal patient movement efforts, if necessary
3. Determine if evacuation from the entire facility is necessary (external evacuation), see **Evacuation** policy
4. Mobilize internal resources (e.g. AST, medical staff from other SMSS areas, etc.) to support response operations
5. Coordinate next steps of the response with the SMSS IC

SMSS Logistics Section Chief and Finance/Admin. Section Chief:

1. Maintain internal and external communications through all available systems (radio, phone, text, runner, etc.)
2. Direct emergency notifications in coordination with the SMSS IC

SMSS Security Unit Leader:

1. At the direction of the SMSS IC, establish communications with 911 and coordinate the dispatch of local fire department resources in accordance with the situation
2. Assign one or more Security Officers to the drop-off/pick-up area of the SMSS to direct and/or escort the fire department to the fire scene

USE OF FORCE

PURPOSE: To provide guidelines for the use of force necessary to maintain a safe and secure environment for patient care in State Medical Support Shelters.

PERSONNEL: All SMSS Security Officers

POLICY:

- Employ only the minimum level of force necessary to assume control of situations that threaten the security of SMSS while:
  - Protecting the Security Officers
  - Protecting the subject from himself or herself
  - Protecting others in the immediate area from danger

- Limit the use of force to those instances when Security Officers reasonably believe that it is the most appropriate method to assure the safety of the environment and control the situation

- When faced with an incident that may require the use of force, Security Officers are expected to assess the situation, determine the Level of Force that will most effectively de-escalate the situation and bring it under control with the least risk of injury to the Security Officers and/or others, including the subject.

- Security Officers must never escalate to a greater Level of Force without first exhausting all less severe alternatives or reasonably believing that any lesser degree of force would be ineffective

- Use of force against patients should be limited to the defensive techniques however, chemical sprays should not be used inside SMSS patient care areas

PROCEDURE:

Levels of Force: The expectations for the use of force within SMSS facilities are defined by the Levels of Force listed below. When faced with an incident that may require the use of force, Security Officers are expected to determine the level of force necessary to effectively de-escalate the situation and bring it under control. The levels are listed in order from least to most severe.

- Level One – Presence: Psychological force established through the Security Officer arrival in the area and symbols of authority such as the uniform. The Security Officers' positioning, stance, and use of a reaction zone aid in the control of confrontations and facilitate officer safety.
    - Always Call for Backup: The prompt appearance of additional uniformed Security Officer will frequently bring the situation under control. Security Officers should refrain from initiating contact until adequate backup has arrived unless immediate action is required to preserve human life.

- Level Two – Verbal Direction and Control: Conversation, advice, commands, or instructions are utilized by Security Officers to control or de-escalate a confrontation. Verbal communication, when applicable, accompanies Security Officers actions, including the Security Officer identifying him or herself. Verbal Direction and Control is the most desirable use of force option.
    - Verbal Compliance: After obtaining verbal compliance, escort non-patient subjects either off of the SMSS campus or to the designated area if he or she is being arrested

- Level Three – Physical Control: Use of physical contact to include touching, assisting, grabbing, and joint manipulations. Contact may include empty hand techniques and handcuffs. Use of handcuffs should be reserved for persons being detained for arrest and will not be used to restrain a patient in lieu of authorized clinical restraints applied under the supervision of a physician or nurse. However, handcuffs may be used when the Security Officer reasonably believes it is necessary to control the subject's movement for the safety of patients, visitors and staff, including the Security Officers involved.

- Level Four – Impact Weapons: Use the expandable baton in accordance with recognized training methods to impede the subject's movements and protect the Security Officers involved and others from assault and serious body injury. The expandable baton will not be used to threaten, intimidate, or strike a patient. The only exception will be when a Security Officer reasonably believes it is necessary to stop a patient from creating the risk of serious injury or death to him/herself or another person and no other means are available to do so.

Reporting the Use of Force: Whenever a SMSS Security Officer uses any level of force above Level Two, the Security Unit Leader and SMSS IMT will be notified. This includes any situation in which the expandable baton is extended but not used. This does not apply to assisting in the restraint of a patient under clinical supervision.

