MHPC

METROLINA HEALTHCARE PREPAREDNESS COALITION

Healthcare Coalition Response Plan
Metrolina Healthcare Preparedness Coalition
January 1, 2020

Record of Changes

Date of Change	Description of Change	Change made by
1/30/19	Updated Contact Information	H. Gompers
6/30/19	-Updated staff contact information -Included list of Mass Fatality Supplies. -Everbridge added to Communications Resources	H. Gompers
10/7/19	EEI Annex Added/COOP Added	H. Gompers

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1. INTRODUCTION

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
1.1 Purpose of Plan	2.1.2	**Introduction:** This plan describes the roles and responsibilities of the Metrolina Healthcare Preparedness Coalition (MHPC) in responding to health care emergency events in Anson, Burke, Catawba, Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Richmond, Stanly, Scotland, and Union counties in North Carolina. **Purpose:** The purpose of this plan is to provide general guidelines for response to natural and manmade events that endanger the patients, visitors, staff, and family members of medical healthcare facilities within the Metrolina region.	
1.2 Scope	N/A	The purpose of the Metrolina Healthcare Preparedness Coalition is to facilitate the coordination and cooperation throughout the Metrolina region in order to help partners can mitigate against, prepare for, respond to, and recover from emergent health and medical events. Members of the Metrolina Healthcare Preparedness Coalition including regional hospitals, EMS agencies, Public Health, County Emergency Management, and Continuing Care/Long-Term Care facilities. In addition, the Metrolina Healthcare Preparedness Coalition works in accordance with guidance from ASPR and NCOEMS-HPP.	

1.3 Situation and Assumptions		• A member organization or the community as a whole can be affected by an internal or external emergency situation that has impacted operations up to and including the need for a facility to evacuate • Impacted facilities have activated their emergency operations plans, and have staffed or have begun staffing their facility emergency operations center • Healthcare organizations will report status on situational awareness, to include facility bed status, but will assume to be able to handle the incident on their own as much as possible before asking for assistance • Incidents must be managed at the lowest possible jurisdictional level and supported by additional capabilities from the next higher tier when needed. • Response to an event may be initiated at any level of organization and should follow the plans, policies, and procedures applicable at the level of response. • Healthcare organizations will take internal steps to increase patient capacity and implement surge plans before requesting outside assistance • Processes and procedures outlined in the response plan are designed to support and not supplant individual healthcare organization emergency response efforts.	
1.4 Administrative Support	1.3 2.1.2	This plan requires the approval of the membership of the Metrolina Healthcare Preparedness Coalition and may be reviewed/approved by the elected MHPC Steering Committee. The plan will be reviewed and approved on a yearly basis by the MHPC staff, Steering Committee, and	

		any other member within the Coalition that wishes to participate in the review. During the review of this plan, MHPC staff and Steering Committee members will identify and gaps within the plan and define strategies to address the gaps on a regional level. Changes to MHPC Response Plan can be found on Page 2 in the Record of Changes table.	

2. CONCEPT OF OPERATIONS

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources
2.1 Introduction	1.3 2.1.2	In accordance with National Incident Management System (NIMS) principles and guidance provided by the Assistant Secretary for Preparedness and Response (ASPR) concerning medical surge capacity and capability, the healthcare partners and coalitions in North Carolina utilize a tiered structure for response and recovery operations. To provide a reliable framework for healthcare partners, coalitions, and the SMRS to prepare for, respond to, and recover from, a disaster or major event. Response goals of the Metrolina Healthcare Preparedness Coalition are to:	Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)

		• Facilitate information sharing among healthcare organizations and jurisdictional authorities to promote common situational awareness. • Facilitate resource support by expediting the mutual aid process or other resource sharing arrangements among Coalition members, and supporting the request and receipt of assistance from local, State, and Federal authorities. • Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response. • Facilitate the interface between the Healthcare Coalition and relevant jurisdictional authorities to establish effective support for healthcare system resiliency and medical surge.	
2.2 Role of the Coalition in Events		The Emergency Response Plan/Regional Healthcare Support Cell of the Metrolina Healthcare Preparedness Coalition operates as an extension of the North Carolina Office of Emergency Medical Services, Healthcare Preparedness, Response, and Recovery Program (NCOEMS-HPR&R). As such, it serves as the initial and primary center for the coordination of State Medical Response System (SMRS) information and resources at the regional level in fulfillment of the Coalition's stated response goals. • The Regional Healthcare Preparedness Coordinator (HPC) or their designee has the authority to implement this plan. However, the coordination of health and	

		medical support outlined in this plan will not supersede the municipal, county or state emergency operation plans or institutional plans, nor will it direct local agency efforts. In addition, the MHPC assumes the roles of the following during an emergency or disaster: • Support evacuation activities • Support Shelter-in-Place activities • Assist with the local EOC and serve as the intermediary for healthcare and information sharing • Assist with resource request and facilitation between partner entities and other NC Coalitions • Promote response strategy coordination • Promote integration into the community emergency response *It is anticipated that many activities of the RHSC may be performed "virtually" outside of this physical location utilizing telephone, radio, e-mail, and other computer-based communications systems available.*	
2.2.1 Member Roles and Responsibilities		Core Members of the Metrolina Healthcare Preparedness Coalition include: • **Hospitals** o Hospitals are expected to share information with the MHPC and with other partners as it pertains to the incident or event that will or has occurred. Hospitals are expected to share resources	Appendix B: Additional HCC Members and Contact Info

		amongst themselves before reaching out to the MHPC for resource support ○ It is the responsibility of the hospital to report an incident to the MHPC Duty Officer. In addition, it is the hospital's responsibility to request Coalition Staff support in the facility EOC. • **Public Health** ○ Public Health agencies are expected to share information with the MHPC and with other partners as it pertains to the incident or event that will or has occurred. Public Health agencies are expected to share resources amongst themselves before reaching out to the MHPC for resource support ○ Public Health agencies are expected to assist with the SNS • **EMS** ○ EMS agencies are expected to share information with the MHPC and with other partners as it pertains to the incident or event that will or has occurred. EMS agencies are expected to share resources amongst themselves before reaching out to the MHPC for resource support ○ EMS agencies within the Metrolina Region are also expected to provide staff and equipment in the event and Ambulance Strike Team (AST) is requested by the ESF8 Desk • **Emergency Management Agencies** ○ Emergency Management agencies are expected to share information with the MHPC and with other partners as it pertains to the incident or event that	

		will or has occurred. It is the responsibility of the Emergency Management agency to contact the MHPC Duty Officer in the event a Coalition Staff Member is needed to assist at the EOC. Emergency Management agencies are expected to share resources amongst themselves before reaching out to the MHPC for resource support • **Long-Term Care Facilities** ○ Long-Term Care Facilities (Skilled Nursing, Assisted Living, Hospice, Home Health, Dialysis, PRTF, FQHC) are expected to share information with the MHPC and with other partners as it pertains to the incident or event that will or has occurred. Long-Term Care Facilities are expected to share resources amongst themselves before reaching out to the MHPC for resource support, including but not limited to: patient transportation, staff, bed availability, medical equipment. ○ It is the expectation of MHPC that Long-Term Care Facilities will create MOUs with other like-type facilities in order to better facilitate actions before, during, or after an emergency A list of additional Coalition Members can be found in Appendix B: Additional Coalition Members	

	Applicable Health Care Preparedness and Response Capability	Description and Considerations	Resources

2.2.2 Coalition Response and Organizational Structure		The organizational structure of the Coalition can be found in Appendix C: MHPC Organizational Chart
		
		The following key positions must be staffed during a Coalition Response:
		• Duty Officer
		  ○ Receive initial incident information and share with team, leadership, and the NCOEMS Shift Duty Officer
		  ○ Determine if the Healthcare Information Sharing System is activated
		  ○ Assumes responsibility and decision-making in regard to the incident occurring and the Coalition's response (decisions must be shared with the HPC prior to activation)
		• Healthcare Information Sharing System/EOC Lead
		  ○ Respond as requested by the local EOC to represent local and regional healthcare infrastructure (primarily hospitals and licensed care facilities)
		  ○ Support local EMS and Public Health as needed
		  ○ Function as the liaison between local and regional healthcare infrastructure and local emergency management or the local EOC.
			Appendix C: MHPC Organizational Chart
			
			Appendix D: MHPC Continuity of Operations Plan

		○ Coordinate information on local and regional healthcare infrastructure operating status ○ Communicate and coordinate healthcare infrastructure resource requests • Operations Lead ○ Coordinate and prioritize the reception of resources requests from regional or state partners ○ Assist with deployment of resources as requested ○ Establish and maintain accountability for operations, logistics and support staffing ○ Assist with reaching out to regional partners to obtain status updates or additional information or delegate to additional personnel as needed ○ For missions requiring SMAT volunteers, initiate Everbridge messaging using appropriate template • Logistics Lead ○ Ensure readiness of appropriate equipment for current or potential mission(s) ○ Report any out of service equipment/resources and potential for corrective actions ○ Work with operations to determine the need for the recall of any previously deployed resources ○ Physically deploy items to location or assist with pick up at the MHPC warehouse ○ Maintain accurate tracking of deployed resources by updating Excel resource tracker ○ Provide any just-in-time training needed for deployed resources ○ Establish and maintain a process for tracking the use of disposable inventory	

		○ Establish and maintain a process for restocking disposable inventory/supplies ○ Receive resource requests from operations and prepare for deployment	
2.3 Response Operations		If the Response Plan/RHSC is activated, the assigned staff will facilitate the execution of health/medical resource and information requests and perform the following operations as tasked and in coordination with appropriate emergency management agency and NCOEMS-HPR&R: 1. Monitor (continue to monitor) communications systems for to maintain situational awareness and requests for resources. 2. Facilitate (continue to facilitate) mutual aid/requests for health/medical resources as necessary. 3. Participate in NCOEMS-HPR&R conference calls at 1100, if SEOC ESF-8A Desk is activated or as otherwise scheduled by NCOEMS-HPR&R 4. Complete, submit, and post the ESF-8A Situation Report at 0700 and 1900. **5.** Activate and deploy functional SMRS teams/assets as tasked through the SEOC ESF-8A Desk and/or NCOEMS-HPR&R.	Appendix E: MHPC Resource Request Process Appendix F: Healthcare Information Sharing System Plan (HISS) Appendix G: SMRS Team Activation and Deployment
2.3.1 Stages of Incident Response	1.2.1	The stages of incident response for MHPC include the following: • Initial notification of event from regional partner or state partner to MHPC Staff member or MHPC Duty Officer	

		○ Duty Officer or Staff Member should inquire about potential resources needed and if facility is going to shelter-in-place based on the incident ○ Duty Officer or Staff Member should also direct facility/partner to contact their County Emergency Manager to let them know about the incident • Team meeting about event and information that is available • MHPC Duty Officer will contact the NCOEMS Shift Duty Officer with information about the event and what the facility is requesting • If resources are requested and can be fulfilled by MHPC, the Operations/Logistics leads will handle the request • If the resources or personnel are above what MHPC can handle, MHPC is to let the facility know they must reach out to County Emergency Management for their assistance ○ If County Emergency Management is unable to handle the request, they may make a formal request for resources or personnel to the ESF8 Desk.	
2.3.1.1 Incident Recognition		The MHPC will be notified or become aware of an event through the following: • Hospital or Healthcare System Coordination Calls • Direct Communications (emails, Everbridge messages, text messages) • WebEOC/NC Sparta entries • Regional Healthcare Conference Calls • State-Level Conference Calls Potential triggers to activate the MHPC Emergency Response Plan and Healthcare Information Sharing System include:	

		• Potential or currently occurring infrastructure issue impacting the facility/agency (Examples: fire, power failure, chiller failure, phone/radio failure, etc) • Potential or currently occurring clinical issues that might require outside assistance (Examples: MCI/Surge, ED Closure, equipment shortages) • Expected or Unexpected opening of the organization's EOC or Command Center • A significant event or disruption of service is planned which could require action on the part of the Coalition and/or its partners. • Any issue where assistance may be needed in communicating an organization's situation to the Region/State (Examples: Situation reporting to partners on local and state levels) • Multi-jurisdictional incident or outbreak • An incident large enough to require resource sharing including SNS deployment, epidemiological investigation, facility evacuation • A request to activate or monitor by a Coalition partner	
2.3.1.2 Activation		The MHPC Response Plan may be activated by the following: • NCOEMS Duty Officer or Program Manager • Metrolina Healthcare Preparedness Coordinator • MHPC Duty Officer – with permission of the HPC • Any Coalition member may request that the Response Plan be activated, but it is at the discretion of the HPC to activate it	Appendix H: RHSC/HISS Activation

		Response Plan Operating Levels: • See Appendix G for full details of Operating Levels	
2.3.1.3 Notifications		During the activation of the MHPC Response Plan/RHSC, notifications may be sent to regional and state partners by the following: • HPC or designee of HPC • MHPC Duty Officer Notification process and systems used: • Healthcare System Conference Calls • Direct Communications – text, email, Everbridge platform • WebEOC/NC Sparta – SMRS Dashboard, Hospital Dashboard, Coalition SitReps • Regional Healthcare Calls • State-Level Healthcare Calls Notifications sent during Response Plan activation includes: • High-level situational overview • Specific impacts to a healthcare system • Pertinent situational updates specific to the agency/organization • Requests for resources, personnel, or additional assistance	
2.3.1.4 Mobilization		Refer to Appendix G for Activation Levels and Mobilization Plan	Appendix G: RHSC/HISS Activation
2.3.1.5 Incident Operations			
2.3.1.5.1 Initial HCC Actions		• Establishing points of contact with jurisdictional authorities and other entities involved in the response for a particular incident	

		• Gathering initial information from regional and state partners, and sharing with responding HCC members • Establishing the operational period • Establish the necessary incident management structure • Notify NCOEMS Shift Duty Officer of incident	
2.3.1.5.2 Ongoing HCC Actions		• Function as a liaison between local and regional healthcare infrastructure and local emergency management or the local EOC • Support region with Resource Requests • Coordinate information on local and regional healthcare infrastructure operating status	Appendix D: MHPC Resource Request Process
2.3.1.5.3 Information Sharing	2.2.1 2.2.3 2.3.3 2.3.4	Information sharing/management, information sharing procedures, and communications can be found in the Health Information Sharing System Plan in Appendix E.	Appendix E: Healthcare Information Sharing System Plan (HISS)
2.3.1.5.4 Resource Coordination	3.3.1 3.3.2	• Equipment and supply cached • Inventory Access • Inventory Management Process • Inventory Storage • Inventory Movement • Inventory Resupply/Replacement	Appendix D: MHPC Resource Request Process Appendix D, Att 4: MHPC Resource List Appendix J: Inventory Rotation Process
2.3.1.5.5 Patient Tracking		Patient Tracking System: MHPC utilizes the patient tracking system provided by NCOEMS/ESF-8. The system is able to track patients from initial	

		contact to the area or hospital they have been transferred to. Information can be seen by all who are involved in the event with the proper access to the system.
		
		Triggers for Patient Movement Plan:
		• The need for patient distribution from a Long-Term Care Facility
		• Hospital decompression or evacuation
		• Major MCI patient distribution
		• Patient reception from another county, region, or state
		
		Patient Movement Process:
		• MHPC receives notification from one of the following:
		  ○ Directly from impacted facility in the region
		  ○ Local EMS or EM on scene
		  ○ In-Region Transfer Center
		  ○ NCOEMS/ESF-8 Desk
		  ○ Another Coalition or their Transfer Center
		• MHPC initiates conference calls with participating Transfer Center Supervisors/Leads
		  ○ Attendees
		  ▪ Atrium Physician Connection Line
		  ▪ Novant Doctors Line
		  ▪ NCOEMS HPP Shift Duty Officer
		  ○ Purpose
		  ▪ Situational overview
		  ▪ Assign needs based on requests/situation
		  ▪ Establish a follow-up/report-back all
		• If needed, MHPC initiates a conference call with regional EMS/Transport Programs
		  ○ Attendees	

		▪ Local EMS/AST Services ▪ MedCenter Air/FlightWatch ▪ Novant CCT ▪ If needed, CHS Events Medicine (for trucks) ▪ NCOEMS Shift Duty Officer o Purpose ▪ Situation overview ▪ Determine resource availability ▪ Obtain initial response commitment ▪ Evaluate resource commitments for a protracted event ▪ Response planning: • Coordinating agency/person • Communications plan • Staging location • MHPC will work with receiving hospitals in the region to help place patients based on bed availability and patient acuity	
2.3.1.6 Demobilization		*RHSC/HISS Deactivation:* When the RHSC's incident-related responsibilities have ceased as determined by the HPC or their designee, deactivation activities may be initiated. • **Resources:** RHSC staff should begin process for the return any mobilized/deployed resources to their original locations. • **Notifications:** RHSC staff and other entities (hospitals, EMA, health departments, etc.) contacted at the beginning of the event may need to be contacted once again regarding event deactivation details. This should be done through the most effective method of communication available at the time.	Appendix H: SMRS Team Demobilization and Recovery

		• **Documentation:** Documentation on the details of the incident and the RHSC's response to the incident is a responsibility of the assigned Planning Section Chief, or RHSC staff as designated by the HPC. The event may also require a formal After-Action Review to be submitted by the Planning Section Chief to the HPC and/or OEMS. • **System Demobilization:** RHSC staff should ensure that all information entered on systems utilized during the incident (WebEOC/NC Sparta, etc.) is saved for documentation purposes and that these systems are restored to their pre-event status.	
2.3.1.7 Recovery/Return to Pre-Disaster State		**Healthcare Coalition Recovery Responsibilities** • Advocate for full health care service delivery restoration for member facilities and organizations within coalition boundaries • Advocate for members to receive priority infrastructure restoration and reconstruction • Replenish and demobilize regional supply caches maintained by the Coalition • Advocation for full restoration of information technology and communication systems • Assist in coordination between healthcare facilities and EMS Agencies/Transport Agencies for patient transport • Assist with public health service delivery with an emphasis on patients with special needs, at-risk populations, and individuals with functional needs • Prepare After-Action Reports, Corrective Action and Improvement Plans SMRS Demobilization and Recovery can be found in Appendix K	Appendix H: SMRS Team Demobilization and Recovery

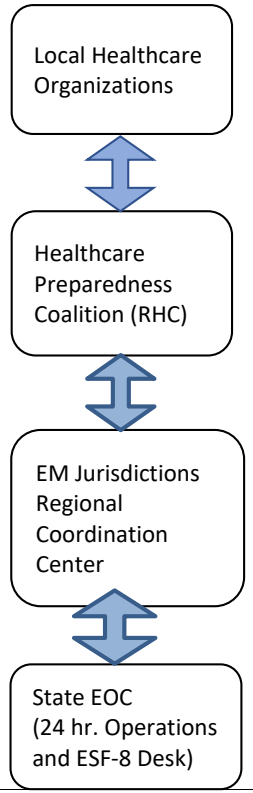
2.4 Continuity of Operations	3.2.2 3.2.3 3.6	• **Order of Succession and Delegation of Authorities** • **Continued Administrative and Finance Management** • **Evacuation, Shelter-in-Place**	*MHPC COOP will be drafted in FY 18-19*

3. APPENDICES

Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)
Appendix B: Additional HCC Members and Contact Information
Appendix C: MHPC Organizational Chart
Appendix D: MHPC Resource Request Process
- Attachment 1: Resource Request Process and Form
- Attachment 2: Health and Medical Resource Process Algorithm
- Attachment 3: Requesting NC SMRS Assets During an Emergency
- Attachment 4: MHPC Resource Listing

Appendix E: Healthcare Information Sharing System Plan (HISS)
Appendix F: SMRS Team Activation and Deployment
Appendix G: RHSC/HISS Activation
Appendix H: SMRS Team Demobilization and Recovery
Appendix I: Communications Plan
Appendix J: Inventory Rotation Process
Appendix K: MHPC Regional HVA 2017-2018

Appendix A: Overview of Health/Medical Support in the State Medical Response System (SMRS)

Overview of Health/Medical Support in the State Medical Response System (SMRS)		
Tier 1	**Organization:** Hospital, Nursing Home, Clinic, etc. **Level of Response:** Internal and mutual aid **Info Sharing**: Tier 2 **Resource Support:** Tier 2 (through Local EM).	
Tier 2	**Organization:** Healthcare Preparedness Coalition **Level of Response:** Local to State-wide (when SMRS activated) **Info Sharing**: Tier 3 & 4 **Resource Support:** Tier 2 & 4 (through ESF-8 Desk)	
Tier 3	**Organization:** Local/Region EM agencies **Level of Response:** Local to State-wide (when RCCs activated) **Info Sharing**: Tier 1-4 **Resource Support:** Tier 2 (Local) & Tier 4 (Regional)	
Tier 4	**Organization:** NCOEMS - HPR&R Program **Level of Response:** Regional to State-wide **Info Sharing**: Tier 2 & 3 **Resource Support:** Interstate (Region IV) & Federal	

Tier 1 – Local agencies and healthcare organizations that deliver "point of service" medical care within a municipal, geographic, or healthcare delivery area. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. Notify Tier **2 and/or 3 organizations of the event. Refer to** Notification-Process**.**
2. Execute internal plans and agreements to utilize their resources and the resources of their mutual aid partners to mitigate event hazards.
3. **Request additional support/resources, as necessary, to mitigate hazards and minimize the disruption of service within healthcare delivery area. Refer to** Section IV Assets and Resource Requests**.**

Tier 2 – Regional coalitions of healthcare partners that share health/medical information and resources within their established Healthcare Preparedness Region. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. **Notify appropriate Tier 3 and/or 4 organization(s) of the event. Refer to** Notification-Process.
2. Execute regional health/medical plans and agreements to:
   a. Share incident information,
   b. Exchange resource status information to support mutual aid,
   c. Interface with local/regional jurisdictional authorities to exchange information,
   d. Provide health/medical and logistic resources to support Tier 1 (local), Tier 2 (other coalitions), Tier 3 (local/regional emergency management jurisdictions), and Tier 4 (State ESF-8) organizations as necessary to mitigate event hazards.

Tier 3 – Local/regional agencies with jurisdiction over the impacted areas and overall responsibility for response/recovery and support operations. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. Notify appropriate Tier 2 and/or 4 organizations of the event.
2. Execute local/regional emergency operations plans and agreements to mitigate event hazards.
3. Coordinate, as appropriate, with Tier 1, 2, or 4 organizations for the provision of health/medical information and resources.
4. Receive, stage, and execute local/regional requests for health/medical support from Tier 1, 2, or 4 organizations

Tier 4 – State-level health/medical (ESF-8) organizations that support Tier 1-3 organizations by managing statewide and sub-State regional coordination of the healthcare response. In response to/recovery from emergency or disaster events, these organizations are expected to:

1. **Notify Tier 2 organizations of the event.**
2. Execute state health/medical plans and agreements to mitigate event hazards in coordination with Tier 2 and Tier 3 organizations.
3. C**oordinate, monitor, and support the sharing of health/medical information and provision of state-level ESF-8 resources within one or more Healthcare Preparedness Regions.**

Appendix B: Additional HCC Members and Contact Information

Attachment 1: Additional HCC Members

Behavioral Health Services
Alexander Youth Network
Children's Hope Alliance
Mecklenburg County DSS
Behavioral Health Charlotte/Davidson – Atrium Health
Metrolina Medical Reserve Corps
Dialysis Centers
Fresenius Dialysis
Federal Facilities
VA Outpatient Clinic - Charlotte
Home Health Agencies
Healthy at Home – Atrium Health
Local Public Safety Agencies
Cabarrus County Sheriff Department
Charlotte – Mecklenburg Police Department
Non-Governmental Organizations
Red Cross
Salvation Army
Outpatient Health Care Delivery
Novant Health – Outpatient Facilities
Schools and Universities
University of North Carolina – Charlotte
Central Piedmont Community College
Long-Term Care Facilities
PACE of the Southern Piedmont
Senior TLC – PACE Organization

Jessie Helms SNF – Atrium Health
Sardis Oaks SNF – Atrium Health
Huntersville Oaks – Atrium Health
Cleveland Pines SNF – Atrium Health
Stanly Manor SNF – Atrium Health
5-Star Senior Living
Aldersgate
Brian Center - Gastonia
Autumn Care Shelby
Brookdale Shelby
Clear Creek Nursing and Rehab
Covenant Village
House of Peace Family Care
Lakewood Continuing Care
Lincolnton Rehabilitation Center
Monroe Rehabilitation
Peak Resources – Cherryville/Shelby
Royal Park of Matthews
Sharon Towers
Southminster
Stanly Total Living Center
Summit Place of Mooresville
The Pines at Davidson
Trinity Ridge
White Oak Manor – Shelby/Kings Mountain/Rutherfordton
Hospice Agencies
Hospice of Scotland County
Hospice of Cleveland County
Hospice of Burke County
Hospice and Palliative Care Charlotte Region

	Novant Hospice
	Hospice of Union County – Atrium Health
	Hospice of Cabarrus County – Atrium Health
	Catawba Regional Hospice
	Hospice and Community Care
	Hospice of Stanly
	The Carolinas Center
Federally Qualified Health Centers	
	Gaston Family Health Services
	Rowan Cabarrus Family Health Clinics
Medical Examiners	
	Mecklenburg County Medical Examiner

Attachment 2: MHPC Contact Information

Address: Metrolina Healthcare Preparedness Coalition
3311-A Beam Rd
Charlotte, NC 28217

Staff:

Hannah Gompers Healthcare Preparedness Coordinator 704-579-4150 Hannah.gompers@atriumhealth.org	Kariena "KC" Bernesser Asst. Healthcare Preparedness Coordinator 704-258-8966 Kariena.bernesser@atriumhealth.org	Scott Hess Asst. Healthcare Preparedness Coordinator 704-221-2818 Michael.hess@atriumhealth.org	Mike Tessari Asst. Healthcare Preparedness Coordinator 704-351-8832 Michael.tessari@atriumhealth.org

Attachment 3: Partner Contact Information

Hospitals	***EMS Agencies***	***Emergency Management***	***Public Health***
Carolinas Healthcare System - Anson 2301 U.S. Highway 74 W Wadesboro, NC 28170 (704)994-4500	**Anson County EMS 605 McLaurin St Wadesboro, NC 28170 (704) 694-5342**	**Anson County Office of Emergency Management 2230 Country Club Rd Wadesboro, NC 28170 (704) 994-3272**	**Anson County Health Dept 110 W Ashe St Wadesboro, NC 28170 (704) 694-5188**
Carolinas Healthcare System Blue Ridge - Morganton 2201 South Sterling St Morganton, NC 28655 (828) 580-5000 Carolinas Healthcare System Blue Ridge – Valdese 720 Malcom Blvd Valdese, NC 28690 (828) 580-5000	**Burke County EMS 200 Avery Avenue Morganton, NC 28680 (828) 433-6609**	**Burke County Emergency Management 200 Avery Ave Morganton, NC (828) 433-6609**	**Burke County Public Health 700 East Parker Rd Morganton, NC 28655 (828) 764-9150**
Carolinas Healthcare System – Northeast 920 Church St. North Concord, NC 28025 (704) 403-3000	**Cabarrus County EMS 31 Willowbrook Dr Concord, NC 28027 (704) 920-3000**	**Cabarrus County Office of Emergency Management 30 Corban Ave SE Concord, NC 28025 (704) 920-2143**	**Cabarrus Health Alliance 300 Mooresville Rd Kannapolis, NC 28081 (704) 920-1000**

Catawba Valley Medical Center **810 Fairgrove Church Rd** **Hickory, NC 28602** **(828) 326-3000** **Frye Regional Medical Center** **420 N. Center Street** **Hickory, NC 28601** **(828) 315-5000**	**Catawba County EMS** **100-A Southwest Blvd** **Newton, NC 28658** **(828) 465-8234**	**Catawba County Office of Emergency Management** **100 SW Blvd A** **Newton, NC 28658** **(828) 465-8233**	**Catawba County Health Department** **3070 11th Avenue Dr SE** **Hickory, NC 28602** **(828) 695-5800**
Carolinas Healthcare System – Cleveland **201 E. Grover St** **Shelby, NC 28150** **(980) 487-3000** **Carolinas Healthcare System – Kings Mountain** **706 W. King St** **Kings Mountain, NC 28086** **(980) 487-5000**	**Cleveland County EMS** **100 Justice Pl** **Shelby, NC 28150** **(704) 484-4822**	**Cleveland County Office of Emergency Management** **PO Box 2232** **Shelby, NC 28151** **(704) 484-4841**	**Cleveland County Public Health** **200 South Post Rd** **Shelby, NC 28152** **(980) 484-5100**

Caromont Regional Medical Center 2525 Court Drive Gastonia, NC 28054 (704) 834-2000	**Gaston County EMS 615 N Highland St Gastonia, NC 28052 (704) 866-3300**	**Gaston County Office of Emergency Management 615 N Highland St Gastonia, NC 28052 (704) 866-3350**	**Gaston County Health Department 991 W Hudson Blvd Gastonia, NC 28052 (704) 853-5000**
Lake Norman Regional Medical Center 171 Fairview Road Mooresville, NC 28117 (704) 660-4000	**Iredell County EMS 400 S Meeting St Statesville, NC 28677 (704) 878-3025**	**Iredell County Office of Emergency Management 349 N Center St Statesville, NC 28687 (704) 872-7468**	**Iredell County Health Department 318 Turnersburg Hwy Statesville, NC 28625 (704) 878-5300**
Carolinas Healthcare System – Lincoln 433 McAlister Rd Lincolnton, NC 28092 (980) 212-2000	**Lincoln County EMS 720 John Howell Memorial Dr Lincolnton, NC 28092 (704) 736-9385**	**Lincoln County Emergency Management 1 Court Square Lincolnton, NC 28092 (704) 736-8530**	**Lincoln County Department of Public Health 115 W Main St Lincolnton, NC 28092**

Carolinas Medical Center **1000 Blythe Blvd** **Charlotte, NC 28203** **(704) 355-2000** **Carolinas Medical Center – Mercy** **2001 Vail Ave** **Charlotte, NC 28207** **(704) 304-5000** **Carolinas Healthcare System – University** **8800 N Tryon St** **Charlotte, NC 28262** **(704) 863-6000** **Carolinas Healthcare System – Pineville** **10628 Park Road** **Charlotte, NC 28210** **(704) 667-1000** **Novant Health – Huntersville** **10030 Gilead Rd** **Huntersville, NC 28078** **(704) 316-4000** **Novant Health – Matthews** **1500 Matthews Township Pkwy** **Matthews, NC 28105**	**Mecklenburg County EMS** **4525 Statesville Rd** **Charlotte, NC 28269** **(704) 943-6000**	**Mecklenburg County Office of Emergency Management** **500 Dalton Ave** **Charlotte, NC 28206** **(704) 336-2412**	**Mecklenburg County Department of Public Health** **249 Billingsly Rd** **Charlotte, NC 28211** **(704) 336-4700**

(704) 384-6500 **Novant Health – Presbyterian** **200 Hawthorne Lane** **Charlotte, NC 28204** **(704) 384-4000**			
Sandhills Regional Medical Center **1000 West Hamlet Ave** **Hamlet, NC 28345** **(910) 205-8000**	**Richmond County EMS** **1401 Fayetteville Rd** **Rockingham, NC 28380** **(910) 997-8238**	**Richmond County Office of Emergency Management** **1401 Fayetteville Rd** **Rockingham, NC 28380** **(910) 997-8200**	

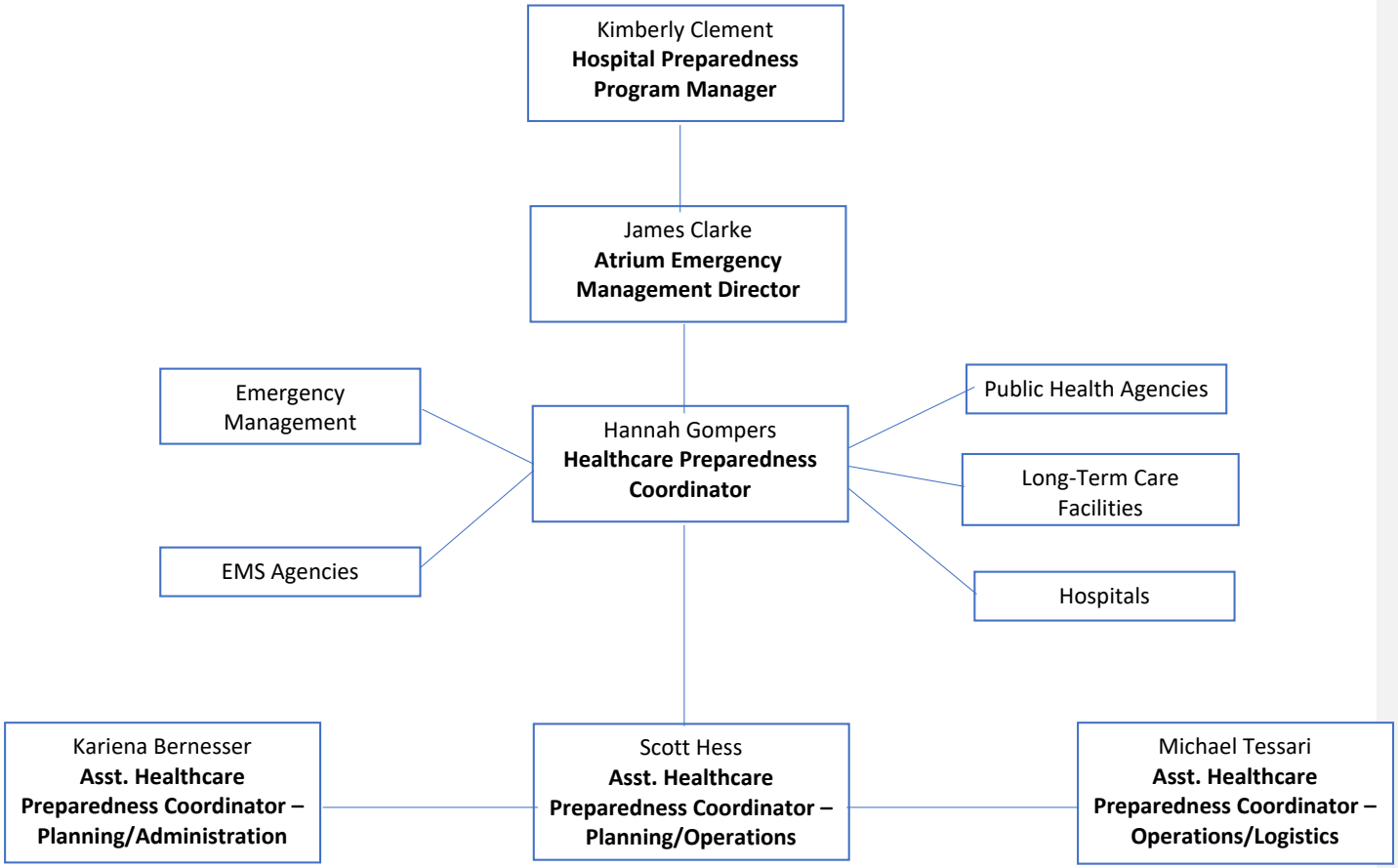
Scotland Memorial Hospital **500 Lauchwood Dr** **Laurinburg, NC 28352** **(910) 291-7000**	**Scotland County EMS** **1403 West Blvd** **Laurinburg, NC 28352** **(910) 276-1313**	**Scotland County Office of Emergency Management** **1403 West Blvd** **Laurinburg, NC 28352** **(910) 276-1313**	**Scotland County Public Health** **1405 West Blvd** **Laurinburg, NC 28352** **(910) 277-2454**
Carolinas Healthcare System – Stanly **301 Yadkin St** **Albemarle, NC 28002** **(704) 984-4000**	**Stanly County EMS** **201 South Second St** **Albemarle, NC 28001** **(704) 986-3650**	**Stanly County Office of Emergency Management** **201 South Second St** **Albemarle, NC 28001** **(704) 986-3650**	**Stanly County Public Health** **1000 N 1st St** **Albemarle, NC 28001** **(704) 986-3845**
Carolinas Healthcare System – Union **600 Hospital Dr** **Monroe, NC 28112** **(980) 993-3100**	**Union County EMS** **1403 Dove St** **Monroe, NC 28112** **(704) 226-2001**	**Union County Office of Emergency Management** **500 N Main St** **Monroe, NC 28112** **(704) 283-3575**	**Union County Health Department** **1224 W Roosevelt Blvd** **Monroe, NC 28110** **(704) 296-4800**

Attachment 3: State and Coalition Contacts

Coalition and State Offices			
NC Office of EMS 2707 Mail Service Center Raleigh, NC 27699-2717	Kimberly Clement Healthcare Preparedness, Response, and Recovery Program Manager	kimberly.clement@dhhs.nc.gov	Bus: (919) 855-3936 Fax: (919) 733-7021
	Brad Thompson ESF#8 Liaison	Brad.thompson@dhhs.nc.gov	Bus: (919) 855-4686 Cell: (919) 410-4289
	Wally Ainsworth Central Regional Manager	wally.ainsworth@dhhs.nc.gov	Bus: (919) 855-4678
	Allen Johnson Eastern Regional Manager	allen.johnson@dhhs.nc.gov	Bus: (252) 355-9026
North Carolina Office of Emergency Management 24 Hour Center 800-858-0368	Steve Powers Central Branch Manager	steve.powers@ncdps.gov	Bus: (919) 575-4122
	Dianne Curtis Eastern Branch Manager	dianne.curtis@ncdps.gov	Bus: (252) 520-4923
	Greg Atchley Western Branch Manager	greg.atchley@ncdps.gov	Bus: (828) 466-5555 Cell: (704) 929-0015
	Todd Brown Emergency Services Group Supervisor	todd.brown@ncdps.gov	Bus: (919) 825-2259 Cell: (919) 622-8375
NCEM Area 1 – Camden, Chowan, Currituck, Dare, Gates, Hertford, Pasquotank, Perquimans	Brian Parnell Area Coordinator	Brian.parnell@ncdps.gov	Cell: (252) 340-6325
NCEM Area 2 – Beaufort, Bertie, Hyde, Martin, Pitt, Tyrell, Washington	Charles Tripp Area Coordinator	Charles.tripp@ncdps.gov	Cell: (252) 558-5443
NCEM Area 3 – Carteret, Craven, Greene, Lenoir, Pamlico, Wayne	Melissa Greene Area Coordinator	Melissa.greene@ncdps.gov	Cell: (252) 933-7315
NCEM Area 4 – Cumberland, Duplin, Jones, Onslow, Pender, Sampson	Vacant Area Coordinator		

NCEM Area 5 – Bladen, Brunswick, Columbus, Hoke, New Hanover, Robeson	Zak Whicker Area Coordinator	Zak,whicker@ncdps.gov	Cell: (910) 409-7997
NCEM Area 6 – Franklin, Granville, Halifax, North Hampton, Person, Vance, Warren	Tim Byers Area Coordinator	tim.byers@ncdps.gov	Cell: (252) 676-5240
NCEM Area 7 – Edgecombe, Harnett, Johnston, Nash, Wake, Wilson	Alan Byrd Area Coordinator	alan.byrd@ncdps.gov	Cell: (919) 427-7248
NCEM Area 8 – Anson, Chatham, Lee, Montgomery, Moore, Richmond, Scotland	Yancy King Area Coordinator	yancy.King@ncdps.gov	Cell: (919) 208-1003
NCEM Area 9 – Caswell, Davie, Forsyth, Rockingham, Stokes, Surry, Yadkin	Dennis Hancock Area Coordinator	Dennis.hancock@ncdps.gov	Cell: (336) 380-2662
NCEM Area 10 – Alamance, Davidson, Durham, Guilford, Orange, Randolph	David Leonard Area Coordinator	David.leonard@ncdps.gov	Cell: (336) 266-2642
NCEM Area 11 – Alexander, Alleghany, Cabarrus, Iredell, Rowan, Stanly, Wilkes	Area Coordinator		Cell:
NCEM Area 12 – Ashe, Avery, Caldwell, Gaston, McDowell, Mitchell, Watauga	Tiawana Ramsey Area Coordinator	Tiawana.ramsey@ncdps.gov	Cell: (828) 230-8184
NCEM Area 13 – Burke, Catawba, Cleveland, Gaston, Lincoln, Mecklenburg, Union	Eric Wiseman Area Coordinator	Eric.wiseman@ncdps.gov	
NCEM Area 14 – Buncombe, Cherokee, Graham, Haywood, Madison, Swain	Jimmie Ramsey Area Coordinator	Jimmie.ramsey@ncdps.gov	Cell: (828) 712-1987
NCEM Area 15 – Clay, Henderson, Jackson, Macon, Polk, Rutherford, Transylvania	Danny Gee Area Coordinator	Danny.gee@ncdps.gov	Cell: (828) 230-8184

Appendix C: MHPC Organizational Chart



Appendix E: MHPC Resource Request Process

Attachment 1: Regional Resource Request Process

Regional Resource Request Process

Purpose:
To identify the proper procedure within the Office of the Metrolina Healthcare Preparedness Coalition for fulfilling a request for personnel or equipment from a regional partner.

Guideline:
The Office of the MHPC will assist as needed in the procurement of equipment and/or volunteer personnel requested by any regional partner for events that fall within the Scope of Work of the MHPC, and deemed necessary to carry out ESF-8 operations or identified as fulfilling one or more of the Healthcare Preparedness Capabilities for the Metrolina Region.

Procedure:
Begins when a request for resources is received into the Office from a regional partner.

1. Contacted MHPC Staff member will complete the "MHPC Resource Request Form" (Form A).
2. Identify the following:
   - ☐ Who is this and whom do you represent?
     Name:
     Agency:
   - ☐ What is your callback number and email address?
     Phone:
     Email:
   - ☐ Provide MHPC callback number to caller.
   - ☐ What is the request?
   - ☐ Is the EOC open? If so, is there contact information for the EOC? Phone:

Questions to consider:
- What is the issue?
- What do they need to solve the problem?
- Are there other alternatives?
- If requesting personnel, what credentials and how many?
- What has been done to resolve the problem?
- Have any MOUs been activated or other resources utilized?

- ☐ Has the county emergency management been notified? If so, who and what is their contact info?
  Yes No
  Contact:
- ☐ Has NC OEMS been notified? Yes No
- ☐ Tell the caller what the next steps are and when you will return their call with additional information.
- ☐ If the caller is NCOEMS or EM, is there a state mission number?
  Yes No Number:

3. Considerations before proceeding with deployment
   - ☐ Are there resources available to fulfill this request? Or can the resources be obtained within the time allotted?
   - ☐ Is there an MHPC Staff member(s) available to accompany the equipment/ volunteer personnel for the duration of this event? If so, who?
   - ☐ If necessary, is grant or other funding available (and approved) for the requested event?
   - ☐ Will the event interfere with a coinciding previously approved mission(s), or mission of higher priority as determined by the MHPC Staff?

4. Next Steps
   - ☐ Determine if able to complete the mission. Contact the appropriate personnel based upon the request to determine the capability.
   - ☐ Notify the following of the pending request and resolution if available.
     - Michael Daniels
     - NC OEMS
     - County EM as appropriate
     - Regional partners as appropriate
   - ☐ If the request is approved, notify the requestor.

- They will need to assume responsibility for the assets, unless otherwise noted.
- MHPC will complete a formal written request for assets
- MHPC will print a loan form, Form C below, for the facility POC to sign upon receipt (2 copies)
- MHPC will check item out of icams inventory to recipient
- MHPC will notify OEMS immediately if they will be out of service
- MHPC will assign responsibility of equipment to a staff member, who will be responsible for the deployment and establishment of resource. Once it is delivered, it becomes the responsibility of the requestor.

☐ If the request cannot be completed, MHPC work with the requestor and regional/ state partners to identify a resolution.

5. All requests approved or denied receive an MHPC mission number. Add approved requests to the mission board when possible.

6. If assets are requested, complete the "MHPC Resource Request Form" (Form A) for the requesting regional partner.

7. If volunteer personnel are requested, complete the "SMAT Volunteer Request Form" (Form B) for the requesting regional partner.

8. Communication Update Standards

☐ Updates should be provided every 2- 4 hrs, or at other pre-designated times, as appropriate. They should be provided to:

- Impacted Facility
- MHPC staff
- CMC Administration
- Regional Partners
- State Partners
- Others as determined by event

☐ Updates should include

- Resources deployed
- Potential impact on the region/ state
- Status of deployed resources

☐ Requestor Updates
- Ability to meet need
- Estimated time of arrival
- Team leader on deployment with contact information

☐ Team leader with deployed resources shall notify MHPC lead
- Every 2 hours with situation update or more frequently as needed
- Departure from warehouse
- Arrival at destination
- If an issue is encountered

9. Demobilization

☐ Upon completion of the event, the assigned MHPC staff will return personnel and equipment to service ASAP. If out-of-service status was caused by deployment, status updates on return-to-service will be provided to NC OEMS every 24 hours via email until return to normal operations.

☐ Upon completion of the event, and return of all equipment and volunteers, primary MHPC staff member for the event will send the "MHPC Resource Evaluation Form" (Form D) to the requesting regional partner.

☐ After Action Report will be completed by the Lead MHPC staff within 4 weeks. This will be submitted to NC OEMS and regional partners as soon as it is complete.

☐ Scan and file all associated mission documentation for future use. Save all documentation to J:/@MHPC/MHPC Deployments. Save in the calendar year folder with the mission number and event name. i.e. "14-07 SMRS FSX"

MHPC Resource Request Form

Date of Request: _____/_____/_____ MHPC staff receiving request: _____

Requesting Agency _____ Emergent Request: ☐ Yes ☐ No

Requesting Agency Point of Contact _____

POC phone: _____-_____-_____ Email:

Title of Event: _____ Mission Number (if approved): _____

Date of event: _____

Requesting: ☐ Equipment ☐ Personnel (Please complete SMAT Volunteer Request Form.)

Provide a brief description of the expectations of the Office of the MHPC:

_____

_____

_____

_____

MHPC Planning Section:

Equipment required (Attach List) readied by _____(Staff) on ____/____/____.

Funding needed _____ (Attach Budget). Or N/A

SMAT Volunteer Request Form

Date of Request: _____/_____/_____ MHPC staff receiving request: _____

Requesting Agency _____ Emergent Request: ☐ Yes ☐ No

Requesting Agency Point of Contact _____

POC phone: _____-_____-_____ Email:

Title of Event: _____ Mission Number (if approved): _____

Date of event: _____

Requesting: ☐ Personnel ☐ Equipment (Please complete MHPC Resource Request Form.)

Provide a brief description of the expectations of the SMAT Volunteers:
(If medical personnel are required, please indicate which specialties are required.)

_____
_____
_____

MHPC Planning Section:

Needed personnel will be notified by _____(Staff) by ___/___/____, __:__

- Attach message with date and time sent.

ServNC Mission Created ☐ IAP Completed ☐ Contact with OEMS ☐

Funding needed _____ (Attach Budget).

MHPC

3311-A Beam Rd
Charlotte, NC 28217
704 357-8517

I,_____, have received the following equipment from the

Metrolina Healthcare Preparedness Coalition on behalf of _____.
(Agency or facility accepting equipment)

The anticipated date of return for this equipment is _____/_____/_____.

- **Please see attached equipment list.**
  - ◊ This is a printed list of equipment checked out to the above agency, as documented in the Metrolina SMAT iCams inventory system.

- **Brief description of anticipated utilization of equipment:**
  - ◊ Please see the Resource Request document with associated MHPC Mission number listed below.

- **Please read and initial.**

By my signature, I acknowledge receipt of the items listed on the attached form, and affirm that I am aware that in the event of damage to and/or loss of this equipment, I, or the agency/facility that I represent, will be held responsible for all expenses involved with the repair or replacement of said equipment. Please Initial Here: _____

- **Please note any equipment faults or changes here.**

_____

Signature: _____ Date: _____

Print name: _____

MHPC Staff: _____ Date: _____

MHPC Mission Number/ Event Name: _____

Return of equipment witnessed by: _____
(Must be MHPC Staff)

Date Returned: _____

MHPC Resource Evaluation Form

Date of Evaluation: _____/_____/_____
Evaluating Agency _____
Evaluating Agency Point of Contact _____
POC phone: _____-_____-_____ Email:
_____

Title of Event: _____ Mission Number:
Date of event: _____
_____

Requested: ☐ Equipment ☐ Personnel

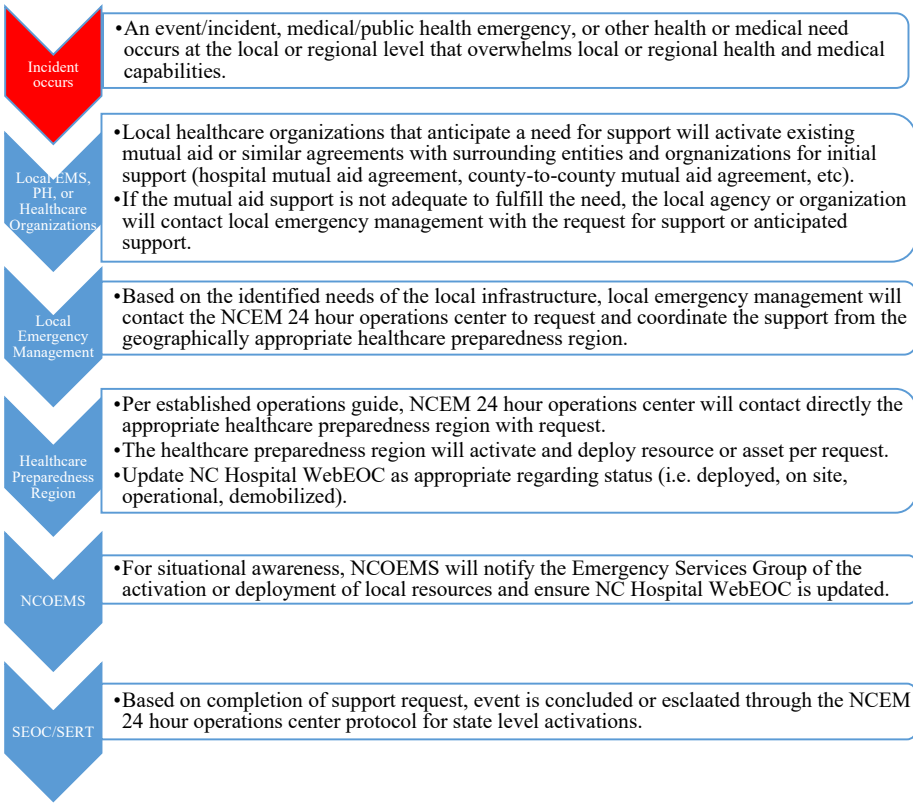
Provide a brief description of your experience with the Office of the MHPC:
_____
_____
_____
_____
_____
_____
_____

Please describe any Opportunities for Improvement that you identified:
_____
_____
_____
_____
_____
_____
_____

Please describe any exemplary areas of performance that you identified in your experience with the MHPC Staff, SMAT Volunteers, and/or equipment usage:
_____
_____
_____
_____

Attachment 2: Health and Medical Resource Process Algorithm

Health and Medical Resource Process Algorithm



Attachment 3: Requesting NC SMRS Assets During an Emergency

Requesting NC SMRS Assets During an Emergency

Overview: North Carolina is fortunate to have significant ESF 8 resources that have been funded by HRSA and ASPR within the State Medical Response System (SMRS). These ESF 8 resources are housed with various agencies across the state in a number of organizations that include, but are not limited to: EMS agencies, local emergency management, healthcare organizations, and state agencies. With this in mind, this document is intended to serve as guidance for accessing these resources in a timely fashion during an event. Assets and resources maintained at each of the eight Healthcare Preparedness Regions may be deployed during an emergency or disaster to meet the immediate needs of the healthcare infrastructure or provide health and medical support.

Process: Requests for immediate assistance will be made in accordance with the **Health and Medical Resource Request Algorithm**. For local agencies and healthcare organizations, the initial point of contact should always be the respective local emergency management agency. Based on the request and needs for support, the local coordinator through NCEM will contact the appropriate Regional Healthcare Preparedness Coordinator to assist with ESF 8 needs. Assets and resources can be provided as single resources or as packages and may be accompanied by a Unit Leader unless transferred to the requesting agency or jurisdiction.

Administration and Reimbursement:

1. **Pre-planned or special events:** Federal HPP funding may not be utilized. The requesting jurisdiction or organization will be invoiced based on the established agreement with that healthcare preparedness region. That specific healthcare preparedness region must have:
    a. A plan in place to maintain the capability of that specific asset utilizing other assets or resources across the system, or
    b. A plan to recover the asset in the event the capability is needed to address an emergent event within the region or state.
2. **Emergent events:** The requesting jurisdiction or organization should be prepared to incur the following expenses related to request and deployment of an asset or resource locally:
    a. For fuel for those assets or resources that utilize fuel for operation,
    b. For any damage sustained by asset or resource,
    c. For usage of disposable medical supplies or goods.

For events that require deployment of personnel packages in excess of the HPP-funded program or healthcare preparedness regional staffs, approval and activation will be made by ESF 8/NCOEMS.

Note: An emergency declaration is often not made immediately and as such, the requesting organization or jurisdiction should be prepared to reimburse the above-mentioned items. For

events that escalate to state or federal declarations, reimbursement may not be required by the requesting organization or jurisdiction. Additionally, establishment of a mission number through North Carolina Division of Emergency Management does not automatically trigger SMRS activation, nor does an activation order automatically have a mission number associated.

Attachment 4: MHPC Resource Listings & Mass Fatality Supplies

MHPC Resource Listings

This is a brief overview of the types of resources that are available through the Coalition and the State Medical Response System. As this is NOT an all-inclusive list, please contact your coalition for details and availability.