Documenting the Use of Force: Every use of force above Level One, other than the restraint of a patient under clinical supervision, will be documented in an SMSS Use of Force Report. When a person is removed from the facility or escorted off the facility and no force is used, a statement that "no force was used" will be included in the appropriate report.

Missing Person

Scope: This procedure addresses missing patients admitted to the SMSS and all pediatric visitors (under 18 years old). A missing person at the SMSS is a serious event, requiring immediate response.

Situation: Each deployment is unique, requiring differing planning and response. This plan should be seen as a guideline and can be altered by the SMSS IMT as needed. Weather and SMSS deployment location are among the factors to be considered in planning efforts.

Concept of Operation: In the event of a missing person is discovered to be missing, the following actions will be taken:

1. Conduct initial search and notification
    a. Restrict facility access
    b. Gather information, and
    c. Expand/contract search resources as situation dictates
2. Maintain search operations to conclusion
    a. Provide situation updates until search concluded (e.g. every 30 min.)
    b. Report results of search to the SEOC ESF8 Desk

<u>Initial Search and Notifications</u>

Affected SMSS Area: The staff member discovering that a person is potentially missing will notify their Unit Leader and other area staff to immediately confirm that the person is not in the area. The Unit Leader will provide the SMSS IMT with the following information:

- Name
- Age
- Sex
- Skin and hair color
- Clothing type and color
- Time last seen
- Photo, if available

SMSS IMT: The Logistics Section Chief, Communications Specialist, or their designee will:

- Notify the Operations Section Chief and Security Unit Leader (SUL) of the missing person and provide them with the missing person information
- Ensure that the SMSS IC and all other SMSS Unit Leaders are notified and request staff to assist with search if necessary or requested by the SUL

Security Unit Leader: SUL will immediately:

- Report to the affected SMSS area to interview staff collect information about what happened and,
- Dispatch on-shift Security Officers (SO) to establish restricted access to the SMSS with one entry/exit into the facility and begin a perimeter search
- Notify off-shift SOs of the potential need for their assistance and contact local law enforcement to assist if deemed necessary or if requested by the SMSS IC.

- Abduction: If abduction is suspected, the SUL will notify local law enforcement immediately

Search Operations Responsibilities

All SMSS Areas:

- Unit Leaders will:
  - Coordinate with CMO to identify staff not critical to patient safety and make them available to participate in searches of surrounding areas
  - Direct the search their unit areas
  - Report the results of their area searches back through their chain of command

SMSS IMT:

- SMSS Incident Commander will:
  - Contact the SEOC ESF8 Desk to report the event, provide current status, and request any necessary support needs
  - Coordinate with SEOC ESF8 Desk on plans to inform missing individual's family if person is not found in one (1) hour from start of search
  - At close of search, receive updated Unusual Event Form from Operations Section Chief and submit to the SEOC ESF8 Desk

- Operations Section Chief will:
  - Ensure that the Chief Medical Officer and AST Leader are notified
  - Complete an Unusual Event Form on the missing person report and makes copies for SMSS IMT
    - Include Unusual Event Form in next IAP that is sent to the SEOC ESF8 Desk and update until the search is concluded
  - In coordination with the CMO, direct additional staff to assist in search as requested by the Security Unit leader
  - Track the progress of the search
    - Coordinates with SMSS IC on plans to inform missing individual's family if person is not found in one (1) hour from start of search
  - At close of search, work with Security Unit Leader to update the Unusual Event Form and submit it to the SMSS IC

- Chief Medical Officer will:
  - Report to the affected SMSS area to evaluate situation and provide assistance as needed
  - Collect available data on missing person's family contact information and provides to the Operation Section Chief
  - Make rounds on all Patient Care areas and ensures that staff is aware of situation and has searched their area for the missing person

- Security Unit Leader will:

    - Coordinate with local law enforcement for additional support as necessary
    - Report to the affected SMSS area to interview staff, develop report, and report any additional information to the Operations Section Chief
    - If necessary, establish a command post and notify the Operations Section Chief of its location
    - Report status of search every thirty (30) minutes to the Operations Section Chief
    - At close of search, work with Operations Section Chief to update the Unusual Event Form

- Logistics Section Chief/Communications Specialist will:
    - Monitor all channels for information updates
    - Record search-related communications on the Communications Log

Evacuation

Purpose and Scope: To provide basic guidelines for action in the event that an operational SMSS facility has to conduct an external evacuation (planned or no-notice) or an internal evacuation (horizontal or vertical).