Last Updated: June 20, 2018

Resource	Description	Quantity Maintained by the Metrolina HPC
Response Trailers		
Medical Support Unit	3 or 4-bed patient treatment trailer	2
Decontamination Trailer	Field decontamination tent, equipment, and PPE	1
SMSS Trailer	Special Medical Support Shelter supplies	1
Magnum Generator	25 kw 3 phase generator, 500 gal NP water, 31ft 4 lamp light tower	1
Genie Light Tower	28ft 4 lamp light tower 6 kw single phase generator	1
Shelter and Shelter Support		
Western Shelter Tents	19ft x 35ft	7
Western Shelter Tents	20ft x 20ft	2
Deployed Logix Tent	ASAP Tent – 18ft x 15ft	1
HVAC Units	Western Shelter Units- 9 units/Deployed Logix HVAC – 2 units	11
Cots	Westcot 18": 100/ Westcot 28": 35	135
Hand Washing Stations	Portable foot-pump sinks	4
Medical Supplies and Equipment		
Zoll Monitors	Cardiac Monitor, Defibrillator, Pacer, 12-Lead, NIBP, SpO2, and EtCO2	3
Phillips HeartStart MRx Monitors	Cardiac Monitor, Defibrillator, Pacer, 12-Lead, NIBP, SpO2, and EtCO2	4
Phillips IntelliVue MP2 Portable Patient Monitor	Can be used as part of a telemetry system	24
Mobile Telemetry Station	To be used with Phillips IntelliVue MP2 Portable Patient Monitors	2
Ventilators	LTV 1200s; Eagle Transport vents with BiPap	20
Portable Suction		23
Oxygen Delivery System		1
Long Backboards	Adult, pediatric, and infant	90
Communications		
Satellite Communications	Supports VOIP phone system and WiFi internet	1
Fatality Management		
BioSeal System	Remains containment system for 250 persons	1
Refrigerated trailer	53 foot trailer. There are several across the state	1
Cadaver Bags	Various Sizes	706

Educational Supplies		
Inflatable manikins	Adult size	178
Inflatable manikins	Pediatric size	30
Rescue manikins	1 – Pediatric/ 1 - Adult	2
SimMan		1
SMART Triage System	With 1500 triage tags and triage command bag each	4

NC Healthcare Coalitions Mass Fatality Supplies 6/10/2019			
CAPRAC			
Cadaver Bags	100		
Backboards	42		
BioSeal System	1		
53 ft Reefer	1	*42 remain capacity *On-board diesel refrigeration unit that will need to be refueled every 24hrs	
Duke HPC			
BioSeal System	600 ft of material		
Raven Litters	30		
Recovery Supplies (PPE)	Unknown at this time		
Vertical Dispensing Rack	1	*Part of BioSeal System	
53 ft Reefer	1	*30 remain capacity. *Liftgate available	Mezzanine 2
Eastern HPC			
BioSeal System	12 remains/1 heat sealer		
Backboards	50	*Used in conjunction with bags and caskets	
Cadaver Bags	100		
Collapsible Cardboard Casket	50		
Post Mortem Kit (Adult)	20		
Post Mortem Kit (Pediatric)	10		
Trailer - Medical/Logistics			
BioSeal System	1	*12 remains	
Cadaver Bags, Heavy Duty Black	10		
Cadaver Bags, Hospital Morgue Kit	6		
Trailer - Decon			
Cadaver Bags	18		
Trailer - SMSS			
Cadaver Bags	10		
Regional Hospitals	200		In ACF - Surge Trailers
53 ft Reefer	1	*48 remain capacity (12 casket racks/4 remains per rack) *On board Reefer Unit *50 gallon diesel fuel tank (Burn rate 1.4 gal/hr)	
Metrolina HPC			

BioSeal Station	1	*150 remains	
BioSeal Portable Sealing	2 units w/ 2 rolls of material		
Cadaver Bags	460		
Recovery Supplies (PPE)	*Tyvek Coveralls- 2X-Large-100/ Large-425/ x-large-475 *Boot Pullover- Size 9=10/Size 10=9/ Size 11=11/ Size 12=7/ Size13=11/ Size 14=12/ Size 15=11/ Size 16=11 *Boot cover-Large=36/Medium=36/Small=36 *Gloves (box of 100)-Large=140/ Medium=120/ Small=40/ XX- Large=80 *Safety Glasses- 55 *N-95- 2000		
53 ft Reefer	1	*52 remain capacity	MHPC Back Lot
16 ft Morgue Trailer	1	*available July 2019. *6-8 remain capacity	
MidCarolina			
BioSeal	1,500 Remains/3 heat sealers		Sandhils - FMA Unit
Long Backboard	50		
53 ft Reefer	1	*75 remain capacity *Winch on tram *Generator	
Mountain HPC			
Cadaver Bags	16		Logistics Support Trailer
Plywood Coffins - Adult	12		
Plywood Coffins - Pediatric	12		
Long Spine Boards	47		
Heavy Duty Backboards	60		
53 ft Reefer	1	*21 remain capacity. *Fixed Cooling Unit - 25 gallon capacity	
Southeastern HPC			
BioSeal	800 remains		
Bio Seal Vertical Dispensing Rack	1		
Cadaver Bags	1,000		
Stainless Steel Cadaver Trays	48		
53 ft Reefer	1	*48 remain capacity *Diesel and shore power available	
Triad HPC			
BioSeal	250		
Cadaver Bags	340		
Recovery Supplies (PPE)	none at this time		
Morgue Trailer #1	1	*16 remain capacity	
Morgue Trailer #2	1	*6-8 remains. *Owned by local EMS Agency	
53 ft Reefer	1	*36 remain capacity. *Onboard Diesel Unit *Rolling Racking System	Exterior

Appendix F: Healthcare Information Sharing System Plan (HISS)

MHPC
METROLINA HEALTHCARE PREPAREDNESS COALITION

Healthcare Information Sharing System (HISS)

June 30, 2019

Table of Contents

OVERVIEW

The HISS plan is designed to support the RHSC by providing specific details/actions for how regional situational awareness and information sharing is conducted. The HISS plan also provides additional details on regional response plan operations including activation levels, operation and resource status/information, and an outline of the resource request process and job action sheets for personnel.

INFORMATION GATHERING

Information is gathered from participating hospitals or healthcare systems conference calls, direct reports from healthcare partners, entries made in WEBEOC, participating in state level conference calls and through regional healthcare infrastructure conference calls. Examples of the information obtained through each include:

A. Hospital or healthcare system conference calls
    a. Bed capacity
    b. Staffing Plan
    c. Resource Status or Gaps
    d. HICS Activation
B. Direct Communications
    a. Similar information to above
    b. EMS Agency Status
        i. Staffing plan
        ii. Potential resource or staffing gaps
        iii. Mutual aid or AST availability
    c. Licensed Care Facilities
        i. Available beds
        ii. Staffing plan
        iii. Available transportation resources
        iv. Potential resource for staffing gaps
C. WebEOC Entries
    a. Local EM SitReps containing:

i. Preparedness actions
ii. Response operations
iii. Power outages/ infrastructure issues
iv. Damage assessments/reports

D. Regional Healthcare Conference Calls
   a. Verification of information received from other sources
   b. New information not shared through other sources
   c. County-by-county role call for representation and any important updates

E. State level conference calls
   a. Status of other coalitions
   b. Status of state resources
   c. State level priorities
   d. Updates on potential or occurring missions
      i. In and out of state
   e. Updates on neighboring states that may be impacted
   f. Legal updates related to:
      i. State of Emergency
      ii. CMS Waiver
      iii. EMAC

INFORMATION SHARING

Information is shared in a similar way that it is gathered. Methods of sharing information include Ops Briefs, SitReps, healthcare system conference calls, direct communications/reporting, WebEOC, regional healthcare calls and state level calls. In addition, MHPC has implemented the use of Everbridge to send direct notifications to regional partners in a timely manner.

A. Ops Brief
B. SITREP
C. Healthcare System Conference Calls
   a. Information we share:
      i. High Level situation overview

ii. Specific impacts to HCS
iii. Specific requests for the HCS
1. Staffing, resources, etc

D. Direct Communications
a. How we will share the information:
i. Email, phone calls, Everbridge messages, or texts to or from any of our healthcare partners.
b. Information we share:
i. *Pertinent* situational updates specific to that agency/organization
ii. Specific requests for support needed from that agency/organization

E. WebEOC
c. Information we post:
i. SMRS Dashboard update (Our resource status)
ii. SMRS/regional SITREP
iii. Significant event entries
1. Updates received from partners
2. Resource requests from partners
3. Regional SITREPS and Ops Briefs

F. Regional Healthcare Calls
d. Information we provide:
i. *Pertinent* Situation Update
1. Weather forecast
2. Event summary
3. Specific Intel
ii. Regional Objectives
iii. Current Regional Actions or Operations
iv. Updates from State level

G. State Level Calls
e. Information we provide:

i. Overview of regional healthcare infrastructure preparedness and response operations
ii. Summary of Partner gaps
iii. Summary of available partner support
iv. Current regional resource status and/or gaps
v. Current staff/volunteer availability or gaps

STAFFING PLAN

A. Normal Operations

a. Staffing- minimum of one MHPC staff member in region at all times
b. Communications
    i. As needed: Duty officer will share weather updates/pertinent information from the State and available Intel as appropriate
    ii. Automated Weather: Automatic Weather alerts provided by MHPC Alerts/Everbridge to subscribers based on location

B. "24-hour operational period"

a. Staffing
    i. HISS lead/EOC liaison
    ii. Operations Lead
    iii. Logistics Lead
    iv. Others as needed
b. Communications Schedule

Times subject to changed based on incident

i. 0700 – 24-hour Operations period begins
ii. 0700- Submit SMRS SitRep in WebEOC (Sparta) on the HC – SMRS Situation Report board
iii. 0900- MHPC Staff Meeting
iv. 1000- Regional healthcare infrastructure call
v. 1100- State HPP/SMRS call
vi. 1200- Regional ops brief sent out/dissemination
vii. 1900- Regional SitRep dissemination

viii. 1900- Submit SMRS SitRep in WebEOC (Sparta) on the HC – SMRS Situation Report board

ix. As needed- Weather/situation/hazard information

C. "12 hour operational periods"

a. Staffing

i. Day shift

1. HISS lead/EOC liaison
2. Operations Lead
3. Logistics Lead

ii. Night Shift (include possibility for modified 12-hour night shift with staff operating on call back schedule as needed)

1. HISS lead/EOC liaison
2. Operations Lead
3. Logistics Lead

b. Communications Schedule

Times subject to change depending on incident

i. 0700- Dayshift 12-hour operations period begins

ii. 0700- Submit SMRS SitRep in WebEOC (Sparta) on the HC – SMRS Situation Report board

iii. 0730- MHPC Staff meeting

iv. 0800- Regional Healthcare Call

v. 0900- Regional SitRep Dissemination

vi. 1100- State HPP/SMRS call

vii. 1200- Regional ops brief sent out/dissemination

viii. 1900- Nightshift 12-hr operational period begins

ix. 1900- Submit SMRS SitRep in WebEOC (Sparta) on the HC – SMRS Situation Report board

x. 1930- Shift Swap briefing

xi. 2000- Regional SitRep Dissemination

xii. 2000- Regional Healthcare Call (as needed)

xiii. As needed- weather/situation/hazard information

ACTIVATION PROCESS & LEVELS

A. Notification Triggers

Notification to activate this plan should be made to the MHPC staff whenever a member organization of the Metrolina Healthcare Preparedness Coalition anticipates or is experiencing an emergency or other event that is beyond the organizations capability/capacity to mitigate. Examples include:

a. Potential or currently occurring infrastructure issue impacting the facility/agency (Examples: fire, power failure, chiller failure, phone/radio failure, etc)
b. Potential or currently occurring clinical issues that might require outside assistance (Examples: MCI/Surge, ED Closure, equipment shortages)
c. Expected or Unexpected opening of the organization's EOC or Command Center
d. A significant event or disruption of service is planned which could require action on the part of the Coalition and/or its partners.
e. Any issue where assistance may be needed in communicating an organization's situation to the Region/State (Examples: Situation reporting to partners on local and state levels)

Notifications should be made to the MHPC Duty Officer at (980-349-6472) or by emailing MetrolinaHPC@carolinas.org

B. HISS Activation Levels

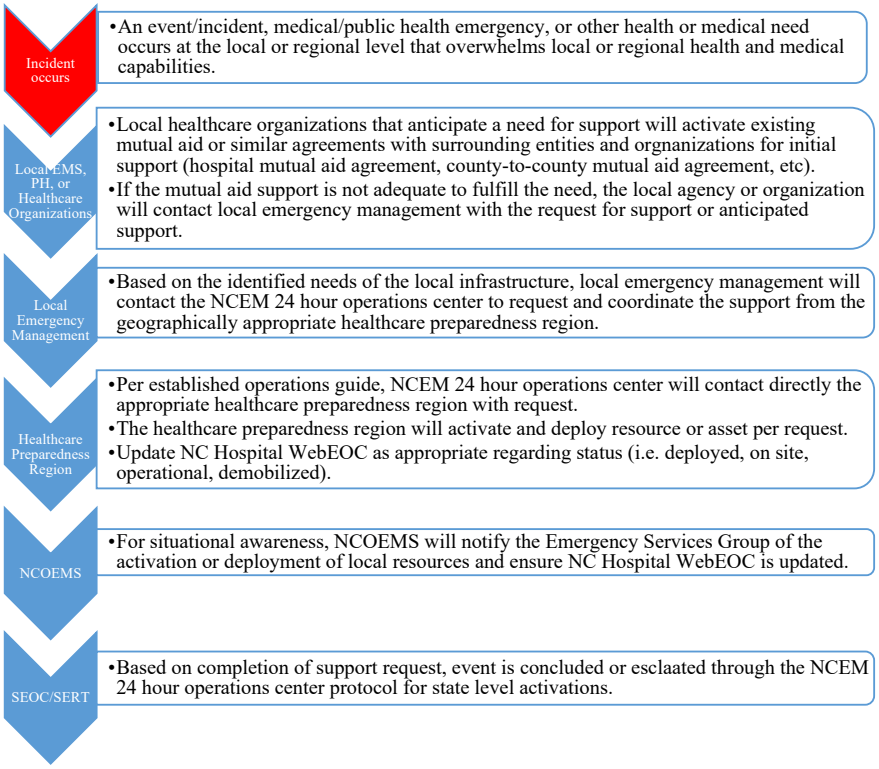
a. Normal Ops – *Level 5*- MHPC duty officer will receive or share information as appropriate.
b. Monitoring- *Level 4*- MHPC awareness of potential weather, currently occurring or expanding incident, or preplanned special event. Passive monitoring of emails, social media, WebEOC and intelligence sources in addition to daily duties. Information may be shared with regional partners depending upon responding agency
c. Alert (Virtual)- *Level 3*- Aggressive active monitoring and sourcing of information.

d. Activation (MHPC or Hospital)- *Level 2*- Physical establishment of Coordination Center inside MHPC offices or physical representation of the HISS by an MHPC staff member at a partner hospital or facility.
e. Activation (Local EOC)- *Level 1*- Physical representation of the HISS by an MHPC staff member in a local EOC.

C. *Response Operations/Status*

a. Normal
    i. No deviation from standard daily operations
b. Readiness
    i. Staff has begun preparing resources for potential deployments and are monitoring the situation
c. Standby
    i. Resources are ready for deployment if needed
d. Deployed
    i. Resources have been deployed to assist other regions or states and are unavailable
e. Partially Deployed
    i. Some resources have been deployed to assist other regions or states, however, some resources may be available for request
f. Out of Service
    i. Resources are not available due to mechanical or equipment failure or repair
g. Delayed
    i. Resources are available for request, but a delay in deployment is anticipated
h. Impacted
    i. MHPC resources are in an impacted area and are unavailable for request

RESOURCE REQUEST PROCESS



JOB ACTION SHEETS

A. *Duty Officer*

- ❑ Monday AM: Complete the duty officer check sheet
  - **See Appendix F – Duty Officer SOG and Checklist*
- ❑ Sign into Google Voice app
  - ❑ Username: metrolinasmat@gmail.com
  - ❑ Password: MHPCsmat700
  - ❑ Ensure Duty Officer phone number is forwarded to correct phone
  - ❑ Select your preferred text message delivery settings
    - ❖ People may text Duty Number (for non-urgent questions)
- ❑ Establish ICS 214 for the week
- ❑ Forward out any pertinent weather info from NCEM as appropriate
- ❑ Forward out any additional pertinent information from local, regional or state partners as appropriate
- ❑ Keep an eye on Twitter and other News sources for unfolding events (planned/unplanned)
- ❑ Be sure you can log into:
  - ❑ CharMeck WebEOC
  - ❑ NC Sparta/HCWebEOC
  - ❑ EverBridge (Computer and ManageBridge on phone)
- ❑ Have your radio with you (and charged batteries)
- ❑ Have access to the SecureBridge App

B. *HISS/EOC Lead*

- **Roles**
  - ❑ Respond as requested by the local EOC to represent local and regional healthcare infrastructure (primarily hospitals and licensed care facilities)
  - ❑ Support local EMS and Public Health as needed
  - ❑ Function as the liaison between local and regional healthcare infrastructure and local emergency management or the local EOC.

- ❑ Coordinate information on local and regional healthcare infrastructure operating status
- ❑ Communicate and coordinate healthcare infrastructure resource requests

- **Responsibilities**
  - ❑ Notify MHPC staff, Atrium leadership, and NCOEMS Shift Duty Officer as appropriate
    - ❑ Review or request MHPC resource status
  - ❑ Establish ICS 214 documentation for event
  - ❑ Receive a SitRep or Briefing from the EOC
  - ❑ Establish access to:
    - ❑ Personal and MHPC Email
    - ❑ Everbridge
    - ❑ Local WebEOC (CharMeck)
    - ❑ NCSPARTA/HCWebEOC
  - ❑ Handle any immediate actions as requested by the EOC
  - ❑ Build or create and share an operations brief or SitRep, whichever needs to go out first.
    - ❑ Ops Brief
      - ❑ Establish objectives
      - ❑ Summarize current actions
      - ❑ Summarize resource status
      - ❑ Establish staffing and communications plan.
    - ❑ SitRep
      - ❑ Complete SitRep template with information as appropriate.
  - ❑ Utilize E-mail to disseminate pertinent information to appropriate partners as needed
  - ❑ Utilize Everbridge for urgent or emergent communications with appropriate partners for the event or incident
  - ❑ Consider activation of a local or regional healthcare infrastructure conference call

- ❑ Receive, verify and, document resource requests and forward to MHPC operations and logistics for appropriate strategies, tactics and fulfillment

- Resources
  - ❑ Laptop and charger
  - ❑ (2) 800Mhz Radios
  - ❑ Secondary Wi-Fi Source (Atrium Phone or Mi-Fi)

C. Operations Lead

- ❑ Report to warehouse or other duty location assigned
- ❑ Obtain incident/event briefing or update to maintain situational awareness
- ❑ Coordinate and prioritize the reception of resource requests
  - ❑ Complete appropriate resource request paperwork
  - ❑ Document resource request on Excel resource tracker
- ❑ Assist with deployment of resources as needed
- ❑ Determine the need for additional operations, logistics or support staffing
- ❑ Provide a briefing to additional operations, logistics and support staffing
- ❑ Establish and maintain accountability for operations, logistics and support staffing
- ❑ Establish and maintain ICS 214 for the operational periods
- ❑ Ensure that logistics staff document their actions on the ICS 214 for the operational period
- ❑ Review resource status with logistics lead
  - ❑ Report/document as needed
  - ❑ Update SMRS Dashboard in HCWebEOC/NC Sparta
  - ❑ Complete SMRS SitRep in HCWebEOC/NC Sparta
- ❑ Assist with reaching out to regional partners to obtain status updates or additional information or delegate to additional personnel as needed
- ❑ For missions requiring SMAT volunteers, initiate Everbridge messaging using appropriate template

D. Logistics Lead

- ❑ Report to warehouse or duty location as assigned.

- ❑ Ensure readiness of appropriate equipment for current or potential mission(s)
- ❑ Report any out of service equipment/resources and potential for corrective actions
- ❑ Work with operations to determine the need for the recall of any previously deployed resources
- ❑ Receive resource requests from operations and prepare for deployment
    - ❑ Re-verify availability in iCAMS
    - ❑ Physically verify and ready the resource
    - ❑ Check out or deploy the resource in iCAMS
    - ❑ Print inventory list/manifest from iCAMS
- ❑ Document actions taken on ICS 214
- ❑ Determine the need for Mobile Medicine drivers and request through the appropriate process. ***See Appendix G - Mobile Medicine Driver Request*
- ❑ Physically deploy items to location or assist with pick up at the MHPC warehouse
- ❑ Maintain accurate tracking of deployed resources by updating Excel resource tracker
- ❑ Provide any just-in-time training needed for deployed resources
- ❑ Establish and maintain a process for tracking the use of disposable inventory
- ❑ Establish and maintain a process for restocking disposable inventory/supplies

BED COORDINATION AND PATIENT MOVEMENT

Note: This plan is currently being revised and updated and will be changed. This is only a recent draft

This section outlines the process of bed coordination and patient movement between regional partners.

A. Purpose
    a. To assist facilities with:
        i. LTC patient distribution
        ii. Hospital decompression or evacuation
        iii. Major MCI patient distribution
        iv. Patient reception from another area, region, or state

B. Process
    a. MHPC Receives Notification from the Following:
        i. Directly from impacted facility in the region
        ii. From Local EM or EMS on the scene
        iii. From an in-region transfer center
        iv. From NCOEMS
        v. From another Coalition or their transfer center
    b. MHPC initiates a conference call with participating Transfer Center Supervisors/Leads
        i. Attendees:
            1. CHS Physician Connection Line (704) 512-7878
            2. Novant Doctors Line (verify name and insert # here)
            3. NCOEMS HPP Shift Duty Officer (919) 855-4687
        ii. Purpose:
            1. Situation Overview
            2. Assign needs based on request/situation
            3. Establish a follow-up/report back call
    c. If needed, MHPC initiates a conference call with regional EMS/Transport Programs:
        i. Attendees:
            1. Local EMS/AST Services
            2. MedCenter Air/FlightWatch
            3. Novant CCT
            4. If needed, CHS Events Medicine (for trucks)
            5. NCOEMS Shift Duty Officer
        ii. Purpose
            1. Situation overview
            2. Determine resource availability
            3. Obtain initial response commitment
            4. Evaluate resource commitments for a protracted event
            5. Response planning:

a. Coordinating agency/person
b. Communications plan
c. Staging location

MHPC Operations Briefing

If you no longer wish to receive this weekly update, please contact Hannah.gompers@carolinas.org.
If you have upcoming planned events that you would like to share with the region via the Weekly Ops Brief, please email them to Hannah.gompers@carolinas.org by the preceding Sunday. Thank you.

24 Hour Emergency Contact:
877-262-6397 or 704-512-7878

Staff:

KC Bernesser	Available	ON CALL
Scott Hess	Available(Mon,Wed-Fri) Out of Region/Limited Availability (Tues)	
Hannah Gompers	Available (Mon-Wed) In Region/Limited Availability (Thurs & Fri)	

Examples of times to notify the MHPC:

- Potential or currently occurring infrastructure issue impacting your facility/agency
  - (Examples: fire, power failure, chiller failure, phone/radio failure, etc)
- Potential or currently occurring clinical issues that might require outside assistance
  - (Examples: MCI/Surge, ED Closure, equipment shortages)
- Expected or Unexpected opening of your EOC or Command Center
- Any issue where you may need assistance communicating your situation to the Region/State

**Even if you don't have specific need or resource request, let us know your situation early.*

Upcoming Planned Events:

- **MHPC Monthly and Quarterly Newsletter**
  - Email metrolinahpc@carolinashealthcare.org to be added to our mailing list!

- **Intro to Emergency Management Continuing Education Workshop**

  - Tuesday, Jan 26th, 09:00a – 5:00p, Gaston County Citizens Resource Center – 1303 Dallas Cherryville Hwy, Dallas, NC 28034
  - Register here: http://tinyurl.com/MHPC-1-26
  - Class is **FREE**, has CEUs, and lunch will be provided!!!
- **HVA/EOP Continuing Education Workshop**
  - Wednesday, Jan 27th, 09:00a – 5:00p, Novant Health Matthews Medical Center: Community Room A/B – 1500 Matthews Township Pkwy, Matthews, NC 28105
  - Register here: http://tinyurl.com/MHPC-1-27
  - Class is **FREE**, has CEUs, and lunch will be provided!!!

- **Check** https://terms.ncem.org **for upcoming classes being offered around the State.**

- **Hospital WebEOC Training is now available**
  - On the NCWebEOC website

Regional Equipment Status:

Metrolina SMAT Equipment Status:

Resource	Availability	Notes
F-550	Available	
Volvo Tractor	Available	
M-8 Trailer	Available	90% packed
SMSS Trailer	Available	85% packed
AST Trailer	Available	At MEDIC
MSU 1	Available	
MSU 2	Available	
Re-Supply Trailer	Available	95% packed
Decon Trailer	Available	95% packed
Reefer Trailer	Available	
Comms Unit	Available	
25kw Gen	Available	
Genie Light Tower	Available	
BioSeal Remains Containment System	Available	For more info, visit: http://bioseal.com/products1.php
Medical Equipment	Call for info	

MED-1 Equipment Status:

Mack Tractor M-1	Unavailable	100 kW GenSet
Mack Tractor M-2	Unavailable	100 kW GenSet
F650 Prime Mover-1	Unavailable	25 kW GenSet
F650 Prime Mover-2	Unavailable	25 kW GenSet
F-350 Prime Mover	Unavailable	
SUV Prime Mover	Unavailable	
Mission Support Unit	Unavailable	Showers/ Laundry/ Support
MED-1 Mobile ED	Unavailable	

MED-2 Medical Support	Unavailable	
Logistics Trailers	Unavailable	
Logistics Support Unit	Unavailable	Equipment/ Tool Support
Satellite Trailer	Unavailable	

Regional Weather:

Mon 01/11	Tue 01/12	Wed 01/13	Thur 01/14	Fri 01/15	Sat 01/16	Sun 01/17
Today: Sunny, high near 45. WNW wind 3 to 5 mph. **Tonight:** Partly cloudy, low around 28. SSW wind around 5 mph after midnight.	**Day:** Sunny, high near 49. SW winds 6 to 15 mph, with gusts up to 23 mph. **Night:** Mostly clear, low around 26. WNW wind 7 to 13 mph, with gusts up to 18 mph.	**Day:** Sunny, high near 43. W wind around 6 mph. **Night:** Mostly clear, with low around 26.	**Day:** Sunny, with high near 50. **Night:** Partly cloudy, with low around 33.	**Day:** Partly sunny, high near 52. **Night:** Mostly cloudy, low around 38. 40% chance of showers after 8pm.	**Day:** Mostly cloudy, high near 51. 40% chance of showers. **Night:** Mostly cloudy, low around 39. 30% chance of rain.	**Day:** Partly sunny, high near 50. 30% chance of showers.

Source and Updates: http://1.usa.gov/1wktp4F
Mobile Forecast: http://mobile.weather.gov/index.php?lat=35.21&lon=-80.94

For More MHPC Information:

www.MetrolinaPreparedness.org

Or Follow us on Social Media for real-time information sharing
Facebook: MetrolinaHPC or MetrolinaSMAT
Twitter: @MetrolinaHPC or @MetrolinaSMAT

Attachment B: Situational Report Template

1. Incident Name	2. Incident Start Date/Time
3. Situation Summary: Background, primary hazards, etc.	
4. Approval and Routing Information	

Prepared By:	Position:	Date/Time Prepared:	Date Time Submitted:
Approved By:	Position:	Signature:	Primary Location, Organization, or Agency:

5. Incident Objectives			
5a. Objectives:	5b. Strategies:	5c. Resource Required: (Reference Critical Asset List)	5d. Assigned To:

6. Prepared by:

Print Name: _____ Signature: _____

Date/Time: _____ Facility: _____

Attachment C: Email Template

Regional Partners,

Please see the attached (document) for (date). In addition to being sent via email, all MHPC SitReps for this event are posted on WebEOC.

If you have not had a chance, please take a moment to update the Partner Status Update Form through the following link: (SurveyMonkey link).

(Include pertinent situational information, ie weather, past events causing issues, future events).

Please let us know if there are any needs you may have. Contact an MHPC Staff Member using the On-Duty Number: 980-349-6472.

Metrolina Healthcare Preparedness Coalition
www.MetrolinaPreparedness.org
Duty Officer: 980-349-6472

Attachment D: SMAT Message Template (Active)

Active Responders:

The North Carolina State Medical Response System has currently been placed on an *ADVISORY* status due to *(INSERT REASON/SITUATION)*

At this time please take the following actions:
1. Check with your employer and family to determine you potential availability.
2. Check your deployment equipment
3. Respond by *(INSERT DATE/TIME)* using the options below

We currently DO NOT have a mission. Please DO NOT contact the office/warehouse for additional information. Additional information will be pushed out to by phone, email, or ServNC as we receive it. Responding now WILL NOT commit you to any potential mission, but will assist us in determining our current status. A response of "Not Available" is just as important to us.

Response Option:
I am AVAILABLE to deploy
Call Bridge Number (if applicable):

Response Option 2
Response Option:
I can not deploy, but can help with preparation at the Warehouse
Call Bridge Number (if applicable):

Response Option 3
Response Option:
I MIGHT be available
Call Bridge Number (if applicable):

Response Option 4
Response Option:
I am NOT available
Call Bridge Number (if applicable):

Response Option 5
Response Option:
Please deactivate my profile. I am no longer available or interested in participating

Attachment E: SMAT Message Template (Reserve)

Reserve Responders:

The North Carolina State Medical Response System has currently been placed on an *ADVISORY* status due to *(INSERT REASON/SITUATION)*

At this time please take the following actions:
1. Check with your employer and family to determine your availability to assist with Warehouse/Team preparation for deployment
2. Respond by *(INSERT DATE/TIME)* using the options below

We currently DO NOT have a mission. Please DO NOT contact the office/warehouse for additional information. Additional information will be pushed out to by phone, email, or ServNC as we receive it. Responding now WILL NOT commit you to any potential mission, but will assist us in determining our current status. A response of "Not Available" is just as important to us.

Response Option:

Response Option 1
I am AVAILABLE to assist with preparations
Call Bridge Number (if applicable):

Response Option 2
Response Option:
I MIGHT be available
Call Bridge Number (if applicable):

Response Option 3
Response Option:
I am NOT available
Call Bridge Number (if applicable):

Response Option 4
Response Option:
Please DEACTIVATE my profile at this time. I am no longer interested in/available to participate.

Purpose:
To identify the proper procedure within the Office of the Metrolina Healthcare Preparedness Coalition for handling on-call for staff members.

Guideline:
The Office of the MHPC will have at least one staff member on call to assist regional partners with resource or personnel requests and share situational awareness that fall within the Scope of Work of the MHPC, and deemed necessary to carry out the ESF-8 operations or identified as fulfilling one or more of the Healthcare Preparedness Capabilities for the Metrolina Region.

Procedure:

1. Staff members will rotate on-call schedule based on staff availability and regional events. An on-call staff calendar is located on the MHPC Calendar on Outlook.

2. Designated on-call staff member will login to Google Voice and select themselves as the designated on-call person to receive phone calls/text messages.

3. Designated on-call staff member is responsible for the following while they are on-call:

    a. Answering and responding to all phone calls, emails, and texts sent to the On-Duty Phone Number (980-349-6472) and metrolinahpc@carolinashealthcare.org

    b. Monitoring and sending out local weather alerts/events to regional partners

        i. *If Sub-region staff member is available, on-call staff member may ask them to reach out to contacts if their area is affected*

    c. Responding to requests made by NCOEMS or regional partners

    d. Respond to events where resources/personnel are requested

    e. Alerting the NCOEMS Shift Duty Officer (dhsr.ncoems.sdo@dhhs.nc.gov) of the event, providing brief description of what occurred, who has been notified about the incident, any Coalition resources that have been requested, and if there are any patients/people that have been affected by the incident.

        i. NCOEMS Shift Duty Officer can also be reached at 919-855-4687

4. When a request for resources is received into the Office from a regional partner, the on-duty staff member will:

    10. MHPC Staff member will complete the "MHPC Resource Request Form" (Form A).
    11. Identify the following:
        - ☐ Who is this and whom do you represent?

Name:
Agency:

☐ What is your callback number and email address?
Phone:
Email:

☐ Provide MHPC callback number to caller.

☐ What is the request?

☐ Is the EOC open? If so, is there contact information for the EOC? Phone:

☐ Has the county emergency management been notified? If so, who and what is their contact info?
Yes No
Contact:

☐ Has NC OEMS been notified? Yes No

Questions to consider:
- What is the issue?
- What do they need to solve the problem?
- Are there other alternatives?
- If requesting personnel, what credentials and how many?
- What has been done to resolve the problem?
- Have any MOUs been

☐ Tell the caller what the next steps are and when you will return their call with additional information.

☐ If the caller is NCOEMS or EM, is there a state mission number?
Yes No Number:

12. Considerations before proceeding with deployment

☐ Are there resources available to fulfill this request? Or can the resources be obtained within the time allotted?

☐ Is there an MHPC Staff member(s) available to accompany the equipment/ volunteer personnel for the duration of this event? If so, who?

☐ If necessary, is grant or other funding available (and approved) for the requested event?

☐ Will the event interfere with a coinciding previously approved mission(s), or mission of higher priority as determined by the MHPC Staff?

13. Next Steps

☐ Determine if able to complete the mission. Contact the appropriate personnel based upon the request to determine the capability.

☐ Notify the following of the pending request and resolution if available.
- James Clarke
- NC OEMS

- County EM as appropriate
- Regional partners as appropriate

☐ If the request is approved, notify the requestor.
- They will need to assume responsibility for the assets, unless otherwise noted.
- MHPC will complete a formal written request for assets
- MHPC will print a loan form for the facility POC to sign upon receipt (2 copies)
- MHPC will check item out of icams inventory to recipient
- MHPC will notify OEMS immediately if they will be out of service
- MHPC will assign responsibility of equipment to a staff member, who will be responsible for the deployment and establishment of resource. Once it is delivered, it becomes the responsibility of the requestor.

☐ If the request cannot be completed, MHPC work with the requestor and regional/ state partners to identify a resolution.

14. All requests approved or denied receive an MHPC mission number. Add approved requests to the mission board when possible.
15. If assets are requested, complete the “MHPC Resource Request Form” for the requesting regional partner.
16. If volunteer personnel are requested, complete the “SMAT Volunteer Request Form” for the requesting regional partner.
17. Communication Update Standards

☐ Updates should be provided every 2- 4 hrs, or at other pre-designated times, as appropriate. They should be provided to:
- Impacted Facility
- MHPC staff
- CMC Administration
- Regional Partners
- State Partners
- Others as determined by event

☐ Updates should include
- Resources deployed
- Potential impact on the region/ state
- Status of deployed resources

☐ Requestor Updates
- Ability to meet need
- Estimated time of arrival

- Team leader on deployment with contact information

☐ Team leader with deployed resources shall notify MHPC lead

- Every 2 hours with situation update or more frequently as needed
- Departure from warehouse
- Arrival at destination
- If an issue is encountered

18. Demobilization

☐ Upon completion of the event, the assigned MHPC staff will return personnel and equipment to service ASAP. If out-of-service status was caused by deployment, status updates on return-to-service will be provided to NC OEMS every 24 hours via email until return to normal operations.

☐ Upon completion of the event, and return of all equipment and volunteers, primary MHPC staff member for the event will send the "MHPC Resource Evaluation Form" to the requesting regional partner.

☐ After Action Report will be completed by the Lead MHPC staff within 4 weeks. This will be submitted to NC OEMS and regional partners as soon as it is complete.

☐ Scan and file all associated mission documentation for future use. Save all documentation to J:/@MHPC/MHPC Deployments. Save in the calendar year folder with the mission number and event name. i.e. "14-07 SMRS FSX"

Mobile Medicine Driver Request Process

1. Log into the Fleet Management Dispatch Request system
    a. Navigate to: http://mmweb.carolinas.org/modules/GD/GDRequestPublicDetail.aspx
    b. Log in using your Atrium credentials

2. Enter the date and time that a driver is needed.

    a. If the date is flexible or can occur over a range of dates, enter the **earliest known date** into the Request Date field and use **08:00** as the request time.
    b. In the "Comments" field, make note that the date is flexible and add any additional information needed.

    For example:
    "Vehicle can be moved any time during the week of June 15th – must be moved and on site no later than June 20th."

3. Select the vehicle to be driven from the dropdown menu.

4. Enter the address at which the vehicle is located.

5. The "Your Information" field (requestor information) should automatically populate. If it does not, enter the applicable contact information.

6. Click "Save" at the bottom left of the page.

7. If there are any questions or additional follow up required, contact **Mobile Medicine** at mobilemedicinefleetmgt@carolinashealthcare.org or call 704.617.9927.

Appendix G: Essential Elements of Information

Purpose: The purpose of the Essential Elements of Information appendix is to provide the types of data that will be requested on an everyday basis of a facility or organization, and the types of data that will be requested during an incident or an emergency. MHPC uses two separate forms, Foundational and Emergent, to collect data based on the situation.

Dissemination: The forms below can be printed out and distributed to emailed to partners. In addition, each for is listed under the MHPC SurveyMonkey account and the link will need to be mailed out to the appropriate partners when requesting information.

Attachment A: Hospital Foundational Form

Hospital Information

1. Hospital Name
2. Is the facility open or is it permanently closed?
    - Open
    - Closed
3. Which of the following best describes the hospital fiscal type?
    - Private for Profit
    - Private Not for Profit
    - Public
    - Other
4. If "OTHER" was selected in Question 3, please explain below
5. Which of the following BEST describes the hospital type?
    - Critical Access Hospital: Maintain no more than 25 inpatient beds, located greater than 35 miles from nearest hospital (15 miles by mountain or secondary road), located in a rural area, maintain an annual average stay of 96 hours or less per patient, provide 24 hours emergency care services
    - Short Term Acute Care Hospital: A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries for a shorter-term illness or condition. NOTE: Most hospitals will fall into this category
    - Psychiatric Hospital: Primarily engaged in providing, by or under the supervision of a Doctor of Medicine or Osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons on a 24-hour basis
    - Children's Hospital
    - Rehabilitation Hospital
    - VA Hospital
    - Long Term Care Acute Hospital
    - Department of Defense Hospital
    - Religious Non-Medical Health Care Institution
    - Other/Specialty Hospital

6. Which of the following best describes the hospital's designation as a trauma center?
- Level 1 Trauma Center
- Level 2 Trauma Center
- Other Trauma Designation
- Not Designated
- Unknown

Hospital Demographics

7. Name
Company
Address
Address 2
City/Town
State/Province
ZIP/Postal Code
Country
Phone Number

Facility Bed Types

8. Total numbers of beds LICENSED by the state
9. Total number of STAFFED beds
10. Number of STAFFED ADULT acute care medical/surgical floor beds
11. Number of STAFFED PEDIATRIC acute care medical/surge floor beds
12. Number of beds in the nursery
13. Number of beds in the neonatal intensive care unit (NICU)
14. Number of intensive care unit (ICU) beds
15. Number of pediatric intensive care unit (PICU) beds
16. Number of psychiatric inpatient beds
17. Number of rehabilitation unit beds
18. Number of beds within the nursing facility

Hospital Infrastructure

19. What type of fuel does the facility use for backup power?
- Gasoline
- Diesel
- Gasoline and Diesel
- Unknown
- Other (please specify)

20. Number of gallons of fuel stored onsite
21. Number of hours this amount of fuel could power the facility's generator (assuming emergency loads).
22. Is the facility's HVAC system powered by the emergency generators?
- Yes
- No

- Unknown

23. During the last exercise or real event at the facility, did any of the following communications equipment NOT function properly?

- Two-way radio (hospital to ambulance, hospital to hospital, etc)
- Amateur (HAM) radio
- Landline phone(s)
- Cellular phone(s)
- Satellite phone(s)
- Internet

Attachment B: Hospital Emergent Form

Hospital Demographics

1. Hospital Name
2. Facility Information
    - Company
    - Address
    - Address 2
    - City/Town
    - State/Province
    - ZIP/Postal Code
    - Country
    - Phone Number
3. Select the option which BEST represents the status of the facility as it relates to treating patients:
    - Open (business as usual)
    - Open-limited (services are restricted - some inpatient, some ED, etc)
    - Closed (facility closed)
    - ED Only (only ED is functioning - no inpatients)
    - Temporary Space (using tents, mobile facility, or other alternate care space)
    - Unknown
    - Mixed status (indicates more than one of the above apply)
4. Total number of inpatients in the facility
5. Are there concerns about the facility's ability to receive and safely provide care for patients?
    - Yes
    - No
    - If Yes, please specify

Hospital Infrastructure

6. Select the option which best represents the structural damage to the facility?
    - No damage
    - Minor damage
    - Critical damage
    - Unknown
7. Select which option BEST describes the facility's security status:
    - No security threat
    - Potential threat requiring access controls
    - Incident occurred or high likelihood or violence/threat requiring access controls
    - Unknown
8. Select the option which best represents the evacuation status of the facility:
    - Sheltering-in-place (indicates facility is weathering storm with patients and staff)
    - Fully evacuating (facility under evacuation)
    - Fully evacuated (facility evacuated with no patients)
    - Partially evacuating (facility under partial evacuation)

- Partially evacuated (facility partially evacuated with some patients)
- Not Applicable/Unaffected
- Unknown

9. Select the option which best represents the power status of the facility
    - Commercial power
    - Generator power
    - Mixed commercial / generator power
    - No power
    - Unknown
10. Is the facility's HVAC system on generator backup?
    - Yes
    - No
    - N/A (HVAC not powered by generator)
    - Unknown
11. Is the facility on its usual water supply?
    - Yes
    - No
    - Unknown
12. If the facility is not on its usual water supply, is the facility using bottled water or an alternate water supply for potable water?
    - No, using usual water supply
    - Bottled water
    - Alternate supply (e.g. well)
    - Combination of both
    - No potable water is available
    - Unknown
13. How many days supply of potable water does the facility have?
14. Are sewer systems functioning (e.g. are toilets flushing)?
    - Yes
    - No
    - Unknown
15. Is there a reliable water supply for dialysis services?
    - Yes
    - No
    - Not applicable
    - Unknown
16. Are all communications functioning?
    - Yes
    - No
    - Unknown
    - If no, please describe which communications are offline as well as communications needs

Immediate Needs

17. Does the facility have any of the following immediate MEDICAL SUPPLY needs impacting its ability to receive or care for patients to the capacity needed?
    - Vaccines: YES OR NO
    - Ventilators: YES OR NO
    - Other medications: YES OR NO
    - Beds: YES OR NO
    - Monitors: YES OR NO
    - PPE: YES OR NO
    - Oxygen: YES OR NO
    - IV Fluids: YES OR NO
    - Blood: YES OR NO
    - If yes, please specify what the need is within the next 48 hours:
18. Does the facility have any of the following immediate needs impacting its ability to receive or care for patients to the capacity needed?
    - Medical Staff: YES OR NO
    - Food: YES OR NO
    - Water: YES OR NO
    - Power: YES OR NO
    - Fuel: YES OR NO
    - HVAC: YES OR NO
    - Communications: YES OR NO
    - Security: YES OR NO
    - Infrastructure or Building Repairs: YES OR NO
    - Responder Needs (e.g. food, water, gasoline for transportation): YES OR NO
    - Community Sheltering Support: YES OR NO
    - Transportation: YES OR NO
    - Behavioral Health Services: YES OR NO
    - Waste: YES OR NO
    - Management/Sanitation/Infection Control: YES OR NO
    - Debris Removal/Improved Access to Facility: YES OR NO
    - If yes, please specify what the need is within the next 48 hours:

Miscellaneous

19. How many functioning ventilators, including full function transport ventilators with alarms, are available?
20. How many ventilators are currently in use?
21. Is critical care triage being used?
    - Yes
    - No
    - Unknown
22. Are alternate care sites open in the community or at the hospital for INPATIENT overflow?
    - Yes

- No
- Unknown

23. Do you have any other concerns that you would like to describe?

Attachment C: Long-Term Care Foundational Form

Facility Information

1. Name of Nursing Home
   - Company
   - Address
   - Address 2
   - City/Town
   - State/Province
   - ZIP/Postal Code
   - Country
   - Phone Number
3. Is the facility open or is it permanently closed?
   - Open
   - Closed

Facility Bed Types

4. Total number of STAFFED beds
5. Average daily census of facility
6. Number of rehabilitation unit beds

Facility Infrastructure

7. What type of fuel does the facility use for backup power?
   - Gasoline
   - Diesel
   - Gasoline and Diesel
   - Unknown
   - Other (please specify)
8. Number of gallons of fuel stored onsite
9. Number of hours this amount of fuel could power the facility's generator (assuming emergency loads).
10. Is the facility's HVAC system powered by the emergency generators?
    - Yes
    - No
    - Unknown
11. During the last exercise or real event at the facility, did any of the following communications equipment NOT function properly?

    - Two-way radio (hospital-to-ambulance, hospital-to-hospital, etc): YES OR NO
    - Amateur (HAM) radio: YES OR NO
    - Landline phone(s): YES OR NO
    - Cellular phone(s): YES OR NO
    - Satellite phone(s): YES OR NO
    - Internet: YES OR NO
    - If any of the communications equipment did NOT function properly, please describe.

Attachment D: Long-Term Care Emergent Form

Facility Information

1.Name

- Company
- Address
- Address 2
- City/Town
- State/Province
- ZIP/Postal Code
- Country
- Phone Number

2. Select the option which BEST represents the status of the facility as it relates to treating patients:

- Open (business as usual)
- Open-limited (services are restricted)
- Closed (facility closed)
- Temporary space (using tents, mobile facility, or other alternate care space)
- Unknown
- Mixed Status (indicates more than one of the above apply)

Facility Bed Types

3. Total number of STAFFED beds

4. Total number of patients in the facility

Facility Infrastructure

5. Are there concerns about the facility's ability to safely provide care for patients?

- Yes
- No
- If yes is selected, please describe below

6. Select the option which best represents the structural damage to the facility

- No damage
- Minor damage
- Critical damage
- Unknown

7. Select which option BEST describes the facility's security status:

- No security threats
- Potential threat requiring access controls
- Incident occurred or high likelihood of violence/threat requiring access controls
- Unknown

8. Select the option which nest represents the evacuation status of the facility:

- Sheltering-in-place (indicates facility is weathering storm with patients and staff)
- Fully evacuating (facility under evacuation)
- Fully evacuated (facility evacuated with no patients)

- Partially evacuating (facility under partial evacuation)
- Partially evacuated (facility partially evacuated with some
- patients)
- Not Applicable/Unaffected
- Unknown

9. Select the option which best describes the facility's power status:
    - Commercial Power
    - Generator Power
    - Mixed commercial/generator power
    - No Power
    - Unknown
10. Is the facility's HVAC system of generator backup?
    - Yes
    - No
    - N/A (HVAC not powered by generator)
    - Unknown
11. Is the facility on its usual water supply?
    - Yes
    - No
    - Unknown
    - If no, what is the issue affecting water supply?
12. If the facility is not on its usual water supply, is the facility using bottled water or an alternate water supply for potable water?
    - No, using usual water supply
    - Bottled water
    - Alternate supply (e.g. a well)
    - Combination of both
    - No potable water is available
    - Unknown
13. How many days supply of potable water does the facility have?
14. Are the sewer systems function (e.g. are toilets flushing)?
    - Yes
    - No
    - Unknown
15. Is there a reliable water supply for dialysis services?
    - Yes
    - No
    - Not Applicable
    - Unknown
    - If no, please describe
16. Are all communications functioning?
    - Yes
    - No
    - Unknown

17. Does the facility have ANY of the following immediate MEDICAL SUPPLY needs impacting its ability to receive or care for patients to the capacity needed?

- Vaccines: YES OR NO
- Ventilators: YES OR NO
- Other medications: YES OR NO
- Beds: YES OR NO
- Monitors: YES OR NO
- PPE: YES OR NO
- Oxygen: YES OR NO
- IV Fluids: YES OR NO
- Blood: YES OR NO
- If yes, specify which needs you have within 48hrs
- If yes, specify what is needed within the next 48 hours

18. Does the facility have ANY of the following immediate needs impacting its ability to receive or care for patients to the capacity needed?

- Medical Staff: YES OR NO
- Food: YES OR NO
- Water: YES OR NO
- Power: YES OR NO
- Fuel: YES OR NO
- HVAC: YES OR NO
- Communications: YES OR NO
- Security: YES OR NO
- Infrastructure or Building Repairs: YES OR NO
- Responder Needs (e.g. food, water, gasoline for transportation): YES OR NO
- Community Sheltering Needs: YES OR NO
- Transportation: YES OR NO
- Behavioral Health Services: YES OR NO
- Waste Management/Sanitation/Infection Control: YES OR NO
- Debris Removal/Improved Access to Facility: YES OR NO

Equipment

19. How many functioning ventilators, including full function transport ventilators with alarms, are available?
20. How many ventilators are currently in use?
21. Is critical care triage being used?
    - Yes
    - No
    - Unknown
22. Do you have any other concerns you would like to describe?

Appendix H: SMRS Team Activation and Deployment

Purpose: To provide a standardized method of volunteer activation throughout the NC SMRS.
Procedure:
Notice Event

1. Receive notification from NCOEMS of possible, or high probability of, state wide mission and/or regional notification of a regional event.
2. Utilize ServNC or alternative communication method to send notice to all team members. Place on “Advisory” Status. *(Alternate pathway for stand down)
3. Volunteers are to notify their employers and family members of advisory status, and ensure all personal readiness initiatives are complete, per SMAT ITP Module 6. Volunteers are to verify leave approval with their supervisors.
4. When appropriate, send “Alert” notification via ServNC or alternative communication method to request availability. * (Alternate pathway for stand down)
5. Based upon mission Regional Staff, or their designee, will create assignments and roster SMRS personnel in ServNC.
6. Complete ICS 211 based upon ServNC information.
7. Send “Activation” notification via ServNC or alternate communication method to rostered SMRS personnel to include reporting location, assembly time, and deployment circumstances and duration.

No Notice Event:

1. Receive notification from NCOEMS of possible or high probability of state wide mission and/or regional notification of a regional event.
2. Send “Alert” notification via ServNC or alternate communication method to include request availability and advise to assess personal readiness. * (Alternate pathway for stand down)
3. Based upon mission Regional Staff, or their designee, will create assignments and roster SMRS personnel in ServNC.
4. Complete ICS 211 based upon ServNC information.
5. Send “Activation” notification via ServNC or alternative communication method to rostered SMRS personnel to include reporting location, assembly time, and deployment circumstances and duration.

* “Stand down” can occur at any time during the activation procedure. Should the mission be cancelled, or a change of resources be required, notice should be sent via ServNC or alternative communication method to all personnel that received the “Advisory” notification (or “Alert” in the no-notice scenario). This will help to ensure that all volunteers that might be on alert receive notification to stand down.

SMRS Mobilization Plan

Purpose

The purpose of this plan is to provide a guideline for the activation and mobilization of the Metrolina State Medical Assistance Team 700. The below information should be utilized as guidance, and will be mission specific. The information within this document is not in chronological order and multiple items may be accomplished at the same time. Any issues that may arise within this plan or its application should be forwarded to the appropriate individuals with the Incident Command System (ICS) chain of command.

The Metrolina SMAT 700 is a scalable and flexible deployable team made up of logistical and medical personnel. The activation, mobilization and movement of this resource is complex and for the purposes of this plan will only cover the primary objectives. The Metrolina State Medical Assistance Team 700 requires activation, mobilization and movement of both personnel and equipment.

The Metrolina State Medical Assistance Team 700 is a resource of the State of North Carolina supported through Atrium Health and ESF-8 lead, NC Office of Emergency Medical Services (OEMS). This resource is requested and activated through the NC Division of Emergency Management (NCEM). Activation may be in the form of intra-state, inter-state or federal response. The Metrolina State Medical Assistance Team 700 mission will be approved by NCEM and OEMS prior to activation. Once approved this mobilization plan will be utilized in order to provide a structured response.

Assumptions

- The Metrolina State Medical Assistance Team 700 is a scalable and flexible asset that can be utilized for medical augmentation both inter/intra-state.
- The Metrolina State Medical Assistance Team 700 Operations Plan will be applicable to the Metrolina State Medical Assistance Team 700 Mobilization Plan as needed.
- The Medical Coordination Team (MCT) Plan will be applicable to the Metrolina State Medical Assistance Team 700 Mobilization Plan as needed.
- The Metrolina State Medical Assistance Team 700 will be at a minimum 95% loaded at all times to facilitate rapid response.

Activation

The activation of the Metrolina State Medical Assistance Team 700 will occur in two components: personnel and equipment. These activations will occur simultaneously. Once a mission has been accepted by NCEM and OEMS, the activation protocol will be initiated by the OEMS. The team members will be notified via ServNC (NC Volunteer Registry) or alternative communication method, and queried as to their availability for deployment. Personnel receiving the ServNC message or other message will be informed of vital information for the mission. This information may include: reporting time, location, duration of mission, and specific requirements. During this process a roster will be placed into ServNC by the OEMS. This roster will be available for review by the Team Leader and OEMS disaster staff.

Equipment activation of the Metrolina State Medical Assistance Team 700 requires the mobilization of the assets that make up the unit including trailers, medical equipment, communications equipment, lighting, etc. Equipment is managed full time by the Regional Healthcare Preparedness Coordinator and staff. During a time of deployment this staff will have to be augmented by additional staff to load the equipment not currently

packaged in a ready state. The Metrolina HPC RERRC will be in discussion with OEMS during the acceptance phase of a mission and the Metrolina HPC RERRC will activate his/her staff in order to expedite the mobilization process. Activation will then include additional staffing for augmentation as the mission dictates. This augmentation may come from the State Medical Response System (SMRS) or local emergency services personnel around the Metrolina State Medical Assistance Team 700 base of operations. Personnel augmentation will be guided by the full time Metrolina State Medical Assistance Team 700 staff and reference documents listed in the reference section of this document.

Mobilization

The personnel component of the Metrolina State Medical Assistance Team 700, once receiving the notification and approval of the mission, will then begin mobilization. Either through ServNC, or by other means of communication, the personnel will be given mission specific information. Mission briefs will be provided at a later time. Personnel will then report to the assigned location with their appropriate equipment and gear. If billeting is needed for an overnight stay prior to deployment, these arrangements will be made by Metrolina State Medical Assistance Team 700.

Upon notification of the mission, the Metrolina HPC RERRC will activate the full time SMAT 700 staff. Augmentation personnel will be requested by the Metrolina HPC RERRC or OEMS. Once personnel are in place the logistical package of the Metrolina State Medical Assistance Team 700 will be readied for deployment to include the loading of equipment into appropriate packaging and then to the trailers. This phase will also include the requisition of any assets that are not readily available (ie: Road Tractors). The Metrolina HPC RERRC /OEMS will maintain a list of assets that will be provided by contractors should the need arise. This readiness will follow the outlined procedures set forth for the Metrolina State Medical Assistance Team 700.

During the mobilization phase, designated staff of the Metrolina State Medical Assistance Team 700 will begin deployment documents to include the minimum IAP documents (See reference section), convoy plan, finance tracking documents, etc. Mission specific documents will be added to this document as attachments and references as the mission requires.

Deployment

During the deployment phase the Medical Coordination Team (MCT) / Logistics Support Team (LST) and equipment comprise one unit. In instances requiring a forward deployment of the MCT in advance, deployment will occur at an earlier time following the same guidelines in this document. Upon completion of the mobilization phase, the Metrolina State Medical Assistance Team 700 (personnel and equipment) will transition to deployment status. Deployment will begin with a systematic check of all equipment and personnel to include; load plan, personal gear, travel route, communications plan, convoy plan and other items as dictated. The deployment phase begins at the end of mobilization and does not end until the unit arrives at its prearranged destination. During travel the Metrolina State Medical Assistance Team 700 will follow the communications plan to include the telephone directory of travelers. Should emergency assistance be required during transport, the designated emergency Metrolina State Medical Assistance Team 700 contact will be contacted by radio or cell phone. Travel procedures will be included in the convoy plan and will be written to insure safety and security.

During out of state declared deployments of the Metrolina State Medical Assistance Team 700, a member of the OEMS staff will travel with the assets and be authorized, or have the mechanism, to acquire approval for expenditures.

Appendix I: RHSC/HISS Activation

Purpose:

This document is meant to assist the Healthcare Preparedness Coordinator (HPC) and Regional Healthcare Support Cell (RHSC) staff by defining general processes for the efficient activation and operations of the RHSC. The Healthcare Information Sharing System Plan (HISS) is intended to supplement the RHSC.

Concept of Operations:

General: Response actions will be based on *activation levels* as determined by the HPC or their designee and are described below. The activation level assigned for the specific incident will be determined based on the information initially obtained and is subject to change as more information becomes available. The level of activation, once assigned, will help determine the appropriate resources necessary to effectively and efficiently support incident response efforts. The response actions outlined in this Activation Plan are guidelines only.

Notification: Upon notification that an event/incident has occurred or has the potential to occur, the RHSC will activate. RHSC staff will verify the event/incident information and confer with the HPC or their designee to determine the appropriate activation level and response.

Activation Levels: Defining activation levels gives RHSC staff a basic response guideline for any given situation. The following table describes the RHSC Activation Levels, along with potential scenarios where each may apply. These are guidelines only.

RHSC ACTIVATION LEVEL	INCIDENT/EVENT DEFINITION	RHSC STATUS	EXAMPLE
0	A situation that does not require additional response from the RHSC except for situational awareness and monitoring.	**Not Open**	
1	A localized, contained incident that is quickly resolved with limited assistance. Does not affect the overall functioning of hospitals/healthcare agencies within the coalition region.	**Open** - at the discretion of RHSC Staff	
2	A serious emergency that completely disrupts one or more hospital's operations within a county or area. Outside emergency services as well as major efforts from within the hospitals will be required.	**Open -** additional RHSC staff designated to RHSC as needed	
3	A community-wide disaster that seriously impairs or is expected to impair operations of several healthcare facilities within an area (city, county, region, etc.). External emergency response resources from state agencies and	**Open** - additional RHSC Staff designated to RHSC	

	the potential of federal assistance will likely be required.		

Activation Level Response Actions: These provide a method for effective initial and ongoing support functions by the RHSC staff. These guidelines should be utilized in conjunction with Job Action Sheets in order to orient RHSC staff to specific responsibilities for responding to the incident. Although the following response actions are presented in a step-by-step format, it is up to the HPC, or their designee, to determine the need for and/or appropriate order of actions as required for the particular event.