Planned Evacuations

Situation: Due to internal (e.g. expected loss of power) or external (e.g. expected rise of flood waters) circumstances the SMSS must be evacuated within a known but not immediate time period.

Decision to Evacuate: This decision will be made by NC-SERT in coordination with the SEOC ESF8 Desk. The potential negative impacts on patient health outcomes must be considered in any decision to evacuate. Depending on these impacts, it may be decided to shelter in place and provide additional assistance as needed to "ride out the storm" and continue operations as indicated.

Roles and Responsibilities: Once the decision to evacuate has been made the following actions must be taken:

SEOC ESF8 Desk will:

1. Identify secondary locations that meet the established need and support SMSS standards for operation
2. Request any additional resources (e.g. staff, material handling equipment, trucks, etc.) necessary to relocate the SMSS within the available time window

SMSS IMT will:

1. Provide the SEOC ESF8 Desk with the following minimum information:
    a. Number of ambulatory and non-ambulatory patients (to identify needed patient transportation units)
    b. Number of additional staff required
    c. Material-handling equipment needs (forklifts, trucks, etc.)
    d. Staff transportation needs
    e. Estimated time it will take to prepare patients, staff, and equipment for evacuation
2. Develop an evacuation IAP and brief all SMSS Unit Leaders
3. Direct the packing and loading of SMSS equipment and supplies
4. Coordinate the staging of patient transportation units as close as possible to the SMSS if the designated patient drop-off/pick-up area is unsafe

SMSS Unit Leaders will:

1. Ensure that all patients under care in their areas are packed and staged for quick movement to available patient transportation units

a. Staff assigned to accompany patients will ensure that the patient's medications, DMEs, and Medical Records are with the patient and that these items are tagged with the patient's name

2. Ensure that all area supplies, and equipment are packed and loaded onto the SMSS Trailer they came from under the direction of the Logistics Section Chief

SMSS Patient Care Unit Leader (Charge Nurse) will:

1. Ensure that the Patient Care area maintains a limited operational capability until all patients are transported from the SMSS facility
2. Document what transportation unit transported each patient and what facility the patient is moved to. This document must be verified by the Operations Section Chief before the Charge Nurse leaves the SMSS facility

No-Notice Evacuations

Situation: Due to internal (e.g. fire) or external (e.g. flash flood) circumstances the SMSS must be evacuated immediately.

Decision to Evacuate: This decision will be made by SMSS IC in coordination with the SEOC ESF8 Desk. The potential negative impacts on patient health outcomes must be considered in any decision to evacuate. Depending on these impacts, it may be decided to shelter in place and provide additional assistance as needed to "ride out the storm" and continue operations as indicated.

Roles and Responsibilities: Same as for Planned Evacuations. Immediate life safety concerns are the priority, patients must be moved rapidly. Non-ambulatory patients may need to be moved in their beds or on litters with four-person carries. Semi-Ambulatory patients may be evacuated in wheelchairs if available.

Horizontal Evacuations

Situation: The extent of the hazard (e.g. fire, loss of power, etc.) is limited and does not affect the entire facility housing the SMSS. Evacuation of a portion of the SMSS may need to happen immediately or within a known time period.

Decision to Evacuate: Same as for No-Notice Evacuations.

Roles and Responsibilities: Same as for Planned Evacuations. Patients must be moved as quickly as possible to protected areas of the facility (e.g. areas beyond firewalls, areas with functioning HVAC, etc.).

Vertical Evacuations

Situation: Same as for Horizontal Evacuations.