ACTIVATION LEVEL 0 RESPONSE (HIGH ALERT ONLY)		
Response Action		**Task**
1	**Verify the Incident.** Verify that the incident is actually occurring.	Use the following methods to verify information, if required. Call/contact the number/address received and discuss incident details with the caller. Verify the incident via credible reporting methods. Contact local first responders or emergency management in the affected area as appropriate. *Use RHSC Activation Checklist (below) for collecting event/incident information.*
2	**Contact HPC or other RHSC staff.** Update them on current situation.	Enlist support with communications as required for event / incident (e.g., update WebEOC/NC Sparta, develop messaging, conducting coordination).

ACTIVATION LEVELS 1-3 RESPONSE		
Response Action		**Task**
Perform actions 1 and 2 from Level 0 above first.		
3	**Open RHSC location (if necessary).**	Open the designated RHSC/HISS location. If working remotely, determine the best location for the RHSC/HISS and/or operate a "virtual" RHSC/HISS, as resources allow (cell phone, laptop computer, connectivity, etc.).
4	**Confer with HPC/Coalition Leadership**	Regarding options for a RHSC/HISS Liaison to be sent to the county or hospital EOC once opened.
5	**Contact Office of Emergency Medical Services (NCOEMS)**	For activations involving the deployment or potential deployment of SMRS resources, the NCOEMS Shift Duty Officer should be notified via email DHSR.NCOEMS.SDO@dhhs.nc.gov or phone 919-855-4687.
Continue performing response actions 6-8 below until additional MHPC Staff are given assignments in the RHSC/HISS.		
6	**Notification to Off-Duty MHPC Staff**	All incidents greater than Level 0 warrant communication to be sent to off-duty RHSC Staff to apprise them of the situation. Additional MHPC staff may be required to support the event as determined by the HPC, or their designee. In such an event, MHPC staff may be requested to do the following: • **Report to the RHSC/HISS –** RHSC staff that are in or near the building in which the RHSC is located, should report to it directly to

ACTIVATION LEVELS 1-3 RESPONSE		
Response Action		**Task**
		assume a role as assigned by the HPC. Bring laptop computer and other necessary equipment/materials as requested.
7	**Access and update WebEOC/NC Sparta and communication / information systems.**	Log into WebEOC/NC Sparta and provide updated status. Utilize available communication and information systems to collect and share essential elements of information as appropriate. Develop and submit Healthcare Preparedness Coalition/SMRS situation reports, ServNC staffing requests, etc. as necessary or as otherwise requested.
8	**Alert to Healthcare Preparedness Coalition Member Organizations**	Utilize available communication and information systems to alert appropriate entities (Coalition hospitals, Coalition members etc.) to notify them of the event. *Messages should be as specific as possible regarding the incident and actions you need them to perform such as entering hospital-specific information into WebEOC/NC Sparta or Continuum, responding to ServNC messages, or using VIPER radios for communications.*

RHSC/HISS Deactivation: When the RHSC's incident-related responsibilities have ceased as determined by the HPC or their designee, deactivation activities may be initiated.

- **Resources:** RHSC/HISS staff should begin process for the return any mobilized/deployed resources to their original locations.
- **Notifications:** RHSC/HISS staff and other entities (hospitals, EMA, health departments, etc.) contacted at the beginning of the event may need to be contacted once again regarding event deactivation details. This should be done through the most effective method of communication available at the time.
- **Documentation:** Documentation on the details of the incident and the RHSC's response to the incident is a responsibility of the assigned Planning Section Chief, or RHSC staff as designated by the HPC. The event may also require a formal After Action Review to be submitted by the Planning Section Chief to the HPC and/or OEMS.
- **System Demobilization:** RHSC/HISS staff should ensure that all information entered on systems utilized during the incident (Healthcare WebEOC, etc.) is saved for documentation purposes and that these systems are restored to their pre-event status.

RHSC/HISS Activation Checklist

Date	**Hospital**	**Person Reporting**	**Contact Info** **Phone:** **Cell:** **Email:**
HOSPITAL STATUS		**FACILITY IMPACT**	
Command Center Open? Receiving victims? Lockdown?		**Interruption of Patient Care Services?** **Damage to Facility?** **Security Issues?**	

	Emergency Power?
POWER OUTAGE	**MASS CASUALTY INCIDENT**
Estimated time of restoration? ED on Diversion? Interruption of Patient Care Services? Hospital Census? How many ventilator patients? Updated Healthcare WebEOC/Continuum?	**Number of anticipated victims?** **Triage Levels (how many of each have they received?)** **Red** | **Yellow** | **Green** | **Black** **ED on Diversion?** **Other Facilities receiving patients?** **Change in patient care services?**
PATIENT CARE ISSUES	**IMPENDING EVACUATION**
Number of patients involved? Number of patients admitted? Infectious/Isolation Procedures? Coalition agencies involved (EMA, Public Health)?	**Hospital Census?** **Number of patients on ventilators?** **Transportation plans in place/activated?** **ED on Diversion?**
What do you need from the RHSC/HISS? Would you like the RHSC to send a message to particular Coalition agencies? If yes, which ones (hospitals, Long Term Care, EMA, etc.) and what information do you want released?	

Appendix J: SMRS Team Demobilization and Recovery

Purpose:

This document is meant to assist the Healthcare Preparedness Coordinator (HPC), Regional Healthcare Support Cell staff (RHSC), and deployed SMRS leadership by providing a protocol for the 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 of State Medical Response System (SMRS) personnel, assets, and resources.

Concept of Operations:

General

As response objectives are achieved and the emergency situation comes under control, the Incident Commander may direct the demobilization of various response elements. This process includes:

- The collection of health records/reports and coordination with support agencies for continued response, care, or monitoring;
- The release of personnel and equipment assets which are no longer needed;
- The collection of fiscal and administrative documents generated as part of the response;
- The collection of response performance/evaluation reports, After Action Reports (from each response element), debriefing of incident management staff, and development of a Corrective Action Plan.

Assessment & Decision to Demobilize

At the beginning of every new operational period the Incident Commander, HPC/RHSC staff, or the ESF-8 Desk at the SEOC as appropriate, will make an assessment of the remaining response objectives and determine what response elements, if any, should be demobilized and recovered back to normal operations. If it is determined that further control and closure of the incident no longer requires all the response elements available, they will take the following actions:

- Determine the extent of the demobilization.
- Determine demobilization priorities.
- Determine constraints on demobilization.
- Task deployed SMRS team leaders with the development of a plan for the demobilization of SMRS resources.

Incident Demobilization Planning and Implementation

Once the decision has been made to demobilize the SMRS Team Leader will task the Demobilization Unit Leader (DUL) and Demobilization Team (DT) with the development and implementation of a demobilization plan (refer to Roles & Responsibilities and SMRS Incident Demobilization Planning Guidance below).

In preparation for demobilization, the DT will work within the onsite ICS to create and maintain records for tracking and documenting the use of deployed resources, their return, condition on return, and lists of assets, personnel, expended resources (disposables and expendables) to detail any necessary reimbursement or required out-processing. Prior to demobilization, these lists must be approved by the Incident Commander or SEOC ESF-8 Desk, depending on the situation, and any expense reports must indicate that the Incident Commander or requesting organization may be responsible for reimbursement or replacement of items.

The SMRS Team Leader shall ensure that Team Closeout meetings have been completed, obtain names and phone numbers of all personnel demobilizing, and track them from onsite to home base. Demobilization is not complete until all units are back at home base and accounted for.

The HPC and RHSC staff can assist in pre and post demobilization communications and should be utilized to and to track resources. Once all units are accounted for at home base RHSC staff will document the fact and demobilize the RHSC.

Incident Evaluation & Closeout
Personnel identified for demobilization must receive a debriefing of incident events and have an opportunity to provide feedback on their performance.

Team Closeout Meetings will be utilized to debrief SMRS personnel that are released prior to the closeout of the incident. See **Team Closeout Meetings** below.

Incident Closeout Meetings will be utilized to summarize the events during the incident and provide feedback for use in the After Action Report/Corrective Action Plan. See **Incident Closeout Meetings** below.

Roles & Responsibilities:
Proper demobilization and recovery of SMRS assets to pre-incident operations requires the coordinated effort of all individuals under the incident command system.

The following is a summary of ICS position-specific responsibilities during demobilization and recovery. Individuals holding specific ICS positions should refer to their Job Action Sheets for more information.

Incident Commander
The Incident Commander will stay with the incident until its absolute conclusion and the "closing out" of the incident and is responsible for:

- Establishing release priorities
- Reviewing tentative release lists
- Approving resource orders and the demobilization plan
- Approving the closeout meeting agenda and facilitating the final closeout meeting

Liaison Officer
The Liaison Officer will:

- Identify terms of agreements with assisting agencies in regard to release of the resources and special needs and forward this information to the Demobilization Unit Leader.
- Attend the Closeout Briefing.
- Attend any post-incident review activities with other agencies involved in the response and forward this information to the Documentation Unit Leader or other appropriate ICS section (e.g. logistics, Finance).

Safety Officer
The Safety Officer will:

- Ensure that leadership (directors, supervisors, leaders, etc.) collects documentation of injuries to responders which occur while on the incident and forwards this information to the Incident Commander and Finance Section Chief.

- Ensure that leadership considers the physical condition of personnel, travel regulations (if applicable), and assesses the ability of personnel to safely travel.
- Attend the Closeout Briefing.
- Attend any post-incident review activities with other agencies involved in the response.

Operations Section

The Operations Section Chief will:

- Identify operational resources that are, or will be, excess to the incident and prepare a list for Demobilization Unit Leader.
- Collect documentation of injuries to responders which occur while on the incident and forward to the Safety Officer.
- Collect all financial documentation and information for restitution and forward to the Finance Section Chief.
- Attend the Closeout Briefing

Planning Section

The Planning Section Chief will:

- Oversee the coordination and development of the demobilization plan; develop the closeout briefing (agenda and handouts) and assign appropriate tasks to the planning section unit leaders to accomplish these tasks.
- Facilitate Team Closeout Meetings
- Collect documentation of injuries to responders which occur while on the incident and forward to the Safety Officer.
- Collect all financial documentation and information for restitution and forward to the Finance Section Chief.
- Complete the After Action Report (AAR) for the incident after demobilization is complete.
- Submit the AAR to the Director of the Office of Emergency Preparedness, North Carolina Office of Emergency Medical Services within 30 days of incident closeout.

Demobilization Unit: The Demobilization Unit Leader and Demobilization Team will develop the specific, individual plan document, and outline of the process, and monitor plan implementation.

Documentation Unit: The Documentation Unit Leader and staff will package all incident documentation for archiving with the responsible agency or jurisdiction.

Resource Unit: The Resource Unit Leader (RUL) assists the Demobilization Unit Leader in determining total resources assigned, home units, length of assignment, and travel needs. The RUL will also will identify planning resources that are, or will be, excess to the incident and prepares list for Demobilization Unit Leader.

Logistics Section

The Logistics Section Chief will:

- Oversee the coordination and execution of logistics unit tasks and ensure that unit leaders accomplish these tasks.
- Collect documentation of injuries to responders which occur while on the incident and forward to the Safety Officer.
- Collect all financial documentation and information for restitution and forward to the Finance Section Chief.
- Attend the Closeout Briefing.

Facilities Unit: The Facilities Unit Leader and staff are responsible for demobilizing all incident facilities, such as the command post and incident base. This Unit will inspect all sleeping and work areas and ensure that they are cleaned up and returned to their original condition before personnel are released.

Supply Unit: The Supply Unit and staff will collect, inventory, and arrange to refurbish, rehabilitate, or replace resources depleted, lost, or damaged at the incident. This will include: 1) Implementing an equipment inspection program to identify damage caused by use during the incident; and 2) Ensuring that all issued property items are returned or accounted for prior to release.

Ground Support Unit: The Ground Support Unit and staff will ensure that there will be adequate ground transportation during the release process and that vehicles are inspected. This will include: 1) Implementing transportation inspection program to identify damage caused by use during the incident; 2) Identifying and resolving special transport needs; and 3) Conducting safety checks on departure of released units.

Communications Unit: The Communications Unit and staff will identify and resolve any special communications needs and ensure that all radios not needed to maintain communications after demobilization are returned or are accounted for. The Unit will inspect all communication equipment for damage caused by use during the incident.

Food Unit: The Food Unit will ensure that there will be adequate meals for those being released and for those remaining in camp.

Finance and Administration Section

The Finance Section Chief will:

- Collect any service documentation prior to units (resources) departing the incident to verify services and agreed-upon work schedules.
- Collect any documented damage claims to vehicles and equipment.
- Collect documentation of injuries to responders which occur while on the incident.
- Collect any other financial documentation and information for restitution.
- Process claims, time records, and incident costs, for released personnel and equipment.
- Assist the IC in determining release priorities.
- Attend the Closeout Briefing.
- Continue to complete any necessary incident-related documentation after incident demobilization.

Other Leadership (branch directors, division/group supervisors, and unit leaders)

These leaders will:

- Identify excess resources and provide lists and release priorities up their chains of command and through their Section Chiefs for forwarding to the Demobilization Unit Leader.
- Conduct Team Closeout Meetings with the assistance of the Planning Section prior to release and forward “Lessons Learned” and any performance recognition up their chains of command and through their Section Chiefs to the Documentation Unit Leader.

HPC/RHSC Staff/SEOC ESF-8 Desk (as appropriate for the situation)

Personnel in these roles will:

- Provide support to the DUL and DT
- Provide information for reassignment of released resources to other incidents
- Review tentative releases
- Notify the Demobilization Unit Leader with release approvals, reassignments, and travel information

SMRS Incident Demobilization Planning Guidance:
SMRS demobilization plans will contain a cover page and the following five (5) sections. Refer to the *Sample Demobilization Plan* below to review a sample plan.

Cover Page: This section will include the incident name and contain the signature blocks of the Planning Section Chief (as the preparer) and the other Section Chiefs, HPC (as appropriate), and Incident Commander/SMRS Team Leader (as approvers).

General Information: This section will further identify the incident and include the following points:
- Authorization for Demobilization
- Initiation of the release process
- Release location(s)
- Release restrictions/requirements
- Transport/travel requirements
- Closeout briefing requirements
- Coordination requirements
- Performance recognition
- Safety requirements and location(s) of safety checks

Responsibilities: This section will detail command and staff responsibilities for the implementation of the demobilization plan.

General release priorities: This section will detail the order of release approved by the incident command and general staff. The IC/TL and SMRS staff must consider the following factors when determining the priority of release:
- Number of resources that can be processed for release at one time
- Union work rules/policies
- Local, regional, state, or national guidance on release priorities
- Inter-agency policies/procedures or agreements (MOA/MOU)
- Safety requirements and regulations (e.g. required rest periods for drivers).

Specific release procedures: This section will detail the specific release procedures for the incident including:
- Critical resource identification
- Surplus resource release process
    - Command/general staff coordination
    - Released staff/unit responsibilities
    - Demobilization Unit responsibilities
- Travel information (work/rest requirements, permitting, other requirements)

Directories (maps, telephone listings, etc.): This section will provide any contact information, response area maps, specific convoy routes, or other information necessary to facilitate the demobilization.

Team Closeout Meetings
Team Closeout Meetings are short, informal sessions to debrief responders due to be released from an incident.

Purpose: The purpose for these meetings is to collect "lessons learned" information and recognize outstanding responder performance while incident actions are still fresh in responder's minds. This

information is critical to improving future response performance and enhancing the morale and of responders and their teammates.

Responsibilities: All incident leadership from the Unit Leader-level up, are expected to conduct team closeout meetings. These meetings must take place prior to release for the incident and/or the Incident Closeout Briefing. Planning Section staff will facilitate and document these meetings.

Format: The suggested format for these meetings is:

1. Debrief of current incident situation (given by Planning Section Staff).
2. Identify actions performed by the team (what, when, and how).
3. What went well?
4. What needs improvement?
5. What lessons were learned (corrective actions)?
6. Outstanding performance?

Incident Closeout Briefing

Purpose: The Incident Closeout Briefing is a formal meeting of SMRS incident command/general staff and remaining active SMRS personnel to summarize the events during the incident and provide feedback for use in the After-Action Report/Corrective Action Plan.

Responsibilities: As discussed above, the meeting agenda will be developed by the Planning Section Chief and approved by the Incident Commander/Team Leader. The IC/TL or his designee may facilitate this meeting. Planning Section Staff will document the meeting. All staff remaining on the incident scene should attend this meeting.

Format: The suggested format for these meetings is:

1. Incident summary
2. Discussion of major events within the incident that may have lasting ramifications
3. Turnover of appropriate incident documentation, to include components that are not finalized
4. Allowing an opportunity for the SMRS staff to bring up concerns prior to the incident ending
5. A final evaluation of incident management by the SMRS leadership & staff

After Action Report: The following framework is suggested for the After-Action Report:

1. Report
    a. Accumulation of all incident documentation.
2. Investigation
    a. Cause
3. Analysis
    a. In-depth examination of deficiencies: plan, operational, and organizational.
4. Follow-up
    a. Present recommendations to correct the identified deficiencies.
    b. Designation of required actions and responsible parties.

The HPC/RHSC staff will ensure that an AAR is completed within thirty days of incident closeout and a CAP is produced within sixty days. The AAR and the CAP will be distributed to the Exercise Coordinator, other identified Healthcare Preparedness Coalition staff, identified community partners, and grantees, as requested. The AAR and CAP from each exercise will be used to make improvements to SMRS emergency plans and improve future capabilities-based training and exercise planning.

REIMBURSEMENT

Deployments not assigned by the SEOC: Each Coalition adds their processes.

SEOC-assigned Deployments: All deployed teams must obtain a **Mission Reimbursement Workbook** from NCOEMS to be maintained throughout their deployment to capture operational costs and expenditures over the deployment. The workbook is tabulated with each tab used to capture a specific cost or expenditure. Deployed teams utilize the workbook to record transactions during deployment as they are incurred. A current copy of this workbook is maintained by NCOEMS in the **Emergency Response Reporting Documents** folder of the North Carolina Healthcare WebEOC File Library.

The Logistics Section Chief for deployed teams utilize the **Materials**, **Rental Equipment**, and **Contracts** tabs of the workbook which capture costs/expenditures of supply/resupply operations as they pertain to expended supplies (Materials), rented equipment (Rental Equipment), and purchased services (Contracts).

Once teams have demobilized and recovered home the SMAT Team Leaders review all recorded costs and expenditures with their Finance/Administration Lead and officially complete the Mission Reimbursement Workbook. SMATs submit completed workbooks to NCOEMS for review and approval within 25 days of team demobilization. NCOEMS submits approved workbooks to NCEM for reimbursement within 30 days of team demobilization.

The following set of procedures are the responsibility of the Logistics Section Chief and the Finance - Administration Lead for the deployed SMAT asset or their designees (e.g. Warehouse Unit Leader).

1) **Generate ICAM reports (standard or ad hoc) to collect expense information necessary for reimbursement purposes and for the completion of the Mission Reimbursement Workbook (refer above to steps 1b-c in the On-Site Resupply section of the SMRS Resupply SOG and below).**
   a) **Develop "Mission Reimbursement Report" in ICAM.** This report will assist the deployed SMAT in filling out the Mission Reimbursement Workbook required by NCEM for reimbursement. The workbook asks for the following information, if applicable, regarding purchases (corresponding iCAM term):
      i) **Item** (Description),
      ii) **Date Purchased** (Date Created),
      iii) **Stock #** (Part #).

   b) In the "View" tab drop down, run an "Inventory Deployment Transactions" report filtering the "Action" by "Issue" and "Date Created" by deployment dates to generate a list of supplies expended over the course of the deployment.
      i) In the Transaction section type in "Issue"
      ii) In the Date Created section filter to include dates ≥ the start date of the deployment and ≤ the end date of the deployment.
      iii) Use the Field Chooser to add the data fields identified in **a)** and remove any other unwanted field.
      iv) Format information as desired, export and print report.

2) **Complete draft of logistics tabs in Mission Reimbursement Workbook.**
   a) Utilize generated ICAM reports and other information as necessary to complete the **Materials**, **Rental Equipment**, and **Contracts** tabs of the Mission Reimbursement Workbook. Basic instructions are provided within the workbook and each tab. Information covering expended supplies are recorded in the Materials tab, rented equipment in the Rental Equipment tab, and purchased services in the

Contracts tab.

3) **Review all expenditure reports and draft Mission Reimbursement Workbook with their Finance/Administration Lead and complete final copy.**

4) **Submit completed workbook to NCOEMS for review and approval within 25 days of team demobilization.**

Appendix K: Communications Plan

The following guidelines are identified to promote interoperable communications for North Carolina State Medical Response assets.

A. READINESS

1. SMRS DESIGNATIONS

It is recommended that state medical response system assets communicate by plain language designations. Currently there are eight SMAT II regions geographically located and numbered 100-800. Additional SMRS assets such as SMAT III's are labeled by geographic location; (Ex Halifax SMATIII). Ambulance Strike Teams (AST) are labeled by SMATII attachment (Ex AST600).

2. SPECIFIC RADIO CALL SIGNS

When calling other SMRS resources – It is recommended that positions are hailed by plain language and/or team number. While the call sign is longer than plain numbering, there is less confusion with plain language. Examples can be "SMAT100 Team Leader, SMAT 600 Operations, SMAT 800 Logistics" etc. A similar approach can be applied for vehicles such as "SMAT100 M8". During a large scale event the ICC (Incident Communications Center) or COML (Communication Unit Leader) can aide in call sign assignments.

3. VIPER (VOICE INTEROPERABILITY PLAN FOR EMERGENCY RESPONDERS)

The North Carolina Viper radio system is the preferred method for interoperable and wide area communications. The SMRS has a variety of options available for statewide communication. The following talk groups are available for immediate use without clearance: NCSMAT, VML79501 (HOME). The following talk groups are available for emergencies but should be coordinated by the ICC or ComL: VML79600 (Command), VML79601 (Logistics), VML79700 (Staging), VML79701 (Transport), VML79800 (SMRS Ops1), VML79801 (SMRS Ops2).

4. NCMCN (NORTH CAROLINA MEDICAL COMMUNICATION NETWORK)

North Carolina maintains a secondary legacy UHF radio network which can be utilized for SMRS needs. Currently the NCMCN system is utilizing the same infrastructure as the Viper system which is prone to the same system failures. With the large amount of suitcase (PACK) carried radios and facility radios, this is still a viable vehicle for local, regional and statewide communications. Additional information can be found in the OEMS Viper and DTMF Reference: http://www.ncdhhs.gov/dhsr/EMS/technolg.shtml

5. UHF (ULTRA-HIGH FREQUENCY) CACHE

The UHF radio cache is the preferred method for local on site communications for a majority of SMRS resources. Some SMRS assets are capable of conducting operations on Viper, but usually have a limited number handheld radios. The UHF cache offers a quick, easy solution that is independent of existing infrastructure. The most common channels used are the SMAT "F" channels, MED channels and UCALL/TACS. The current (16) channel SMRS UHF template is:

SMAT 16 CH. UHF RADIO TEMPLATE

CHANNEL #	CH. NAME	RX	RX TONE	TX	TX TONE	W/N
CH. 1	SMAT 1	458.025	173.8	458.025	173.8	N
CH. 2	SMAT 2	458.075	173.8	458.075	173.8	N
CH. 3	SMAT 3	458.125	173.8	458.125	173.8	N
CH. 4	SMAT 4	458.175	173.8	458.175	173.8	N
CH. 5	UCALL 40D	453.2125	NONE	453.2125	156.7	N
CH. 6	UTAC 41D	453.4625	NONE	453.4625	156.7	N
CH. 7	UTAC 42D	453.7125	NONE	453.7125	156.7	N
CH. 8	UTAC 43D	453.8625	NONE	453.8625	156.7	N
CH. 9	UCALL 40	453.2125	NONE	458.2125	156.7	N
CH. 10	UTAC 41	453.4625	NONE	458.4625	156.7	N
CH. 11	UTAC 42	453.7125	NONE	458.7125	156.7	N
CH. 12	UTAC 43	453.8625	NONE	458.8625	156.7	N
CH. 13	UMED 8 DIR	463.175	NONE	463.175	173.8	N
CH. 14	UMED 8 RPT	463.175	***	468.175	***	N
CH. 15	UMED 10 DIR	462.975	NONE	462.975	173.8	N
CH. 16	UMED 10 RPT	462.975	***	467.975	***	N
*** DENOTES LOCAL NCMCN REPEATER SITE TONE						

6. NPS (NATIONAL PUBLIC SAFETY) CHANNELS

North Carolina maintains a vast number of National Public Safety conventional repeaters that are strategically located. The repeaters are available in the current standard 8CALL90 and 8TAC91-94. NPS repeaters are a good backup on 800MHz in the event of trunk system failure. Out of state resources should have these frequencies in common if using 800MHz equipment.

7. SATELLITE COMMUNICATIONS

A majority of SMRS resources have the ability to utilize MSAT satellite radio/telephones. MSAT units are an excellent failsafe for communications during disaster. Currently ALL MSAT units in North Carolina contain the following two-way talk groups: NCEM TSKFRC (Team communications), EBO (Eastern Region), CBO (Central Region), WBO (Western Region) and STATEWD (NCEOC). Additional talk group information and telephone numbers can be obtained from the NCOEMS Communication Manager.

8. TELEPHONE

Day to day and initial activation communications between NCOEMS, State EOC and the SMRS resources will be through standard telephone devices and email traffic (If available). Additional resources are available to assist with telephone priority such as GETS and WPS (Wireless priority service). Landline telephones and cellular should be considered alternate forms of communication during large scale emergencies and disasters.

B. SMRS ACTIVATION

1. COMMUNICATION NEEDS DURING ADVISORY, ALERT OR ACTIVATION

   a. Advisory – No specific action is necessary unless deemed by the team leader. Situational awareness for possible movement.

   b. Alert – Ensure communication readiness such as batteries, vehicles and cache equipment. Consider researching communication assets and needs of the potential affected areas.

   c. **Activation – Address communication paths with regional coordination centers (RCC's), NCEOC if required, requesting agency and internal team needs including transit frequencies/ talk groups.**

2. COMMUNICATIONS CONSIDERATIONS DURING ACTIVATION:

   - Communications with NCOEMS coordination (WBO, CBO, EBO and/or EOC)
   - Communications within the team
   - Communications with other teams

Communications with the home base

- Communications with local agencies

C. OPERATIONS

3. COMMUNICATIONS SYSTEM PLANNING

   Communication planning must be conducted in the advance of the BoO (Base of Operations) site selection process. This assures that an assessment of the disaster area and the BoO will meet the communication requirements (Satellite look angles etc).

4. COMMUNICATIONS RF PLAN CONSIDERATIONS

   The ICC/COML will consider the following when developing the communications plan:

   - Command and Control
   - Operations

   Logistics

5. RECOMMENDED COMMUNICATION ROUTES

- Transit operations: VIPER (NCSMAT) if able. If limited with Viper equipment units can communicate with UHF. In this situation it is recommended that the team leader maintain contact with RCC/NCEOC and fleet simultaneously.
- Coordination and Control with OEMS: VIPER (RCC Branch TG if activated) and/or NCEOC Talk group.

  **Note: In a large scale event communications should occur with the assigned RCC for asset tracking. If the regional RCC is not activated yet communications should occur with NCEOC. Resources may be assigned State Event talk groups along with DPR talk groups based on the incident type.

- On site operations: VIPER if able. Majority of SMRS assets are equipped with UHF equipment. UHF can be utilized for on-site operations limited to line of sight communications. Larger footprints can be accomplished with UHF repeaters and utilizing the NCMCN repeaters.

6. PRIORITY OF COMMUNICATION MODES

Wide area: VIPER, MSAT, NCMCN, HF Amateur radio

Local area: VIPER/NPS, UHF and NCMCN, VHF, 2m-440 Amateur radio

7. ALTERNATE LINK METHODS

Use of gateways and linking of disparate modes:

Within the SMRS there are a few options for linking such as ACU-M, ACU-T and ACU1000's. There is also a MSAT to VIPER interface to link nets over the MSAT satellite system. Some ACU's also have the ability to provide ROIP (Radio over IP) linking.

8. DATA INTEROPERABILITY / VOIP

Multiple SMRS resources are capable of satellite broadband technology and voice over IP (VOIP) telephone service. It is recommended that each resource know the following information:

- VOIP telephone numbers
- Fax numbers
- IP addresses to modems and controllers
- How to access port forwarding through modems and networks
- Bird location (Satellite name, look angle) for beam conflict avoidance

9. Default ICS 205 Communication plans:

INCIDENT RADIO COMMUNICATIONS PLAN	DEFAULT TRAVEL STANDARD	Date/Time Prepared		Operational Period Date/Time	

4. Basic Radio Channel Utilization					
System	Radio Type/Cache	Group/Channel	Freq/TN	Assignment	Remarks
VIPER	800MHz TRUNK	SWD SMAT	Trunk / 800	TRAVEL	TRAVEL OPS
VIPER	800MHz TRUNK	RCC TG or EOC	Trunk / 800	COORD/CONTR	Secondary option
800 NPS	800MHz Conv.	NPS 90-94	Varied	BACKUP/DIRECT	BACKUP RPT/DIR
NCMCN	UHF SMAT	SMAT F1		SIMPLEX	SIMPLEX
MSAT	MSAT	TSKFRC	N/A	TRAVEL	BACKUP OPTION

INCIDENT RADIO COMMUNICATIONS PLAN	DEFAULT SITE SETUP	Date/Time Prepared		Operational Period Date/Time	

4. Basic Radio Channel Utilization					
System	Radio Type/Cache	Group/Channel	Freq/TN	Assignment	Remarks
VIPER	800MHz TRUNK	SWD SMAT	TRUNK	CALLING	CALLING
VIPER	800MHz TRUNK	RCC TG or EOC	TRUNK	RCC / EOC COORD/CONTROL	RCC / EOC COORD/CONTOL
VIPER	800MHz TRUNK	STATE EVENT TBA	TRUNK	INCIDENT ASSIGNED TG	INCIDENT ASSIGNED TG
VIPER	800MHz TRUNK	VML79501	TRUNK	SMRS CALLING	SMRS CALLING
VIPER	800MHz TRUNK	VML79600	TRUNK	SMRS COMMAND	SMRS COMMAND
VIPER	800MHz TRUNK	VML79601	TRUNK	SMRS LOGISTICS	SMRS LOGS
VIPER	800MHz TRUNK	VML79700	TRUNK	SMRS STAGING	SMRS STAGE
VIPER	800MHz TRUNK	VML79701	TRUNK	SMRS TRANSPORT	SMRS TRANSPORT
UHF	UHF	SMAT F1-F4	VARIOUS	ON SITE OPS	SIMPLEX ON SITE OPS

ADDITIONAL CHANNELS OR TALKGROUPS SHOULD BE AVAILABLE BY ICS217. THE ABOVE DEFAULTS ARE EXAMPLES OF INTEROPERABLE-INITIAL SOLUTIONS

D. DEMOBILIZATION

There are three phases to disengagement. From receipt of notice that operations are to terminate SMRS resources shall prepare for withdrawal from the disaster area, the COMU or TFL designee is responsible for maintaining communications for the assigned resource while packing equipment. Demobilization should include a communications plan for travel and contacting RCC/EOC when the asset has reached their home base.

E. RETURN TO READINESS

10. Breakdown and Rehabilitation

Upon returning from an incident, the COMU or TFL designee will take any steps necessary to ensure that all equipment is made ready for the next mission.

11. Final Critique and Debriefing

All significant inputs of the mission, both positive and negative, must be specifically described during the critique and debriefing sessions. The most common way to provide this is through a AAR (After Action Report). The COML should provide a functional overview to the asset deployed. The formal report should be prepared as lessons learned and for every problem identified, a solution should be submitted. This formal report is to be submitted for inclusion in the final report.

RHSC Communications Policies

Purpose

During events or incidents affecting the Metrolina Healthcare Preparedness region of North Carolina, The Metrolina Healthcare Preparedness Coalition's (Metrolina HPC) Regional Healthcare Support Cell (RHSC) will initiate communication with and provide support services to Metrolina HPC Healthcare Facilities (Metrolina HPC HF). The role of the RHSC is to supplement local resources by:

- Serving as an information clearinghouse
- Assisting healthcare facilities with resources
- Promoting inter-facility communication

Scope

This plan describes the methods, procedures, and resources used by the RHSC to efficiently communicate internally and externally during an event. Additionally, the plan outlines several event or incident-related scenarios and the associated communications systems (notifications, support resources, etc.) necessary to support response actions.

Authority

Metrolina HPC has been given authority by Metrolina Healthcare Preparedness region healthcare facilities (Metrolina HPC HF) CEOs, the Metrolina HPC Steering Committee, and the Metrolina HPC to function as a RHSC during an event or incident affecting healthcare services. This role is recognized by NC OEMS along with NC EM and written into regional and state emergency response plans.

Role and Responsibility

The RHSC role is staffed by the regional Healthcare Preparedness Coordinator (HPC) or other Metrolina HPC staff designated by the HPC and is available on a 24/7/365 basis via a one call phone number (980) 349-6472]. Staff serving in the RHSC must meet position requirements (see the RHSC Job Action Sheet) and receive initial and ongoing RHSC training as required by Metrolina HPC.

RHSC Activation

The RHSC is considered "activated" upon notification that an event/incident has occurred or has the potential to occur that may affect healthcare services. The information will be validated and then used to determine an appropriate activation level and associated response actions. Refer to Appendix G: RHSC/HISS Activation of the Metrolina Regional Healthcare Support Plan for more detailed information.

RHSC Communication Policies

The following policies are recommended as standards for operation in the RHSC and for communication practice within the Metrolina HPC in general. These policies provide a basis for training and response efficiency. However, it is recognized that there are many different methods and resources available to conduct effective communication and, during emergency situations, methods and resources other than those listed below may be more effective.

Equipment/Systems Used: Only Metrolina HPC-assigned and/or RHSC communications systems should be utilized to request and collect any and all information (rosters, equipment lists, status/resource reports (hospital, SMAT, ICS, etc.), manifests, receipts, evaluations, etc.) necessary to document Metrolina HPC and State Medical Response System (SMRS) resource requests and satisfy information requests.

Contact Information for Healthcare Facilities and ESF-8 Agencies: Obtain contact information for the purposes of validation of notification messages, response coordination, etc. from the following sources:

Hospitals, EMS agencies, and other healthcare facilities utilize the State of North Carolina Dial Code Book at: http://ncdhhs.gov/dhsr/EMS/pdf/dialcode.pdf

NCOEMS State and Regional staff utilize **Appendix C, Attachment 1: State and Coalition Contacts** of the Metrolina HPC Regional Support Plan

Regional HPC and SMAT staff utilize **Appendix C, Attachment 1: State and Coalition Contacts** of the Metrolina HPC Regional Support Plan

Communication Resource Utilization: Telephone, computer-based, and radio communication systems available in the RHSC and assigned by Metrolina HPC are provided to ensure that personnel staffing the RHSC have the capability to maintain situational awareness, report essential information, and coordinate the activation and deployment of Metrolina HPC and SMRS resources. These systems, their primary purposes, and assigned uses are listed below.

Communication Resources and Priority of Use below and **Appendix C: HCC Members and Contact Info** of the Metrolina Regional Healthcare Support Plan for more detailed information.

Telephone Communication Systems: Utilize the following systems for all purposes as needed.

Voice-Over-the-Internet-Protocol (VOIP) telephones:
Incoming calls use telephone: (XXX) XXX-XXXX
Outgoing calls use telephone: (XXX) XXX-XXXX

Facsimile (FAX) telephone:
FAX: (XXX) XXX-XXXX

Metrolina HPC-assigned SMART Phones: Utilize as primary text-communication resource and back-up resource to VOIP telephones and computer-based communication systems (e-mail/internet). Numbers as assigned.

Computer-based Communication Systems: Utilize for intended purpose.

Situational Awareness, Reporting, and Mission Tracking

Emergency Management Agencies and Partners: Utilize North Carolina Department of Public Safety WebEOC (NCSPARTA-WebEOC) at: https://www.ncsparta.net/eoc7/

State Medical Response System Organizations: Utilize the North Carolina Healthcare WebEOC/NC Sparta (NCH-WebEOC/NC Sparta) at http://ncsparta.net

Hospitals, EMS Systems, and Healthcare Centers: Utilize North Carolina Continuum at: https://continuum.emspic.org/login

Messaging and Mission Coordination

Metrolina HPC Staff: Utilize hospital system e-mail account.
State Medical Response System: Utilize ServNC at: https://www.servnc.org/

Inventory and Resource Management

State Medical Response System: Utilize the State Inventory Control and Asset Management system (iCAM) at: http://ncoems.icamservice.com/login.aspx?ReturnUrl=%2fDefault.aspx

Radio Communication Systems - Viper Medical Network (VMN): Utilize for all purposes as needed to monitor and communicate with Metrolina HPC partners (hospitals, community health centers), NCOEMS, SMRS organizations (SMATs, etc.), and other organizations utilizing the VIPER (Voice Interoperability Plan for Emergency Responders) radio system.

Communication Information and Equipment

Utilize the Dual-Tone Multi-Frequency (DTMF) Codes and Reference Information Guide for VMN radio channels, talk group, and use guidance at: http://ncdhhs.gov/dhsr/EMS/pdf/dtmfref.pdf

Motorola MC3000 Digital Desksets:

Incoming calls (listening) for Metrolina HPC set one deskset to _____ talk group
Outgoing calls (talking) for Metrolina HPC set one deskset to appropriate talk group, refer to **DTMF**

Motorola XTS5000 800 MHz radios:

Official or external incoming/outgoing calls for Metrolina HPC set one radio to _____ talk group.
Informal or internal incoming/outgoing calls for Metrolina HPC set one radio to _____ talk group

SMRS Communication Guidelines

Utilize the North Carolina State Medical Response System Initial Communication Guidance. This document provides standard guidelines for the planning, establishment, operation, and demobilization of interoperable communications for SMRS teams and assets. SMRS INITIAL DEPLOYMENT COMMUNICATION GUIDANCE V31.docx

VIPER Medical Network Talk Groups – Purpose, Use, and Access

External Coordination – Metrolina HPC RHSC to Partner Agency/Unit:

Find VMN channel of agency in the DTMF Guide, Press Zone button, Scroll 4-way button to match the first three (3) characters of the VMN address, Set Position knob as necessary to match the VMN channel exactly, Press Home button.

Internal Metrolina HPC Coordination/Conference – RHSC Staff to RHSC Staff:
_____ and _____ - Set Position knob to Position _, Press Zone button, Scroll 4-way button to _____ or _____, Press Home button.

External Metrolina HPC RHSC Monitoring - Partner Agency/Unit to Triad HPC RHSC:
_____ - Set Position knob to Position _, Press Zone button, Scroll 4-way button to _____, Press Home button.

External SMRS Monitoring – Partner Agency/Unit to SEOC ESF-8A Desk (SMRS Disaster):
VML79501 - Refer all incoming calls that require ESF-8A Incident Command action to Command (VML79600)
Set Position knob to Position 1, Press Zone button, Scroll 4-way button to VML79501, Press Home button.

Internal SMRS Incident Command – SMRS Unit to SMRS Unit:
Referral channels for active SMRS response/recovery incident command and coordination:
VML79600 Command
Set Position knob to Position 2, Press Zone button, Scroll 4-way button to VML79600, Press Home button.
VML79601 Logistics
Set Position knob to Position 3, Press Zone button, Scroll 4-way button to VML79601, Press Home button.
VML79700 Staging
Set Position knob to Position 4, Press Zone button, Scroll 4-way button to VML79700, Press Home button.
VML79701 Transportation
Set Position knob to Position 5, Press Zone button, Scroll 4-way button to VML79701, Press Home button.
VML79800 Operations 1
Set Position knob to Position 6, Press Zone button, Scroll 4-way button to VML79800, Press Home button.
VML70801 Operations 2
Set Position knob to Position 7, Press Zone button, Scroll 4-way button to VML70801, Press Home button.

SMRS Incident Radio Communications Plan (ICS-205)
To see default communications plan see, **Attachment F: SMRS Incident Radio Communications Plan (ICS-205)**.

Radio Etiquette
The following rules will be followed when communicating over the radio:
- Use plain language, no codes
- Be courteous and professional with language
- Listen for the “chirp” before you transmit
- Transmit your message in a steady and clear tone
- Avoid interrupting others conversations

Communication Resources and Priority of Use

A variety of communication resources are available to RHSC staff for the support of healthcare facility response and recovery operations. The following table provides a summary of these resources by purpose, assigns recommended priorities for use, and identifies capabilities and limitations.

Metrolina **HPC RHSC COMMUNICATION RESOURCES**			
Purpose	**Priority**	**Resource**	**Information**
Voice Communications (for all purposes)	1	VOIP (Voice Over Internet Protocol) telephones	Desk phones but need connection to the internet to function. Primary mode for RHSC staff to communicate with each other and with Triad HPC HFs and other partnering agencies.
	2	Text-capable Phones	Mobile phones also need connection to internet or cell tower to function. Secondary mode for voice communication for RHSC staff but also a resource for e-mail and communication when phone services are disrupted through text messaging services.
	3	800mHz radio	These radios (mobile and portable) operate as part of the VMN radio system. Provides RHCS staff with a redundant mode for voice communications with hospitals and community health centers. Designated as the primary mode for command and control when SMRS units are activated and deployed.
	4	Satellite Telephones	"Last Call" telephone/radio system provides voice communication capability when power is out or other communications systems fail. Requires satellite availability and must be "activated" prior to use.
	5	POTS (Plain Old Telephone System) telephone	Phones served by conventional phone lines (e.g. FAX machine phone). Provide redundant voice communications when internet and/or power is out.
Document/Data Transmission	1	Email	Provided through laptop or other computer but requires internet connection to function. Primary mode for RHSC staff to transmit documents and data with each other and with other partnering agencies.
	2	Healthcare WebEOC/NC Sparta	Similar support requirements as email. Provides a file library for response / recovery documents and secure messaging. May be utilized as

			appropriate for state to region, strategic-level communication and resource documents.
	3	FAX	Provided through POTS, no computer or internet requirement. Provides redundant data transmission capability when internet and/or power is out.
Situational Awareness, Reporting, and Mission Tracking	1	NCSPARTA/Healthcare WebEOC	Web interface with Hospitals / Hospital Emergency Management staff, Regional HPCs, and HPP/NCOEMS organizations/staff with statewide/regional status boards and messaging. Used to maintain situational awareness, for internal posting and coordination of ESF-8 resource / mission requests, and reporting (IAP, situation reports, ICS forms). Provides two-way communication not possible with Continuum.
	2	Continuum	Web interface with hospitals, EMS systems, and health care centers. Used for situational awareness, status reporting (beds, resources), notification of events, missions (mission rostering efforts), dissemination of general messages, and information gathering (queries) for special reporting needs. One-way communication to hospitals, EMS, and healthcare centers. Results of queries must be requested from the EMS Performance Improvement Center (PIC).
	3	Everbridge	Mass notification system available to all partners that sign up. Notifications can be shared via email, phone call, or text
Messaging and Mission Coordination	1	Email	Provided through laptop or other computer but requires internet connection to function. Primary mode for RHSC staff to transmit documents and data with each other and with other partnering agencies.

	2	Everbridge	Mass notification system available to all partners that sign up. Notifications can be shared via email, phone call, or text
Mapping and Facility Information	1	Multi-Hazard Threat Database (MHTD)	GIS application providing information on **all** healthcare facilities regulated under DHHS - Division of Health Service Regulation. Used for gathering facility info, mapping facilities, weather, and hazards. Main source of information for nursing homes, mental health, long term and adult/elder care facilities.
Inventory and Resource Management	1	Inventory Control and Asset Management (iCAM) System	Web interface with SMRS organizations. Used for inventory and resource tracking of SMRS equipment and supplies. System is active at all times and can be used to monitor equipment status/availability and supply par-levels to support/inform resource management decisions.
Patient Tracking	1	NC Patient Tracking Program	Cloud-based program that allows for patient tracking within a fixed location and in between facilities.

NORTH CAROLINA SMRS ESF-8

Incident Radio Communications Plan (ICS 205)

1. Incident Name: ESF-8 DESK	**2. Date/Time Prepared:** Date: Time:	**3. Operational Period:** Date From: Date To: Time From: Time To:

4. Basic Radio Channel Use:

Zone Grp.	Ch #	Function	Channel Name/Trunked Radio System Talkgroup	Assignment	RX Freq or HEX	RX Tone/NAC	TX Freq or HEX	TX Tone/NAC	Mode (A, D, or M)	Remarks
VML	2	COMMAND	SMRS COMMAND	COMMAND	CCEB		CCEB		D	SMRS COMMAND TALKGROUP
VMJ	5	TACTICAL	STATE EMS	ESF8 DESK	CCCB		CCCB		D	OEMS / EOC CONTACT
VML	1	TACTICAL	SMRS HOME	ESF8 DESK	CCEA		CCEA		D	ESF8 / NCEOC
VML	3	TACTICAL	SMRS LOGS	LOGISTICS	CCEC		CCEC		D	LOGISTICS TALKGROUP
VML	4	TACTICAL	SMRS STAGING	STAGING	CCEE		CCEE		D	STAGING TALKGROUP
VML	5	TACTICAL	SMRS TRANSP	TRANSPORT	CCEF		CCEF		D	TRANSPORTATION TALKGROUP
VML	6	TACTICAL	SMRS OPS1	-	CCF0		CCF0		D	AS ASSIGNED
VML	7	TACTICAL	SMRS OPS2	-	CCF1		CCF1		D	AS ASSIGNED
MCN	-	TACTICAL	MED 10	ESF8 DESK	462.975	OST	467.975	OST	A	BACKUP
MCN	-	TACTICAL	MED 8	ESF8 DESK	463.175	OST	468.175	OST	A	BACKUP

Special Remarks:

6. Prepared by (Communications Unit Leader)**:** Name:_____ Signature:_____

ICS 205	**IAP Page** _____	Date/Time:_____

Appendix L: Inventory Rotation Process

Access to Cached Equipment, Supply and Pharmaceuticals

- Use iCam system to search within our or other coalition inventories.
- Search by item, expiration, lot, model, etc.
- Items will be listed under a physical location and can be located there within the facility/vehicle.

Inventory Management Process

Received:

- As inventory is received, it is checked against the purchase order and then input into iCam.
- If it is not on the iCam master list it will needed to be added by contacting Joe Comello with NCOEMS at joe.comello@dhhs.nc.gov.
- Inventory is rotated as inventory expires so that first in equipment is the first out.

Expired inventory:

- Expired inventory is physically removed from the location and separated into an expired goods box and usually donated.
- These items are issued to MHPC expired/lost/deleted in iCam.

Stored Inventory

- Inventory is stored in trailers, vehicles, tri-wall boxes, totes, rolling carts, pod boxes, and crash carts.
- Some inventory is stored loose on shelves/racks and some are stored stacked on pallets.
- The location of all items can be located in iCam by searching location, item, or model

Resource and Inventory Movement

Checked out/checked in: Goods that will need to be returned (non-disposable) are checked out to the individual taking them and checked in when they are returned.

Moves: If items are physically moved from one location to another, it will need to be rectified to show the move in iCam.

Deployment: Items can be deployed to an event and returned from the deployment after the event. Used items that cannot be returned will need to be taken from the total item quantity when that item type is returned.

Resupply/Replacement Process

- As items expire, they are replaced by items in the resupply trailer totes.
- The new items replace the ones moved from the resupply trailer totes so that deployed items (MSU's, M.O. bags, pods, carts) contain items with the shortest time to expiration and the resupply trailer totes contain the ones with the longest time to expiration.
- Each year, two large orders are place where the current inventory is checked against the par levels to ensure the necessary amount of each item is in each location

Appendix M: 2017-2018 MHPC Regional HVA

Metrolina Healthcare Preparedness Coalition Hazard Vulnerability Analysis 2017-2018

Commented [GHM1]: Change to 18-19 HVA

Project Overview

The Healthcare Coalition (HCC) is obligated to identify and plan for risks. Such an assessment can determine available resources and identify existing gaps. This process not only identified facility or agency-level risks as reported by the coalition partners, but also identified and prioritized risks across both sub-regions and the overall Metrolina region. Using this information, the Metrolina Healthcare Preparedness Coalition (MHPC) will be better able to target those gaps in order to assist regional partners throughout all phases of the disaster cycle.

This HVA is to be conducted at a regional level and is to occur annually and in coordination with state and local assessments.

Methodology

This Hazards and Vulnerabilities Analysis (HVA) was conducted across the MHPC region and included representatives from all stakeholder types (hospital, EMS, long-term care, public health, etc.). The HVA was conducted using two separate phases.

During the first phase, stakeholders were asked to submit their five most prominent risks according to their own internal HVA. Respondents were not limited to a specific tool to acquire this data (Kiser, THAM, etc.) and were only asked for their results. Results were collected during November 2017. Responses varied in their formats, with some providing empirical support for their top five risks, and some simply providing a list. Several hospital facilities provided links to their HVA documents (Kiser). In cases where no ranking was provided by the respondents, MHPC staff identified the top five risks according to risk score as reported in the provided HVAs.

Risks that were reported to MHPC prior to the meeting were then analyzed and the five highest were ranked in order as they appeared from each sub-region.

For analytical purposes, the risk “severe weather” was coded to include winter weather, snow, ice, hail, and severe thunderstorms. Floods (both internal and external), hurricanes, and tornados were treated as discrete risks.

In initial reporting, workplace violence and active shooter scenarios typically appeared as discrete entries and were therefore not combined during analysis.

Sub-regions were delineated according to current MHPC practice and are as follows:

- North – Cabarrus, Iredell, Burke, Catawba
- East – Union, Scotland, Anson, Stanly, Richmond
- West – Cleveland, Gaston, Lincoln, Mecklenburg (included with West only for HVA purposes)

Highest risks from each sub-region were then used to create an overall top five for the entire Metrolina region.

Due to the differences in reporting methods and availability of supporting data, highest risks were identified by tallying the number of times in which a risk was identified by the respondents as one of their top five highest.

The second part of the process was a facilitated discussion held during the December MHPC Quarterly Meeting. Attendees were seated according to geographic sub-region. After the initial presentation of the results, attendees were divided into two groups – one consisting of the Northern and Eastern regions and one of Western and Mecklenburg County. Each group was encouraged to discuss the initial findings and to share any additional concerns as well as any mitigation steps that have been or could be implemented to address the identified risks. Those who did not respond electronically prior to the meeting were encouraged to share their five highest risks. Additionally, this exercise was intended to place representatives from the same geographic proximity in a face to face setting to foster dialogue and additional problem solving.

Sub-regional Findings

West (including Mecklenburg)

Risk	Frequency occurring in individual top five
Severe weather (snow/ice/hail/t-storm)	18
Active shooter	11
Workplace violence	11
IT failure/Cyberattack	7
Flood	6

East

Risk	Frequency occurring in individual top five
IT failure (including network)	5
Winter weather/ice	2
Hurricane	2
Active shooter	2
Workplace violence	2

North

Risk	Frequency occurring in individual top five
IT failure/cyber attack	3
Ice	3
Hurricane	2
Tornado	2
Supply chain interruption/materials shortage/morgue space	1 each

Metrolina Region (All counties)

Risk	Frequency occurring in individual top five
Severe weather	25

Active shooter	13
Workplace violence	13
IT failure/cyber attack	10
Flood	6

Following the sub-regional discussion, the group was brought back together and led through a final facilitated discussion. During this forum, each group reported out their small group findings. Attendees then worked to collectively identify areas of highest risk and possible mitigation strategies throughout the Metrolina region.

Risk	Current Situation/Strengths	Gaps	Mitigation Strategies
Severe Weather			
Notification/Communications	Majority proactive in finding and reporting information	Vendor-based system sometimes provides late notifications	
	Information sharing among agencies/facilities/counties generally good	EMS leaving facility not always receiving messages	
	Use of alternate and redundant communications systems (Everbridge, etc.)		
Awareness/Monitoring	Cognizant of rise in occurrence		
	Extending awareness to SC/Gaffney/border areas	Little to no communication with bordering SC Coalitions	Working more closely with neighboring SC Coalitions
	Past experience informing current and future decision-making re weather events		
Resources	Generally available and adequate		
Planning	Lessons learned from prior events incorporated into planning efforts		

Human Capital	Urban areas largely able to adapt	Staffing concerns among more rural facilities and agencies. Already small staff will be impacted if roads are impassable, etc.	Alternate transport plans or MOU/MOA with private or public resources.
Risk	**Current Situation/Strengths**	**Gaps**	**Mitigation Strategies**
Active Shooter			
Training	Real-world training incorporated into current drills (Joint Commission, etc.). Joint training with local LEO	Training not held for some agency types (public health voiced concern) Not all Public Safety/Law Enforcement is involved in training	Reach those in non-system/non-hospital environments with increased training opportunities (LTC, hospice, etc.) Hold additional training or include these agencies in training opportunities
	Training often active shooter event-specific		
Coordination	Increasing collaboration with LEO and public safety personnel	Not all Public Safety/Law Enforcement is involved in	

		coordination planning	
Staffing	Security personnel on-site (armed in some facilities/systems). Dedicated LEO in high-risk areas	Vastly different configurations depending on facility type. Home health, hospice, LTC often emotionally charged environments without comparable security	Training of staff in recognition/avoidance and of steps to be taken during incident
			Continued collaboration with LEO/public safety – voice concerns about past troublesome interactions
Awareness	Aware that it is a reality. High levels of situational awareness. Knowledge of buildings/work environments	First responders not always familiar with buildings or plans.	Continued collaboration with LEO/PS including joint training and information sharing
Risk	**Current Situation/Strengths**	**Gaps**	**Mitigation Strategies**
Workplace Violence			
Awareness	Aware of shifting culture of healthcare work	Making all staff and visitors	Publishing notices in public places of felony

		aware of felony crime	crime in assaulting healthcare workers
Coordination	Continued cooperation with LEO and Public Safety	Not all Public Safety/Law Enforcement is involved in coordination planning	
	Improving communications with EMS re patients needing transport		
Training	Some area clinical staff and EMS providers offering mental health training and trained in de-escalation techniques		CISM courses beginning to be offered in the region
Communication	Sharing information with all parties re concerning behaviors or threats		
IT Failure/Cyber Attack			
Awareness	Constant messaging re spear phishing techniques, etc.		Continued monitoring and vigilance for new threats
Training	Multi-year exercises and drills include such scenarios		Resource from DHS shared – group able to evaluate infrastructure and share methods to harden
Policy/Protocol/Tech	Back-up systems in use		

	System security inc malware detection and screening		
	Email warning recipient of external email, etc.		
	Manual workarounds (paper, etc.) present in event of failure		
	Highly regulated nature of healthcare sets parameters for EMR, etc.		
Risk	**Current Situation/Strengths**	**Gaps**	**Mitigation Strategies**
Pandemic/Highly Infectious Pathogen			
Training	Program funding to address narrow, specific incidents (Ebola/hemorrhagic fevers) rather than more common threats	Potential for more common conditions such as influenza or Norovirus/"stomach bug" more likely. Extremely high potential impact for all agency types present	Funding is beginning to be earmarked for an "all-hazards approach" rather than being tailored to more specific illnesses.

4. ANNEXES

1. Scenario Specific Considerations
    - Attachment A: Pediatric Surge
    - Attachment B: Burn Surge
    - Attachment C: Infectious Disease Surge
    - Attachment D: Radiation Surge
    - Attachment E: Chemical Surge
2. Medical Surge Coordination
3. Patient Care Strategies for Scarce Resource
4. Evacuation and Tracking (forthcoming)
5. Disaster Behavioral Health (forthcoming)

1.Scenario Specific Considerations

Appendix A: Pediatric Surge

Appendix B: Burn Surge

Metrolina Healthcare Preparedness Coalition
Mass Burn Incident Annex

Situation and Assumptions

The need to care for multiple burned patients is a rarely encounters but forseeable consequence of potential hazards facing healthcare organizations in North Carolina. Compounding the problem is the very limited resources for the care of burned patients not only locally, but nationwide. On a day-to-day basis, burn patients in North Carolina can be treated at the Wake Forest Burn Center or the UNC Jaycee/Burn Center. These resources can be challenged in a mass burn scenario and the MHPC may provide support through: 1) situation and resource-related information processing, 2) assisting with patient and resource tracking, and 3) facilitating communication and agreements between facilities currently treating burn patients and burn specialty receiving patients. As none of the burn facilities in NC are located in the Metrolina region, the MHPC would have to coordinate with the other Healthcare Coalitions where the burn centers are located.