Decision to Evacuate: Same as for No-Notice Evacuations.

Roles and Responsibilities: Same as for Planned Evacuations. For patients being moved from areas above a first floor, SMSS staff should utilize any vertical evacuation equipment available (e.g. stair-chairs, etc.). For larger, non-ambulatory patients, the use of four-person carries with the patients secured on a bed/litter using 9 ft. straps or sheets folded in 4-6 inch straps may be necessary.

North Carolina Emergency Operations Plan (NCOEMS EOP)
ANNEX G: APPENDIX 13

State Coordinated Shelter (SCS) Medical Support Plan

March 2022

Table of Contents

Introduction

Medical support of public sheltering starts at the local level and is driven by local emergency medical response and recovery needs. However, in anticipation of, or as the result of, a catastrophic event that may overwhelm, or has overwhelmed the capabilities of local governments to provide public sheltering, a State-Coordinated Shelter (SCS) may be opened. SCSs may be established when sheltering for evacuees is no longer available within the mutual-aid host county shelter system. Establishment of an SCS is initiated by local government request to the State Emergency Operations Center (SEOC) and with coordination from North Carolina Division of Emergency Management's Regional Coordination Center (NCEM-RCC) representing the risk counties requiring shelter support.

As identified in the North Carolina Emergency Operations Plan, NC DHHS is the lead agency in North Carolina for Human Services. As such, the Human Services Branch of the State Emergency Response Team (SERT) and NC DHHS lead, and work collaboratively at the state-level, to direct and support the establishment and operation of SCS locations. The Emergency Services Branch of the SERT and, in particular, the North Carolina Office of Emergency Medical Services (NCOEMS), coordinates the medical support for established SCS locations.

Purpose

To provide direction for the establishment of medical support operations to SCS established by the SERT for the purpose of ensuring the continuity of healthcare for sheltered individuals.

Scope

This plan provides an overview of expected roles, responsibilities, and covers the activation, organization, and management of medical support operations for established SCSs by the North Carolina Office of Emergency Medical Services, Healthcare Preparedness Program (NCOEMS-HPP), Healthcare Coalitions (HCC), and other state and local emergency medical services organizations to meet its purpose. It should be used in conjunction with the NCEM State-Coordinated Sheltering Plan and the NCOEMS-HPP Emergency Operations Plan.

Situation

Activation of this plan is most likely to occur during or following catastrophic natural or human-caused events. In these events, various situations could arise requiring the establishment of SCSs and the subsequent provision of medical support services to the individuals sheltered:

- A significant number of localities are impacted by an event and many residents and/or visitors are displaced, and the event has rendered local sheltering infeasible in the impact area

- Evacuation orders have been implemented and coastal counties have activated the Coastal Regional Evacuation and Sheltering (CRES) Plan, but available host county shelters have been identified as being at or near capacity

- After evacuations, host county shelters that are schools have to return to normal operations within their communities thus requiring the closure of those shelters and the establishment of a SCS to house the evacuated population until re-entry to their home counties is possible

Planning Assumptions

- The provision of medical services to sheltered populations is essential to maintain their health and well-being under circumstances which are stressful and conducive to the spread of illness. These services provide a continuity of care and maximize the possibility of good health outcomes for sheltered individuals

- The medical needs of sheltered populations will include individuals, with or without accompanying caretakers, that need some assistance to meet their daily needs including those that are or are affected with:
    - Oxygen dependent
    - Self-ambulating, with or without Durable Medical Equipment (DME), including wheelchair
    - Deaf/Hard of hearing and blind/low vision, with or without assistive devices
    - Diabetes, insulin and diet-controlled
    - Hypertension-controlled with medication
    - Respiratory illness (such as COPD) on daily oxygen
    - Morbidly obese
    - Pregnancy requiring bedrest
    - Dialysis patients

- The bulk of medical services required to meet the medical needs of sheltered populations, beyond health checks during in-processing (initial triage), will involve on-site basic life support and first aid however, the coordination of other health services such as pharmaceutical, telemedicine, and dialysis services, and transportation to health services outside the shelter will also be needed