Assumptions

- Various hazard etiologies are possible that could simultaneously generate a large number of burn victims in the Metrolina region
- Victims of these incidents may sustain co-existent traumatic injuries (inhalation injury, blunt, penetrating, etc.)
- County Fire and EMS agencies would, in most foreseeable cases, be the lead agency for field response to an incident of this nature
- Existing burn beds in the Metrolina Region and at other NC burn facilities are limited and have restricted availability to surge at any given point
- When the surge capacity of burn centers is exceeded, it is expected that non-burn centers may need to provide temporary treatment and supportive care to some burn victims
- Based on historical evidence from other mass casualty burn incidents, many burn patients cared for at non-burn centers may be directly discharged from those facilities after initial treatment is completed
- The optimal final disposition for patients with serious burns is a recognized burn treatment center

Key definitions

- **Mass burn casualty incident**: Any incident generating burn patients that severely challenges or exceeds the current capabilities of the adult and/or pediatric burn centers in the state of North Carolina
- **Triage decision table**: A tool developed by the American Burn Association that will be utilized by Burn Centers to facilitate triage decisions as to which patients should be transferred to a Burn Center or Trauma Center for definitive care (see **Attachment 1**).
- **Hospital tiers**: Hospitals designated to receive burn casualties based on acuity when burn victim counts exceed capacity of designated adult and pediatric burn centers.
    - Tier I: Designated adult and pediatric Burn Centers
    - Tier II: Designated adult and pediatric Trauma Centers
    - Tier III: Acute care facilities with Emergency Departments and Intensive Care Units.

System Description

- Burn Centers: There are two recognized burn centers in the state of North Carolina. The North Carolina Jaycee Burn Center in Chapel Hill and the Wake Forest Baptist Medical Center Burn Center in Winston-Salem are both capable of treating adult and pediatric patients. It is expected that during any Mass Burn Casualty Incident in the Metrolina Region that these two facilities would serve as the primary referral centers for burn surge capacity per their individual facility protocols. When their capacities are exceeded, non-burn trauma centers will be expected to take burn patients.

The burn facilities in NC will provide strategic management guidance regarding placement of patients and clinical management guidelines for non-burn facilities.

- Acute care facilities: In a large incident, any acute care facility with a functioning ED may have some burn patients transported to them.
- Rehabilitation and Skilled Nursing Facilities: The major contribution that rehabilitation and Skilled Nursing Facilities (SNFs) can make will be to facilitate rapid in-take of appropriate patients from acute care facilities to free up space in the hospitals. There may be select situations in which rehabilitation facilities will be able to accept recovering burn patients but this will require additional guidance, resources, and assistance (e.g. from Burn Centers).
- Metrolina Healthcare Preparedness Coalition (RHSC/HISS):
  Projected activities that the RHSC/HISS may conduct to support mass casualty burn response include:
    - Provide initial notification of an actual or potential mass casualty burn incident to member organizations and the jurisdiction
    - Provide on-going notifications regarding any change in the incident status (including hosting situation update teleconferences as per the Coalition Healthcare Information Sharing System Plan).
    - Collect data from the receiving facilities regarding the numbers of patients received and severity of burns
    - Interface with regional coalitions in North Carolina to collect data regarding available resources in those jurisdictions. This task is conducted in conjunction with actions by NCOEMS/ESF #8 Desk
    - Facilitate accumulation of resource needs from all healthcare organizations in the Metrolina Region and work to address through implementation of mutual aid or through support from the jurisdiction (including hosting resource sharing teleconferences as per the Coalition Healthcare Information Sharing System Plan).
    - Support the process of identifying burn center beds for patients in the Metrolina Region
    - Facilitate coordination with jurisdictional response efforts.
- RHSC/HISS staffing pre-plan for mass casualty burn incidents:
    - The initial staffing of the RHSC/HISS will be determined by the RHSC/HISS Leader at the time of activation. The staffed positions will be based upon initial incident parameters and initial response objectives for the team.

Concept of Operations

Incident Recognition

• The most likely scenario will be a burn incident in which EMS recognizes that some burn patients will have to be transported to non-burn facilities due to the

volume/number of patients involved. It is the responsibility of the EMS Agencies, hospitals, and county emergency managers to contact the Coalition Duty Officer.

RHSC/HISS Notification, Activation, and Mobilization

1. The HCRT will mobilize according to the RHSC/HISS Plan with the following specific considerations:
    - The Duty Officer should contact the local hospital or county emergency manager to:
        - Confirm the nature of the incident
        - Obtain location of incident
        - Obtain the projected number of patients
        - Confirm that the number of burn patients will challenge or exceed the usual burn capacity in the Metrolina Region
2. If indicated by the acquired information, the RHSC/HISS is activated. RHSC/HISS positions staffed according to incident parameters utilizing available personnel and positions needing to be filled
3. Once staff positions have been determined, the Duty Officer should disseminate a regional message with details including:
    - Nature of the incident
    - Projected numbers of patients (confirmed or tentative)
    - Informing whether non-burn facilities will be receiving burn patients
    - Requests completion of full bed capacity report on Continuum
    - Requests POC for each facility

RHSC/HISS Incident Operations

• The RHSC/HISS will operate according to the RHSC/HISS Plan with the following specific activities to be considered as applicable:

1. Patient information: The RHSC/HISS Liaison or Operations Section Chief will send out a notification to all facilities receiving burn patients. This notification will notify the facilities of the incident and potentially how many patients they could be receiving
2. Based on evolving incident parameters, availability of jurisdictional representatives, and the need for more robust information exchange, the RHSC/HISS may conduct a Situation Update Teleconference per-protocol.
3. RHSC/HISS captures information about the number of patients being transported to patient care destinations within the Metrolina region and to burn centers in North Carolina. If additional regional beds needs are anticipated, the RHSC/HISS team establishes regional bed data by contacting the hospital emergency managers, and utilizing WebEOC and Continuum platforms.
4. When the MHPC RHSC/HISS is activated, the following steps should be taken:
    - Full situational awareness:
        - Follow up with facilities receiving burn patients to ensure completeness of patient data collection

- An initials teleconference should be established with the following representatives:
    - MHPC RHSC/HISS (all members as staff and as appropriate)
    - All regional hospital emergency managers
    - All regional EMS leaders
    - Wake Forest and UNC burn center representatives
- Help to establish transfer destinations and priorities
    - The purpose of the initial RHSC/HISS teleconference is to:
        - Review summary data and begin to prioritize patients for placement in burn centers
        - Ensure contact has been established with regional facilities and other coalitions to initiate bed availability
        - Establish initial projected transportation needs and determine if incident parameters indicate individual facility may encounter difficulties with this
- Additional teleconferences may be held as needed to finalize patient evacuation priority, bed assignments and transportation resources
- As individual assignments are made, the RHSC/HISS may document in WebEOC
- Each organization is individually responsible for contacting receiving facilities to formally establish transfer requirements.
- Individual facilities should utilize their regular documentation to affect the transfer
- Individual facilities should be instructed to contact the RHSC/HISS when each patient transfer is initiated or if problems are encountered.
- NOTE: As burn patients may become unstable within the first 24 hours, early transfer is a priority. Bed assignments and transportation arrangements should be completed within 12 hours of incident onset if feasible.

5. Transportation: The RHSC/HISS can collect specific individual facility needs as appropriate and forward other regional and state partners. Of note, some of these transportation requirements are expected to include aero-medical transportation assets
6. Federal assistance: RHSC/HISS may, depending on incident parameters, initiate the process for City requests for Federal assistance. This may include:
    - DoD assets: Burn beds and transportation assets
    - ASPR/NDMS:
        - Burn beds nationally
        - Additional equipment and supplies needed in the City
        - Specialty related clinical management guidance (i.e. radiation or chemical burns, etc.)
        - Disaster Medical Assistance Teams (DMATs)
7. In-hospital deaths: It is anticipated that in-hospital deaths from the burn incident will be County Medical Examiner's cases for post-mortem processing. Individual facilities are expected to contact County Medical Examiner's Office for individual

cases. If the in-hospital deaths become excessive, the RHSC/HISS can assist with city/region/state-wide tracking of deaths (as requested), working with local emergency managers, public health, and the ESF8 Desk identify support needs for storage at the facilities, and petitioning for regulatory relief regarding storage of the deceased beyond 30 days

8. Mental health assistance: The RHSC/HISS can catalogue mental health needs anticipated by healthcare facilities and convey to regional and state partners (as needed).

HCRT Demobilization and Transition to Recovery

- Reimbursement: Emergency burn care under mass casualty burn incident conditions can be expensive and incur costs not readily reimbursed by insurance and other payers. The RHSC/HISS may work with regional partners to facilitate recuperation of costs for healthcare organizations. This assistance can include:
  - Facilitate data collection from healthcare organizations regarding non-reimbursed costs to advocate for City and/or Federal reimbursement.
  - Convey instructions (as provided by NC Emergency Management) to facilities regarding funding eligibility and application/documentation procedures
  - Facilitate submission
- Demobilization: refer to the MHPC Response/Emergency Operations Plan

Attachment 1: Triage Decision Table

Burn Triage Decision Table

Burn Disaster Crisis Standards of Care

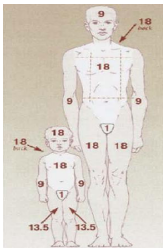
BURN TRIAGE TABLE: This table illustrates the anticipated ratio of resources to benefit from the treatment of burns of various sizes in various aged patients. Each category reflects both the volume of resources necessary to care for the patients in each group, and the expected outcome.

	Burn Size Group, % TBSA All									
Age	0-9.9	10-19.9	20-29.9	30-39.9	40-49.9	50-59.9	60-69.9	70-79.9	80-89.9	≥ 90
0-1.99	Very High	Very High	High	High	High	Medium	Medium	Medium	Low	Low
2-4.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
5-19.99	Outpatient	Very High	High	High	High	High	Medium	Medium	Low	Low
20-29.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
30-39.99	Outpatient	Very High	High	High	Medium	Medium	Medium	Low	Low	Expectant
40-49.99	Outpatient	Very High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
50-59.99	Outpatient	Very High	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60-69.99	Outpatient	High	Medium	Medium	Low	Low	Low	Expectant	Expectant	Expectant
≥ 70	Very High	Medium	Low	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant

Categories are defined as follows:

- **OUTPATIENT:** Survival and good outcome expected without requiring initial admission.

Palmieri TL et al. Triage/Resource Table for a Burn Disaster Developed from the American Burn Association NBR



- **VERY HIGH**: Mortality ≤10%, anticipated length of stay ≤ 14-21 days, 1-2 surgical procedures.
- **HIGH**: Mortality ≤ 10%, anticipated length of stay ≥ 14-21 days, multiple surgical procedures.
- **MEDIUM:** Mortality 10 – 50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.
- **LOW:** Mortality 50 – 90%, even with provision of prolonged, intensive resources.
- **EXPECTANT:** Mortality ≥ 90%, even with prolonged aggressive care.

Patients palm inclusive of fingers = 1% Total Body Surface Area

2.MHPC Continuity of Operations Plan

Purpose

This Continuity of Operations Plan (COOP) will document how Metrolina Healthcare Preparedness Coalition (MHPC) will perform essential operations during an emergency situation or long-term disruption, which might last from two days to several weeks. The plan will identify mission-critical functions, communication methods, and alternate personnel, systems and locations.
The COOP planning process focuses on two key questions:

1. What MHPC operations are essential to the region/state partners?
2. What resources/personnel are required to continue those essential operations during an emergency or disruption?

Planning Framework

MHPC has established three priorities for responding to emergencies:
Priority 1: Maintain communication with regional partners, the state and within MHPC.
Priority 2: Prioritize and triage tasks so efforts are put in towards doing the most good for the region.
Priority 3: Continuing to provide the essential functions of ESF-8.

Key Continuity of Operations Objectives

- Maintain a state liaison (duty officer) during an emergency or disaster-as needed
- Maintain finances and grant management/expense tracking- ongoing
- Maintain communication between partners and state – ongoing
- Continue providing logistical support to partners and state as the situation allows -as needed

Emergency Communications Systems

MHPC Communication with State and Regional Partners

MHPC will communicate with partners using the Everbridge notification system, WebEOC as well as by email and phone.

MHPC Team Communications

To communicate within the MHPC team during COOP plan activation, MHPC employees will use email and cell phones. In the event these are unavailable, utilization of employee portable radio will be enacted on MHPCOps channel.

Leadership Succession

	Name	Title	Phone Number	Alt Phone Number
Head of Department/Unit	Hannah Gompers	Regional Preparedness Coordinator	704-579-4150	
Successor	Kariena Bernesser	Assistant Regional Coordinator	704-258-8966	
Successor	Scott Hess	Assistant Regional Coordinator	704-221-2818	
Successor	Michael Tessari	Assistant Regional Coordinator	704-351-8832	
Successor	NC Office of EMS	NC Office of EMS		

Access to Information and Systems

All critical files for MHPC are stored via the teams Dropbox system to allow for access outside of the office. A portable hard drive is maintained by the Regional Preparedness and updated monthly.
MHPC critical processes are listed out in the Annex of this document for reference.

Other Key Internal Dependencies

Dependency (product or service) : **Provider**:	Pharmacy Needs
	Atrium
Dependency (product or service) : **Provider**:	Medical Equipment Maintenance
	Atrium

Dependency (product or service) : **Provider**: Contact:	Grants/Funding
	Atrium
	Jamie Kintz- Jamie.Kintz@atriumhealth.org Catherine Henry- Catherine.Henry@atriumhealth.org
Dependency (product or service) : **Provider**: Contact:	IT (cell phones, mifi, computers, email, fuel cards and Everbridge)
	Atrium
	704-446-6161
Dependency (product or service) : **Provider**: Contact:	CDL Drivers/Vehicle Repairs
	Mobile Medicine
	James Robinson- 704-617-9927
Dependency (product or service) : **Provider**: Contact:	Building Repairs and Maintenance
	Lincoln Harris
	704-446-6161

Key External Dependencies

	Primary	**Alternate**
Dependency (product or service) :	Equipment and Supplies	
Frequency of Service	**As needed**	**As needed**
Provider	McKesson	Braintree
Primary Contacts		
Phone Numbers		
	Primary	Alternate
Dependency (product or service) :	Radio Communications	
Frequency of Service	As needed	
Provider	Viper	Motorola
Primary Contacts		
Phone Numbers		
	Primary	Alternate
Dependency (product or service) :	Cloud Sharing for Documents	
Frequency of Service	n/a	
Provider	Dropbox	

Primary Contacts		
Phone Numbers		
	Primary	Alternate
Dependency (product or service) :	Cell Phone Provider	
Frequency of Service	N/a	
Provider	Verizon	
Primary Contacts		
Phone Numbers		
	Primary	Alternate
Dependency (product or service)	NC Terms Website	
Provider	State of NC	
Primary Contacts		
Phone Numbers		

Relocation or Reallocation

In some potential scenarios, the MHPC building and physical resources may not be available. In this circumstance, MHPC team members will continue working from home to the best of their abilities. Resources required to perform essential functions include:

	Resource
What physical resources are required to perform your essential functions? Include pre-printed forms, office equipment, computer equipment and telecommunication devices.	Wifi/Internet Source Power Computers Cell Phones Portable Radio Hard Copies/Flashdrives/Dropbox of important files Childcare
How much physical space would your unit need?	Minimal (enough for a laptop)
Does your unit have any special needs such as refrigeration, temperature/humidity controls, etc.?	No special needs

Are there special security requirements for a replacement space?	None.
If the building/office is accessible, but there was an extended loss of power, is there essential equipment or material that would be at risk? Describe plans for back-up power.	The office/warehouse does have a back up generator in case of power failure. There is no critical equipment that would need power to operate. Extended loss of power could result in some loss of medical supplies due to extreme temperatures.
Do you have any high value/difficult to replace equipment?	Our vehicles, trailers, powered medical equipment and communications equipment are all high value in the event they were damaged during an emergency.

Restoration

Resuming normal operations once the emergency situation or extended disruption has passed will require continued communication and coordination. Recognize that restoration could take an extended period of time. Potential considerations include:

- Work backlog
- Personnel availability and stamina
- Logistics stabilization and reconciliation
- Finance reconciliation
- Warehouse structural repairs (if needed)
- Family needs
- Emotional support

Lincoln Harris will be the contact for safety assessment of the building to determine when it can be safely used again for operations following an incident

Mitigation Strategies

- Monthly updates of all critical documents on our Dropbox and computers to an external hard drive maintained by the Regional Preparedness Coordinator
- Private radio channel for MHPC (MHPCOps)
- NC Shares for radio functionality
- Back up coalition support in the event of loss of logistical and operational ability
- MHPC primary back up coalitions are the Triad and Mountain region coalitions.
- Continued regular testing on plans and procedures listed in this document.

Appendices

Appendix A: Disbursement Request

Purpose:
Defines the appropriate steps to ensure correct payment of invoice to vendors for goods or services rendered from the proper account to ensure that payment for goods and services will be compliant with Grant and CHS Guidelines.

Procedure:
Ensure that MHPC SOG- Purchasing has been followed. Have the appropriate invoice, and the vendor's W-9, if applicable.

1. Save Invoice as PDF to the appropriate Capability/ Project folder, with file name to include the Capability for which it refers, the word "Invoice", Vendor name, and Dollar amount (not including tax). For example, "C10 Invoice Southeastern $1,234.56.pdf".

2. Using Internet Explorer or Firefox, open the eForms tab from PeopleConnect and select "Disbursement Request / BERR".

3. Ensure that all of your personal information is correct; then select "Other Disbursement Request".

4. "Is this payment related to a contract?" Select No.

5. Select "Company" and complete Vendor Details. If this is a new vendor, select the "New Vendor" box and input their Federal Tax ID. This can be found on their W-9, which you must attach in Step 9.

6. All vendor info must be in CAPITAL LETTERS. This includes the payee name (Last name, First name), address, and city. Do not use caps lock for an employee with an Employee ID#

7. Payment Details: Set "Terms" to Immediate Payment. Yes, this is a BU12 Grant Funded Project. Input Department Number (270125), select appropriate Project ID [3000340442 (changes annually)] and Activity ID (01). Leave Delivery Options set to "Mail".

8. Input the invoice number and date from the Vendor's Invoice. This will only allow numbers, no letters. If there is no invoice number, input MHPC PO number or "12345".

9. Provide a description of the purchase, including vendor name (Example: Southeastern, IV Fluids). Account Number: 620900. Bus Unit and Dept will automatically populate.

Amount: Item total + shipping. Tax is entered separately in a line below. Ensure that the "Invoice Total" matches the total printed on the invoice.

10. Attach the PDF of the Invoice. If this is a new vendor, also attach W-9.
11. Add Note if Accounts Payable needs to do anything special with this purchase.
    a. "IF THERE ARE ANY QUESTIONS REGARDING THIS DISBURSMENT REQUEST, PLEASE CONTACT: *NAME – Phone Number*"
12. Sign.
13. Route to HPC. Attach Message if additional information is necessary.
14. Route for Approval.
15. Save PDF copy of Disbursement Request to appropriate Capability/ Project folder, with file name matching the Invoice file name, but change the word "Invoice" to "Disburse". For example, "C10 Disburse Southeastern $1,234.56.pdf".
16. Update the Expenditure Tracking Tool spreadsheet, found in the current year Projects folder, with complete information.

Appendix B: Fuel Purchases

Purpose:
This will allow necessary personnel to purchase fuel for vehicle and to enter the receipt in the MHPC system for tracking.
Procedure:

8. Authorization to use a fuel card is conducted through CHS Transportation upon completion of the CHS Defensive Driver Training. (See MHPC SOG- Defensive Driver Training)
9. Insert card (located in the vehicle log book) into the pump and enter authorizing driver ID when prompted.
10. Enter the vehicle odometer reading when prompted.
11. A receipt for the fuel purchase must be obtained. Make sure the receipt is legible and retain it to be saved electronically for future records. Obtain a receipt from the attendant inside when available.
12. Select the appropriate fuel type (Diesel or 87 Octane) and fill the vehicle.
13. Upon returning to the warehouse, provide the hardcopy receipt to the MHPC Program Support Specialist. He/she will then scan the receipt into J:\@Metrolina Healthcare Preparedness Coalition\ASPR Grant*Appropriate Year*\Admin\Invoices\Fuel with the file name as the receipt dollar amount and date ($45.50 12/05/13).

Appendix C: Inventory

Purpose:
To describe the proper maintenance and control of the MHPC Warehouse inventory.
Procedure:
Training

1. MHPC Staff members and SMAT leadership will be trained in the use of the iCAM (Inventory Control and Asset Management) system and be allowed access via username and password authorization.
2. Training will be provided by a designated member of the State Logistics Action Team.

Inventory Management

1. Inventory Locations have been defined as:
    a. Primary- Any location where where patient care is performed from
        i. MSU1 and 2
        ii. PODs 1-4
        iii. POD 5 and 8 (ABC's)
        iv. POD 7 OB/Peds
        v. Crash Cart 1 and 2
        vi. POD 10 and 11 (Wound Care)
        vii. Defib Cage
        viii. Tent Carts 1-6
    b. Restock- Restock trailer
2. Inventory Rotation Process:
    a. Refer to the Inventory Rotation Process Diagram.

b. Items needed for Primary Locations should be filled from the Restock trailer if available.

c. When new inventory is received, it should be placed into the appropriate Restock Tote to ensure a proper inventory rotation process can be maintained.

d. Items should be pulled from Primary Locations and Restock using the following guidance:

    i. MSU 1 and 2: 3 months prior to expiration

    ii. Pods 1-4: Inventory in December and restock through the next November (This ensures that these are immediately available all year, and specifically through hurricane season)

    iii. ABC Pods, Wound Care Pods, Peds Pod, Crash Carts, Tent Carts, Defib Cage: 6 months prior to expiration (can be used to restock MSU's if needed)

e. Aging items should be physically sorted by category, and placed into appropriate tote on Aging Inventory Shelf. (1mo until Exp, 2 mo until Exp, 3-6mo before Exp).

f. Aging items should be virtually moved in iCAM to "YY_Aging Items"

g. A list of Aging Items should be sent to local partners to on a monthly basis to see if they can be swapped/exchanged to help reduce waste/replacement costs.

h. Aging items that were ordered from CHS

i. At the end of each month, expired items should be moved to the expired shelf, and remaining items should be moved to the correct Aging Shelf. (items that were 2mo from expiration should be moved down to 1mo from expiration). Expired items should be moved virtually in iCAM as well. Move them to "XX Expired Items"

3. Medical Supply Ordering Schedule

    1. Refer to the Inventory Ordering Schedule for the Bi-Annual Ordering guideline

    2. Cycle A- Start ordering calculations in June so an order can be placed in Aug/Sept.

    3. Cycle B- Start ordering calculations in November so an order can be placed in Jan/Feb.

4. Refer to Manual Order Calculation Process for guidance on determining needed items.

Ordering from CHS/eMerald

1. Log into eMerald Requisitioning, select “Templates”, and select the “METRO SMAT” Template.
2. This will produce a predefined list of items, but with the quantity set as “0”.
3. If items are needed that are not on the Template:
    a. Upper Left Corner- Click “Add Items”
    b. In ALL CAPS, type in a search term in the second field
    c. Placing % before or after the search term will help expand the search
    d. Review the available options
    e. If unsure about which of several items is best, click the check box next to all of them and then click “Add” (Leave the quantity field as “0”. This will add them to the template so that you can verify availability and check cost.
    f. Once an item is on the template, if you see a Magnifying Glass next to it, that item is stocked in the Distribution Center, and should be immediately available. If not Magnifying Glass, the DC may have to order the item. This may change the price slightly, generate a shipping charge, and result in delay in processing that item.
4. Once all items to be ordered have been added to the template, from the menu button, click save as template so that any additions will be captured for later use.
5. Return to the template and select the items needed.
6. Enter the needed quantities for the items to be ordered. Be sure to pay attention to the unit of measure for each item (Each, Box, Case, etc). To determine how many items come in a Box, Case, or unit other then Each, click on the name of the item, and then click on the “Packaging” Tab. This will give you the quantity per unit. Items should not be ordered in partial units if at all possible.
7. Once all items that will be ordered have been given quantities, click the menu button and select save as draft. Record the Draft # that is given.

8. Close the template, and from the Home Screen click ‘Drafts”
9. Select the appropriate draft from the list
10. Verify that the “Default Project” field is correct.
11. Verify that the items and quantities are correct.
12. If all fields are correct, click submit.
13. Print a copy of the order for use during reception of items.

Receipt of Products

1. As soon as new products are received into the warehouse, they will be checked against the Purchase Order and/or Invoice, per MHPC SOG- Purchasing.
2. Once all products and equipment are verified, all non-disposable items with a value of $50.00 or more should be given an MHPC asset tag and input into the iCam system within two weeks of receipt. (Asset tags will depend whether or not the Master Item Definition in iCAM requires a Serial Number. If no Serial Number, then an asset tag can not be assigned).
3. All appropriate fields must be completed, including but not limited to: Item Description, Location, Category, Quantity, Serial Number, Lot Number, Asset Tag Number(s), Acquisition Date, and Expiration Date. Equipment that requires special monitoring should be noted in the maintenance schedule as well.
    a. Location for new inventory should be @Received Inventory, and the appropriate year and sub location.
    b. Once Medical Supplies have been checked in and entered into iCAM, they should be moved physically and virtually to the appropriate tote in the Restock Trailer. Once in the Restock Trailer, items can be moved to Primary Locations as needed.
    c. See http://ncoems.icamservice.com/Help.aspx for the iCam User Manual.

Audit

1. A systematic audit of the inventory shall be completed on an ongoing basis so that the complete inventory has been verified by June 30 of each year.
   (First audit to be completed by June 26, 2015.)

a. A location in the iCAM system will be selected at random by the Logistics Coordinator or Technician, and the inventory in that location counted and verified for accuracy and completeness.

OR

b. A location in the warehouse will be selected at random by the Logistics Coordinator or Technician, and the inventory in that location verified against the iCAM system for accuracy and completeness.

Purpose:
To standardize the procedure for purchasing and processing of equipment and supplies. This will allow necessary personnel to track purchases and keep everyone informed about what is on order and when it is expected to be delivered.

Procedure:

Orders for Non-CHS Partners:

14. Contact appropriate sales representative to obtain Price Quote, including shipping fees. Once received, file a copy in the appropriate project folder on the J:\ drive with a file name to include the Capability for which it is to be purchased, the word "Quote", Vendor name, and Dollar amount (not including tax). For example, "C10 Quote Southeastern $1,234.56.pdf".

15. Complete all necessary information on the Purchase Order, including contact information at the bottom of the sheet. Include the Quote number in the comments box of the Purchase Order! The PO Number is the year, month, day, order submitted. For example, the second PO submitted on 06/15/13 would be 13061502.

16. Save the PO in the appropriate project folder on the J:\ drive with a file name to include the Capability for which it is to be purchased, the letters "PO", Vendor name, and Dollar amount (not including tax). For example, "C10 PO Southeastern $1,234.56.pdf".

17. Email the PO to the sales representative and copy the MHPC Ops/Logs AHPC in the email.

18. Once an Invoice is received, scan or save the PDF into the appropriate project folder on the J:/ Drive with a file name to include the Capability for which it is to be purchased, the word "Invoice", Vendor name, and Dollar amount (not including tax). For example, "C10 Invoice Southeastern $1,234.56.pdf".

19. When the product(s) arrive, he/she will verify the received items are identical to the Purchase Order, *not the Invoices*. The Ops/Logs AHPC will reconcile the Purchase Order with the associated Invoice(s) and items received.

20. Once the items are received, complete a Disbursement Request as described in "MHPC SOG- Disbursement Request".

Orders for CHS Partners (Med-1, MedCenter Air, Special Events, etc) greater than $500.00.