- The magnitude of medical services needed to support SCS operations will be determined by the significance and duration of an emergency or disaster

- The capacity to meet the magnitude of medical support services needed depends primarily upon the size of the sheltered population and the State's ability to establish SCS operations. In overwhelming circumstances, emergency medical service resources from outside of North Carolina may need to be requested

- Staffing of SCS medical support services will be provided through the NCOEMS Healthcare Preparedness Program (NCOEMS-HPP), regional Healthcare Coalitions (HCC), and other state and local emergency medical services organizations. However, personnel and services from areas affected by the disaster will not be utilized

- Just-in-time training may be needed for personnel who do not normally conduct medical support services in public shelter environments

Concept of Operations

Authority, Mission, and Objectives

Authority: Pursuant to Chapter 166A, North Carolina Emergency Management Act, the North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency responsible for Disaster Medical Services and is managed through the Healthcare Preparedness Program (HPP). NCOEMS has primary responsibility for the coordination of these services during disasters.

North Carolina State-Coordinated Regional Shelter Plan (NCSCRSP) specifically tasks NCOEMS with the coordination of medical support to established SCS locations.

Mission: To provide basic medical support and access to area healthcare services to evacuees housed in large, regional shelters established and managed by North Carolina Emergency Management.

Objectives: Key objectives in support of this mission include:

- Providing NCOEMS liaisons to participate as members of SCS Incident Management Teams (SCS IMTs) as Medical Services Supervisors over the Medical Branch of established SCSs

- Providing medical support services within the SCS Medical Branch including, but not limited to:
    - On-Site Basic Life Support and First Aid (includes Initial Triage)
    - Telemedicine Coordination
    - Pharmaceutical & Dialysis Coordination
    - Medical Transportation
    - Medical Logistics

- Providing staffing for these services by whatever means practical to include agency personnel, county personnel who volunteer to deploy via NCOEMS and out-of-state personnel via EMAC to serve under Operations in the roles of Medical Services Coordinators and Medical Services Workers

- Ensuring that personnel identified to meet staffing requirements complete required training, licensing, or credentialing as prescribed by NCOEMS

- Tracking and reporting status of all resources assigned to medical support services as requested by the SERT

SCS Types and Capacities: Configuration of an SCS is flexible and tailored to accommodate up to 2000 individuals, based on the scope of incident and needs of the local jurisdiction. The three defined types of SCS:

- 500 Shelter – 500 individuals
- 1000 Shelter – 1000 individuals
- 2000 Shelter – 2000 individuals

SCS may be established up to three days prior to impact of weather-related events, such as hurricanes and/or tropical storms, or as requested for local incidents that require evacuations or relocation.

Alert, Notification, and Activation

Decisions to alert NCOEMS, and, if necessary, activate SCS operations will be made by the SERT Incident Commander, or their designee, through the NCEM Human Services Branch Manager. Decisions will be based on either projected disaster impacts (e.g., hurricanes at -120 hours to landfall) or the ability of local jurisdictions to maintain operations of shelters that have already been established.

Upon the initial alert notification from the NCEM Human Services Branch Manager, the ESF8 Lead, or their designee, will activate the NCOEMS Emergency Operations Plan (NCOEMS-EOP) and this plan and begin coordinating staffing and resource planning accordingly in the event the decision is made to open an SCS.

Staffing and Organization

The ESF8 Lead and/or staff assigned to the Support Cell will work in collaboration with the NCEM Human Services Branch Manager, the designated SCS Coordinator, and Healthcare Coalitions, to identify and provide appropriate medical personnel and assets to meet the medical services requirements for the Medical Branch of the established SCS.

Staffing: Staffing for an SCS Medical Branch will include the following positions as outlined in the North Carolina State-Coordinated Regional Shelter Plan (NCSCRSP):

- Medical Services Supervisors
- Medical Services Coordinators
- Medical Services Workers

The number of individuals needed to fill these positions will be dictated by the operational situation and the type of shelter being established. However, it is recommended that basic medical and medical transportation support for each type of SCS should consist of:

- 500 Shelter - One (1) ambulance and two (2) EMS personnel
- 1000 Shelter – Two (2) ambulances and four (4) EMS personnel
- 2000 Shelter – One (1) Ambulance Strike Team (five (5) ambulance and ten (10) EMS personnel)

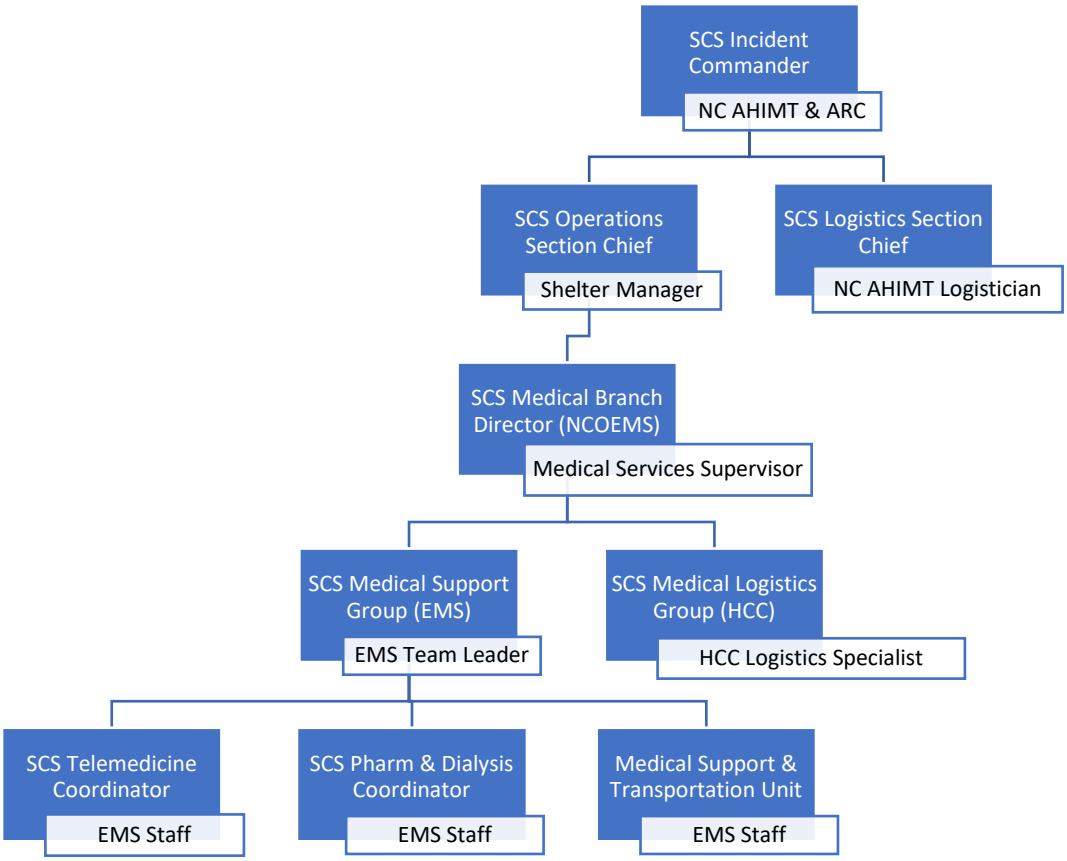
Also, the emergency management credentials, and medical qualifications of personnel needed to fill these positions will be congruent with the NCSCRSP. These requirements are detailed further under **Appendix 1: SCS Medical Branch Staffing Matrix** and **Appendix 2: SCS Medical Branch Job Qualification and Action Sheets**.

Personnel designated to fill these positions may serve in a variety of functional roles necessary to fulfill the responsibilities of an SCS Medical Branch and will be sourced from personnel affiliated with State Medical Response System (SMRS) organizations including NCOEMS, Healthcare Coalitions (HCC), and Ambulance Strike Teams (ASTs). Medical personnel from EMS agencies, local to the SCS site, may also be utilized if they are available.

- Medical Services Supervisors
    - Medical Leads - Filled by NCOEMS
- Medical Services Coordinators
    - Telemedicine Coordination – Filled by supporting EMS/AST
    - Prescription & Dialysis Coordination – Filled by supporting EMS/AST
- Medical Services Workers

- Medical Support & Transportation – Filled by supporting EMS/AST
- Medical Logistics – Filled by designated Healthcare Coalition

SCS Medical Branch Organizational Chart



Medical Support Services

MEDICAL LEADERSHIP – Responsible for overseeing all medical services operations including assignments of staff and communication with Shelter Manager and larger Incident Management Team about supply needs and medical support needs. Acts as the Medical Services Supervisor for the SCS Medical Branch.

ON-SITE BASIC LIFE SUPPORT AND FIRST AID - Provides on-site basic life support and first aid care for sheltered individuals. Includes the performance of health checks at registration (initial triage) and periodically following registration, identification of and assistance with personal care needs if necessary, such as assistance with administering medications or operating medical equipment. Maybe fulfilled by a full or partial Ambulance Strike Team (AST), at minimum, by one Basic Life Support ambulance. Supported by the Medical Support and Transportation Unit.

TELEMEDICINE COORDINATION – Coordinates the delivery of telemedicine services to sheltered individuals within the SCS. This may include assisting them with scheduling and use of the services available. Supported by the SCS Telemedicine Coordinator.

PHARMACEUTICAL & DIALYSIS COORDINATION - Assists sheltered individuals with coordination of pharmaceutical and dialysis services outside the SCS. This may include assistance with the replacement and delivery of prescription medications, scheduling of appointments, and transportation (medical or non-medical) to these services. Supported by the SCS Pharmaceutical & Dialysis Coordinator.

MEDICAL TRANSPORTATION – Provides transportation to local emergency departments and other healthcare facilities to sheltered individuals with an emergent need. May also assist with transportation to healthcare facilities to cover non-emergent healthcare needs of sheltered individuals where local non-medical transportation services are not in service or otherwise unavailable. Maybe fulfilled by a full or partial Ambulance Strike Team (AST), at minimum, by one Basic Life Support ambulance. Supported by the Medical Support and Transportation Unit.

MEDICAL LOGISTICS – Provides a limited inventory of medical supplies including durable medical equipment (DME) to Medical Branch staff for the purpose of meeting the needs of sheltered individuals. If the appropriate medical supplies are not available on-site, works with the Medical Lead and the SCS Logistics Section Chief to facilitate the ordering and delivery of needed medical supplies following established procedures. Supported by the SCS Medical Logistics Group.

PERSONAL MEDICAL SUPPLIES (pharmaceuticals, devices, etc.) – Sheltered individuals for whom medications, devices, and supplies have been prescribed, may bring those items necessary for health maintenance with them to the shelter. These items will remain under the ownership and cognizance of the individual(s) to whom they belong.

Appendices

APPENDIX 1: SCS MEDICAL BRANCH STAFFING MATRIX

Shelter Type	Position	# Day Shift	# Night Shift
500	Medical Services Supervisor	1	1
	Medical Services Coordinator	1	0
	Medical Services Worker	4	3
1000	Medical Services Supervisor	2	2
	Medical Services Coordinator	2	0
	Medical Services Worker	8	6
2000	Medical Services Supervisor	3	3
	Medical Services Coordinator	3	0
	Medical Services Worker	12	9

APPENDIX 2: SCS MEDICAL BRANCH JOB QUALIFICATION AND ACTION SHEETS

SCS MEDICAL LEAD

Organization: NCOEMS
Selected by: NCOEMS ESF8 Lead

Supervised by: SCS Operations Section Chief (Shelter Manager)
Recommended credentials: MD/PA/RN/EMT-P

Works in the role of a Medical Services Supervisor. Responsible, for overseeing all medical services operations including assignments of staff and communication with Shelter Manager and larger Incident Management Team about supply needs and medical support needs. Job actions may include:

- Acting as Pre-Deployment Lead to assist NCEM with shelter site selection and conduct hazard vulnerability assessments of selected sites
- Conducting medical needs assessments of shelter sites
- Communicating medical support and logistics needs to the ESF-8 Lead
- Selecting and directing the setup of medical treatment areas
- Coordinating information exchange between the Shelter IMT and the Medical Branch
- Coordinating the identification of medical logistics needs and acquisitions to fill identified needs between the SCS Logistics Chief and the Medical Logistics Specialist
- Directing the activity of the assigned Ambulance Strike Team (AST) and their personnel assigned to coordinate medical services and provide medical support

SCS Telemedicine Coordinator

Organization: Assigned EMS Medical Staff
Selected by: SCS Medical Lead & EMS/AST Leader

Supervised by: SCS Medical Lead (Medical Services Supervisor)
Recommended credentials: EMT

Works in the role of a Medical Services Coordinator. Responsible for coordinating the delivery of telemedicine services to sheltered individuals within the SCS. Job actions may include:

- Coordinating with designated telemedicine providers to provide services
- Assisting sheltered individuals with scheduling and use of the services available
- Making appointments for sheltered individuals to utilize telemedicine, if necessary
- Taking vital signs and reporting that information to a Telemedicine Doctor
- Reporting to Medical Lead on the daily usage of the service

SCS Pharmaceutical & Dialysis Coordinator

Organization: Assigned EMS Medical Staff
Selected by: SCS Medical Lead & EMS/AST Leader

Supervised by: SCS Medical Lead (Medical Services Supervisor)
Recommended credentials: EMT

Works in the role of a Medical Services Coordinator. Responsible for assisting sheltered individuals with coordination of pharmaceutical and dialysis services outside the SCS. Job actions may include:

- Assisting with the replacement and delivery of prescription medications
- Scheduling and tracking of dialysis appointments
- Coordinating with the Telemedicine Coordinator to obtain patient prescription needs
- Coordinating with the Medical Lead on the daily dialysis needs
- Coordinating with the Medical Support & Transportation unit on medical transportation for scheduled services

SCS Medical Support & Transportation Specialist

Organization: Assigned EMS Medical Staff
Selected by: SCS Medical Lead & EMS/AST Leader

Supervised by: SCS Medical Lead (Medical Services Supervisor)
Recommended credentials: EMT

Works in the role of a Medical Services Worker. Responsible for providing on-site basic life support and first aid care for sheltered individuals and providing transportation to local emergency departments and other healthcare facilities to sheltered individuals with an emergent need. Job actions may include:

- Performing health checks to sheltered individuals at registration and periodically after that in coordination with the SCS Medical Lead
- Identifying and assisting sheltered individuals with personal care needs if necessary, and including the administration of medications or operation of medical equipment
- Assisting sheltered individuals with transportation to healthcare facilities to cover non-emergent healthcare needs where local non-medical transportation services are not in service or otherwise unavailable
- Setting up and maintaining medical treatment areas for sheltered individuals and staff as directed by the SCS Medical Lead

SCS Medical Logistics Specialist

Organization: Assigned HCC (usually HCC in same region as SCS)
Selected by: NCOEMS ESF8 Lead & HCC Healthcare Preparedness Coordinator

Supervised by: SCS Medical Lead (Medical Services Supervisor)
Recommended credentials: HPP Logistics Specialist

Works in the role of a Medical Services Worker. Responsible for providing a limited inventory of medical supplies including durable medical equipment (DME) for the purpose of meeting the needs of sheltered individuals. Job actions may include:

- Assisting the SCS Medical Lead with shelter site assessments and development of initial medical needs
- Coordinating the setup of designated medical treatment areas with the SCS Medical Lead and Medical Support Specialists
- Providing and maintaining medical supplies and Durable Medical Equipment (DME) for designated medical treatment areas
- Coordinating with the SCS Medical Lead and the SCS Logistics Section Chief to facilitate the ordering and delivery of needed medical supplies and equipment following established procedures