*Orders less than $500.00, follow procedure above.

1. Complete Steps 1- 4 above.

2. Contact a Buyer in the Materials Management Acquisitions department.
3. Explain that you need to make a Capital Purchase on the Capital OSR. The number will be obtained annually.
4. Email the Purchase Order to the buyer. Confirm receipt of PO.
5. Follow up with the buyer within two weeks to ensure timely order completion.
6. Once the item is received, forward the invoice to the buyer and request payment. Follow up within two weeks to ensure prompt payment.

Appendix E: Regional Support Cell

Purpose:
The MHPC will support the region and state as requested during and emergency response. This response will require collaboration amongst parties. The primary role of the MHPC will be to share information amongst partners and coordinate resources as requested.
Procedure:

1. Receive Notification of the Incident
2. Call partner involved in incident:
    a. Provide MHPC contact Information
        i. Phone
        ii. Email
        iii. VIPER ID
        iv. Location
        v. If more than one of us
    b. Obtain Facility/ Agency POC and contact information. Ideally, obtain EOC contact information
    c. What assistance is required?
    d. Request permission to notify region of incident.
    e. Request SMARTT activation by facility or obtain permission for MHPC to do it.
        i. Ideally, post SMARTT message provided by impacted
        ii. Generic Message: XXXX has been impacted by (internal/ external) emergency.
            1. Operating Normally; or
            2. Describe restrictions (i.e. ED on diversion but all traumas accepted; ED entrance now at main entrance
    f. Provide partner with next steps. What will you do next? When will you follow up with them? When would you like them to provide an update? etc
3. Determine if more than one facility or area is impacted. Do additional personnel need to be called from MHPC, MHPC partners, other Coalitions to support operations? Do shifts need to be established?
4. Open Inclement Weather/ Response Checklist, Contact List, Resource Request Algorithm , **Situation Report template, IAP template, Activity Log, Situation Message Template** (Need to Create)
5. Notify appropriate MHPC people
    a. MHPC staff
    b. MHPC senior leader

   c. SMAT volunteers as needed
6. Notify appropriate partners
   a. Notify OEMS always
   b. Notify other partners as appropriate
7. Include appropriate information and MHPC Contact information
   a. Phone
   b. Email
   c. VIPER ID
   d. Location
   e. If more than one of us
8. Request bed status via SMARTT, email, or Surveymonkey.
   a. Request bed Status if multiple facilities are impacted or there is the possibility of evacuation
   b. Provide information regarding how often information will be received
9. In messages that need a response, include a need response by:
10. Turn on VMN to VML79501 or SMRS Home
    a. For regional events, VML79801 or SMRS Ops 2
    b. If need additional channels or assistance, OEMS Duty Officer at (919)855-4687 or dhsr.ncoems.sdo@dhhs.nc.gov
11. Turn on computer.
    a. Log into SMARTT, WebEOC
    b. Request Healthcare and SPARTA events with same name at the same time in WebEOC – Insert Contact information via OEMS Shift Duty Officer
12. Establish conference all schedule. Include times.
13. Establish situation report schedule. Minimum q12. Include times
14. Step four would either continue or conclude the process.
15. Don't forget to evaluate when necessary. Evaluations prove that these processes work, or identify opportunities for improvement on the next revision.

Resources Needed for MIC

VIPER Radio (2-4)		Presentation Remote		Stapler	
LCD Projector (2)		Portable printer, scanner, battery operated		Mental Health Tools	
Conference Phone		Multiple USB Charger		Camera/ Charger/ Card	
Portable HotSpot		Laptop Lock		Batteries AA, AAA (2 packs of each)	
HDMI/ VGA cables		Chromecast		Tape dispenser	
Webcam		Extension Cord with multiple Outlets		First Aid Kit, Tylenol, Motrin	

Speakers		Computer Monitor (1-2)		Food, Water	
External Hard drive		NIMS Printed		Large Paper Pads**	
Multicard reader		Map of region		Portable screen**	
Connector for iPad or iPhone		Dry Erase Markers		Videoconference capability**	
Cat 5/6 Cable		Pens (1 box)		Dry Erase Boards**	
		Printed copies of paperwork		** Would ideally have. May request from host	

Appendix F: Disbursement Request for Contractor

Purpose:
Defines the appropriate steps to ensure correct payment of invoice to MHPC Contractors for goods or services rendered from the proper account to ensure that payment for goods and services will be compliant with Grant and CHS Guidelines.

Procedure:

1. Log in to Toggl
    a. Click on Reports
    b. At the top of the right side of the page click "This Week" and set your dates for the report based on pay period
    c. Click PROJECT on the tool bar and type in the name of the contactor. Click to select. Click apply.
    d. At the very top of the page, click DETAILED report
    e. Click the printer icon. A pdf report should appear. Ensure dates are accurate for pay cycle.
    f. Save document in 2017-2018…ASPR Grant…2017-2018…Projects…Cap 4…Logistics Support (you may have to save this in the J Drive as you will have won't be able to access Dropbox documents through PeopleConnect and the Disbursement Requests)
        i. Save document as "Contractor Name Toggl Report – Invoice Number
            1. Ex: Tessari Toggl Report - 171201
2. Create Invoice for Disbursement using template provided
    a. Type in Pay Period dates in Period of Box
    b. Invoice Number format: 17-1201 (Year – Month/Invoice number in sequential order)
    c. Insert Date/Hours in table…this should match up to what is calculated on the Toggl Report for the pay period
    d. Save document in 2017-2018…ASPR Grant…2017-2018…Projects…Cap 4…Logistics Support (you may have to save this in the J Drive as you will have won't be able to access Dropbox documents through PeopleConnect and the Disbursement Requests)

i. “Contractor Name Invoice (invoice number) – Ex: Tessari Invoice 17-1201

3. Using Internet Explorer or Firefox, open the eForms tab from PeopleConnect and select “Disbursement Request / BERR”.
4. Ensure that all of your personal information is correct; then select “Other Disbursement Request”.
5. “Is this payment related to a contract?” Select No.
6. Select “Company” and complete Vendor Details. If this is a new vendor, select the “New Vendor” box and input their Federal Tax ID. This can be found on their W-9, which you must attach in Step 9.
7. All vendor info must be in CAPITAL LETTERS. This includes the payee name (Last name, First name), address, and city. Do not use caps lock for an employee with an Employee ID#
8. Payment Details: Set “Terms” to Immediate Payment. Yes, this is a BU12 Grant Funded Project. Input Department Number (270125), select appropriate Project ID [3000301028 (changes annually)] and Activity ID (01). Leave Delivery Options set to “Mail”.
9. Input the invoice number and date from the Vendor’s Invoice. This will only allow numbers, no letters. If there is no invoice number, input MHPC PO number or “12345”.
10. Provide a description of the purchase, including vendor name (Example: Southeastern, IV Fluids). Account Number: 620900. Bus Unit and Dept will automatically populate. Amount: Item total + shipping. Tax is entered separately in a line below. Ensure that the “Invoice Total” matches the total printed on the invoice.
11. Attach the PDF of the Invoice. If this is a new vendor, also attach W-9.
12. Add Note if Accounts Payable needs to do anything special with this purchase.
    a. “IF THERE ARE ANY QUESTIONS REGARDING THIS DISBURSMENT REQUEST, PLEASE CONTACT: *NAME – Phone Number*”
13. Sign.
14. Route to James Clarke. Attach Message if additional information is necessary.
15. Route for Approval.

16. Send email to James Clarke at james.clarke@carolinas.org listing out the following items:
    a. Disbursement number (provided at the end of disbursement process)
    b. Amount of disbursement
    c. Who/what disbursement is
17. Save PDF copy of Disbursement Request to appropriate Capability/ Project folder, with file name matching the Invoice file name, but change the word “Invoice” to “Disburse”. For example, “C10 Disburse Southeastern $1,234.56.pdf”.
18. Update the Expenditure Tracking Tool spreadsheet, found in the current year Projects folder, with complete information.

Appendix G: Grant Financial Reimbursement

Purpose: Defines the appropriate steps to ensure correct payment of monthly CERs with CHS Research Finance and NCOEMS. Also ensures monthly financial tracking in order stay compliant with grant financial guidance.

MHPC Procedure:

1. After each expense is made, enter the following data on the Expense Tracker for the appropriate year.
    a. Date of purchase made
    b. Item purchased
    c. Cost
    d. Invoice or PO number
    e. Disbursement Number

    Refer to MHPC SOG – Disbursement Request for information on how receipts from purchases are saved. Receipts from all purchases must be saved!
2. Expenses are divided up on the Expense Tracker according to the following capabilities:
    a. Admin
    b. Healthcare and Medical Readiness
    c. Healthcare and Medical Response Coordination
    d. Continuity of Healthcare Service Delivery
    e. Medical Surge

    Expenses should be entered into the correct capability depending upon the expense and project that the expense is related to.
3. On a weekly basis, reconcile disbursement requests in PeopleConnect that are marked PAID status with the Expense Tracker by recording the date the disbursement was made and the check number.
4. Around the 15th of the month, Research Finance will send an excel spreadsheet with backup documentation listed. MHPC will provide the receipts requested by Research Finance within one week of receipt of this email.
5. Backup Documentation Spreadsheet – Tab 1 will contain lists of purchases made that have hit the General Ledger within the past month. Some purchases may be from several months prior due to them hitting the General Ledger more slowly than others.

6. Purchases will require the following backup documentation in order to be sufficient with NCOEMS:
    a. P-Card Purchases: Receipt of Purchase
    b. Disbursement: Invoice
    c. Fuel Purchase: Receipt
    d. Capital Purchase: Copy of OSR
    e. Overnight Travel: Will require a travel packet contains the following items
        i. Signed BTA by NCOEMS
        ii. BD403
        iii. Hotel Receipts
        iv. Food/Parking Receipt
        v. Registration Receipt
    f. Mileage: BD403
        i. *NOTE: BD403 for Regional Coordinator must be signed by Research and Development as supervisor
7. Purchases that Research Finance will have to create or provide an invoice for:
    a. Salary and Benefits
    b. Office Communications (Verizon/ATT)
    c. Surcharges for purchases (i.e. Toggl international fee)
    d. Rent Payment Confirmation
    e. Forklift Rental
    f. Extra Postage and Freight Charges for purchases
8. Go through each item and list what the receipt or supporting documentation has been saved as beside the item.
9. Highlight any items that are questionable or need more detail in red and add comments for additional details

10. Backup Document Spreadsheet – Tab 2 will contain items that the documentation has already been found. Go through those and make sure each purchase is listed in the correct capability. See Item 2 for capabilities they should be listed in.

11. Make any corrections to the right side of the document and email Research Finance with the changes that need to be made.

12. Backup Document Spreadsheet – Tab 3 will contain items that are listed under Project 02. These items do not need backup documentation.

13. Ensure that the purchases listed on Backup Documentation – Tab 3 match the purchases on the MHPC Non-ASPR Funds Spreadsheet found in J Drive: MHPC Folders/MHPC Financial/Non-ASPR Financial Summary/MHPC Funds Tab

14. Gather all in-kind documentation for the month requested. Rosters are saved under the Year/Drawdowns/Month.

a. Submit the following documents to NCOEMS as part of the monthly in-kind packet

i. Monthly In-kind spreadsheet

ii. Any rosters from trainings

iii. Donation invoices

iv. Monthly SMAT Sign-in sheet

15. Use the spreadsheet provided by NCOEMS to calculate In-Kind for each category (Donations, Volunteers, Meetings, Trainings)

a. *NOTE: As of 2017, the volunteer rate is $21.88 per hour

16. Submit all backup documentation requests and In-Kind Packet to Research Finance within one week of receipt of original request.

Research and Development Procedure:

1. Once a month, Research Finance will pull the general ledger and try to locate all the backup documents that they can find.

2. Research Finance will send a “BackUp Needed” spreadsheet with three tabs to review and it has the expenses they need back up for listed

3. MHPC sends Research Finance the missing info, then Research Finance will put the CER together
4. Research Finance will then email MHPC a rough draft of the CER to review
5. MHPC will notify Research Finance that they agree to Research Finance submitting the CER to NCOEMS.
6. Research Finance will get all the appropriate signatures and submit to appropriate contact at NCOEMS

Final MHPC Procedure:

1. NCOEMS will send a signed copy of the monthly CER to MHPC and Research Finance
2. Print out the fully signed CER and place in the yearly binder
3. Print out the monthly CER Packet created by Research Finance and place in the yearly binder

Appendix H: Purchase Card Process (Redo once new process in place)

Procedure:

Ensure that MHPC SOG- Purchasing has been followed. Have the appropriate invoice, and the vendor's W-9, if applicable.

1. Scan/save receipt from Pcard purchase into the appropriate capability folder
2. Log in to Bank of America Works
    a. https://payment2.works.com
    b. Use Hannah's login information
        i. Login name: hgompe01
        ii. Password: Hghg@41487
3. In the Action Items box, click Pending under Current Status
4. Click the Red X
5. When a new window appears, click the box to the left of the red X
6. Working your way across the bar, enter the following information
    a. GL01: Business Unit: 12
    b. GL02: Dept: 270125
    c. GL03: Account: 620900
    d. GL04 Project ID: 3000301028
    e. GL05: Operating Unit: Leave Blank
    f. GL06: Activity ID: 01
7. Click Save, then Click Close
8. On the right side of the screen in the Uploaded Receipt column, click "No" to upload receipt
    a. Receipt should be found in the appropriate capability folder
9. Click Add…New Receipt and upload receipt. You don't have to enter the date on the receipt. Click close once receipt has been uploaded

10. Once on the main screen, click the check boxes next to each of the purchases, then click “Sign Off”.
    a. Enter my initials on the box that pops up, hmg
11. Click the check boxes next to each of the purchases, then click “Add to Expense Report”
    a. In pop-up window: Add expense documents to: click “New Expense Report”
    b. In the Expense Report Name field, enter the date of the first transaction – date of last transaction
    c. Click box at the bottom that says “Sign off on report and all expense report documents”
    d. Click OK
12. Everything should be finalized for the report and the report will be sent
13. Ensure all purchases on the expense report match to the Expenditure Tracker

Appendix I: On-Call Procedure

Purpose:
To identify the proper procedure within the Office of the Metrolina Healthcare Preparedness Coalition for handling on-call for staff members.

Guideline:
The Office of the MHPC will have at least one staff member on call to assist regional partners with resource or personnel requests and share situational awareness that fall within the Scope of Work of the MHPC, and deemed necessary to carry out the ESF-8 operations or identified as fulfilling one or more of the Healthcare Preparedness Capabilities for the Metrolina Region.

Procedure:

5. Staff members will rotate on-call schedule based on staff availability and regional events. An on-call staff calendar is located on the MHPC Calendar on Outlook.

6. Designated on-call staff member will login to Google Voice and select themselves as the designated on-call person to receive phone calls/text messages.

7. Designated on-call staff member is responsible for the following while they are on-call:

    a. Answering and responding to all phone calls, emails, and texts sent to the On-Duty Phone Number (980-349-6472) and metrolinahpc@carolinashealthcare.org

    b. Monitoring and sending out local weather alerts/events to regional partners

        i. *If Sub-region staff member is available, on-call staff member may ask them to reach out to contacts if their area is affected*

    c. Responding to requests made by NCOEMS or regional partners

    d. Respond to events where resources/personnel are requested

    e. Alerting the NCOEMS Shift Duty Officer (dhsr.ncoems.sdo@dhhs.nc.gov) of the event, providing brief description of what occurred, who has been notified about the incident, any Coalition resources that have been requested, and if there are any patients/people that have been affected by the incident.

        i. NCOEMS Shift Duty Officer can also be reached at 919-855-4687

8. When a request for resources is received into the Office from a regional partner, the on-duty staff member will:

    19. MHPC Staff member will complete the "MHPC Resource Request Form" (Appendix J).
    20. Identify the following:
        - ☐ Who is this and whom do you represent?

Name:
Agency:

☐ What is your callback number and email address?
Phone:
Email:

☐ Provide MHPC callback number to caller.

☐ What is the request?

☐ Is the EOC open? If so, is there contact information for the EOC? Phone:

☐ Has the county emergency management been notified? If so, who and what is their contact info?
Yes No
Contact:

☐ Has NC OEMS been notified? Yes No

Questions to consider:
- What is the issue?
- What do they need to solve the problem?
- Are there other alternatives?
- If requesting personnel, what credentials and how many?
- What has been done to resolve the problem?
- Have any MOUs been

☐ Tell the caller what the next steps are and when you will return their call with additional information.

☐ If the caller is NCOEMS or EM, is there a state mission number?
Yes No Number:

21. Considerations before proceeding with deployment

☐ Are there resources available to fulfill this request? Or can the resources be obtained within the time allotted?

☐ Is there an MHPC Staff member(s) available to accompany the equipment/ volunteer personnel for the duration of this event? If so, who?

☐ If necessary, is grant or other funding available (and approved) for the requested event?

☐ Will the event interfere with a coinciding previously approved mission(s), or mission of higher priority as determined by the MHPC Staff?

22. Next Steps

☐ Determine if able to complete the mission. Contact the appropriate personnel based upon the request to determine the capability.

☐ Notify the following of the pending request and resolution if available.
- James Clarke
- NC OEMS

- County EM as appropriate
- Regional partners as appropriate

☐ If the request is approved, notify the requestor.
- They will need to assume responsibility for the assets, unless otherwise noted.
- MHPC will complete a formal written request for assets
- MHPC will print a loan form, Appendix L below, for the facility POC to sign upon receipt (2 copies)
- MHPC will check item out of icams inventory to recipient
- MHPC will notify OEMS immediately if they will be out of service
- MHPC will assign responsibility of equipment to a staff member, who will be responsible for the deployment and establishment of resource. Once it is delivered, it becomes the responsibility of the requestor.

☐ If the request cannot be completed, MHPC work with the requestor and regional/ state partners to identify a resolution.

23. All requests approved or denied receive an MHPC mission number. Add approved requests to the mission board when possible.
24. If assets are requested, complete the "MHPC Resource Request Form" (Appendix J) for the requesting regional partner.
25. If volunteer personnel are requested, complete the "SMAT Volunteer Request Form" (Appendix K) for the requesting regional partner.
26. Communication Update Standards

☐ Updates should be provided every 2- 4 hrs, or at other pre-designated times, as appropriate. They should be provided to:
- Impacted Facility
- MHPC staff
- CMC Administration
- Regional Partners
- State Partners
- Others as determined by event

☐ Updates should include
- Resources deployed
- Potential impact on the region/ state
- Status of deployed resources

☐ Requestor Updates
- Ability to meet need
- Estimated time of arrival

- Team leader on deployment with contact information

☐ Team leader with deployed resources shall notify MHPC lead

- Every 2 hours with situation update or more frequently as needed
- Departure from warehouse
- Arrival at destination
- If an issue is encountered

27. Demobilization

☐ Upon completion of the event, the assigned MHPC staff will return personnel and equipment to service ASAP. If out-of-service status was caused by deployment, status updates on return-to-service will be provided to NC OEMS every 24 hours via email until return to normal operations.

☐ Upon completion of the event, and return of all equipment and volunteers, primary MHPC staff member for the event will send the "MHPC Resource Evaluation Form" (Appendix M) to the requesting regional partner.

☐ After Action Report will be completed by the Lead MHPC staff within 4 weeks. This will be submitted to NC OEMS and regional partners as soon as it is complete.

☐ Scan and file all associated mission documentation for future use. Save all documentation to J:/@MHPC/MHPC Deployments. Save in the calendar year folder with the mission number and event name. i.e. "14-07 SMRS FSX"

MHPC Resource Request Form

Date of Request: _____/_____/_____ MHPC staff receiving request: _____

Requesting Agency _____ Emergent Request: ☐ Yes ☐ No

Requesting Agency Point of Contact _____

POC phone: _____-_____-_____ Email:

Date of event: _____

Requesting: ☐ Equipment ☐ Personnel (Please complete SMAT Volunteer Request Form.)

Provide a brief description of the expectations of the Office of the MHPC: _____

MHPC Planning Section:

Equipment required (Attach List) readied by _____(Staff) on ____/____/____.

Funding needed _____ (Attach Budget). Or N/A

SMAT Volunteer Request Form

Date of Request: _____/_____/_____ MHPC staff receiving request: _____

Requesting Agency _____ Emergent Request: ☐ Yes ☐ No

Requesting Agency Point of Contact _____

POC phone: _____-_____-_____ Email:

~~Name of Event: _____ (If applicable).~~

Date of event: _____

_____

Requesting: ☐ Personnel ☐ Equipment (Please complete MHPC Resource Request Form.)

Provide a brief description of the expectations of the SMAT Volunteers:
(If medical personnel are required, please indicate which specialties are required.)

MHPC Planning Section:

Needed personnel will be notified by _____(Staff) by ___/___/____, __:__

- Attach message with date and time sent.

ServNC Mission Created ☐ IAP Completed ☐ Contact with OEMS ☐

Funding needed _____ (Attach Budget).

Appendix L: Equipment Loan Form

MHPC
METROLINA HEALTHCARE PREPAREDNESS COALITION

3311-A Beam Road
Charlotte, NC 28217
704 357-8517

I, _____ , have received the following equipment from the Metrolina Healthcare Preparedness Coalition on behalf of
.

(Agency or facility accepting equipment)

The anticipated date of return for this equipment is _____/_____/_____.

⏩ Please see attached equipment list.
This is a printed list of equipment checked out to the above agency, as documented in the Metrolina SMAT iCams inventory system.

⏩ Brief description of anticipated utilization of equipment:
Please see the Resource Request document with associated MHPC Mission number listed below.

⏩ Please read and initial.
By my signature, I acknowledge receipt of the items listed on the attached form, and affirm that I am aware that in the event of damage to and/or loss of this equipment, I, or the agency/facility that I represent, will be held responsible for all expenses involved with the repair or replacement of said equipment. Please Initial Here: _____

⏩ Please note any equipment faults or changes here.

Signature: _____ Date: _____

Print name: _____

MHPC Staff: _____ Date: _____

MHPC Mission Number/ Event Name:

Return of equipment witnessed by: _____
(Must be MHPC Staff)

Date Returned: _____

3.Medical Surge Coordination

METROLINA HEALTHCARE PREPAREDNESS COALITION

MEDICAL SURGE PLAN/COORDINATION

Record of Changes

Date of Change	Description of Change	Change made by

TABLE OF CONTENTS

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1. INTRODUCTION

1.1 PURPOSE

This plan exists to enhance the capacity of the Metrolina Healthcare Preparedness Coalition partners and stakeholders to save as many lives as possible in a medical surge situation and to protect the health and well- being of as many members of the Metrolina region as possible—be they residents or visitors. This focus may involve making choices that negatively impact some. The underlying priority of this plan is to provide the greatest amount of care possible to the greatest number of people.

It is recognized that every healthcare resource in the county is valuable and important. However, the need for a response that is focused on providing the greatest amount of good for the greatest number of people necessarily focuses the planning on the larger resources and facilities. To the extent possible, this plan attempts to recognize the contributions made to the healthcare system by all providers.

This plan is developed in order to guide the orderly response to a medical surge event in the Metrolina Region. As such, this plan is a situation-specific annex to the county's emergency response operations plan.

Specific objectives of the plan are to:
Assess and describe available resources within the Metrolina region relating to medical response.
Guide the coordination of and allocation of resources in response to a surge situation, including situations calling for alternate care sites (ACS).
Guide the coordination of mutual aid among healthcare facilities and agencies within the region.

For the purposes of this plan, surge is defined as an overwhelming increase in the number of patients demanding health care needs within the county at a level above 110 – 125% of normal capacity, or an incident necessitating multi- casualty, multi-branch response. A further discussion of surge appears in Attachment A, Surge Definitions.

1.2 Relevant Authorities

The Metrolina Healthcare Preparedness Coalition functions as the health and medical EOC Liaison in any County's Emergency Operations Center with the Metrolina region, responsible for developing and managing an appropriate response to situations that result in a medical surge situation and coordinating between all healthcare entities involved.

The authority of the Healthcare Preparedness Coordinator to respond derives from several sources and is somewhat dependent on the nature of the event and whether or not an emergency has been declared.

2. CONCEPT OF OPERATIONS

Because each potential situation demanding a surge response is unique, each actual response must be unique. The concept of operations for MHPC's surge response is to practice a step-by-step response to each unique surge event: assessing, planning, executing, and evaluating the surge response. This systematic response, coupled with comprehensive job aids and pre-identified resources, helps ensure an adequate surge response.

If a healthcare surge in the continuum of care occurs in conjunction with a mass casualty incident, MHPC will activate the RHSC/HISS and will staff the EOC Liaison position to act as liaison between the field EMS incident commander (or unified incident command post, if appropriate) and the medical branch director. In addition to staffing the medical field operations coordinator position, it is expected that there will be direct horizontal communication between similar positions in the organizational structure and the multi-casualty multi-branch organization field structure, such as between the medical transport patient tracking group supervisor and the patient transport unit leader.

3. ACTIVATION

3.1 Activation Criteria

This plan may be activated by the specific individuals identified below (see: Who May Activate, section 3.2). The following conditions are triggers for activation of this plan:

- Hurricane, flood, fire, or other damage (including bombing or chemical weapon attack) to an existing acute care facility such that evacuation of patients is necessary or significant space is unusable—e.g., damage to surgery suites or Emergency Department of a hospital.
- Similar damage to some other healthcare facility resulting in significant injury, need for evacuation, or nonusability of space—e.g., damage to major community clinic space making it unusable for delivery of ambulatory care.
- Mass casualty event (MCE) causing primary injury (e.g., earthquake, dam breach, explosion) generating a surge in demand on the health care system above 110 – 125% of normal capacity.
- Damage to the transportation system such that patients cannot be transported to or from one of the major hospitals.
- Activation of the MCI Surge Plan Annex of the MCI Management Plan.
- Mass dislocation of people to such an extent that there is an actual or anticipated need for increased ambulatory care needs. This may include not only the dislocation of residents in the Metrolina Region, but also a large number of tourists or other visitors to the area that may be unable to leave due to disruption of transportation routes.
- Any CBRNE (Chemical, Biological, Radiological/Nuclear, Explosive) event or extreme weather event (e.g., sustained hot weather, sustained freezing weather, etc.) generating a surge in demand on the health care system above 110 – 125% of normal capacity. It should be anticipated that this surge may include the worried well, who are likely to clog the emergency rooms.
- Any increase in patients due to a pandemic or other communicable disease emergency, such that the demand for health care services exceeds routine ability to provide care.
- Declaration by the Centers for Disease Control or the California Department of Public Health of a pandemic.

3.2 WHO MAY ACTIVATE

Any member of the Metrolina Healthcare Preparedness Coalition whose facility is experiencing an event that meets Activation Criteria

4. PLANNING ASSUMPTIONS AND SCENARIOS

4.1 PLANNING ASSUMPTIONS

This plan takes an all-hazards approach, while using specific scenarios to plan for the more likely circumstances in the Metrolina Region.

This plan makes the following general assumptions:

- The circumstances leading to a surge in the Metrolina Region are most likely to be severe weather, flood, man-made incidents, and highly infectious disease (flu, norovirus, etc.)
- Continuity of government at the local city, county, and state level is preserved, including non-surge public health functions (e.g., e.g., registration of births and deaths and issuance of burial permits).
- MHPC's surge response may need to embrace tourists as well as residents, migrant workers not captured in standard census measures of the area's population, and conceivably Internally Displaced Persons fleeing disaster in other counties.
- A high degree of internal self-sufficiency and self-reliance is important to the region's response.

Separate plans and provisions have been made for:

-General public health emergency response
-County emergency operations plans
-Mass dispensing operations and strategic national stockpile utilization
-Pandemic influenza, including isolation and quarantine

- Mass casualty incident (MCI) response is not necessarily the same as healthcare surge in the continuum of care. MCI response is described separately in each county's emergency medical services (EMS) agency's MCI management plan. This surge plan identifies areas of overlap with the MCI plan.
- This plan does not cover isolation or quarantine because isolation and quarantine are not medical surge conditions; they are public health containment measures used to combat communicable diseases which may occur in single, cluster, or larger patient quantities.

4.2 SCENARIOS

4.2.1 SEVERE WEATHER

The Metrolina region experiences numerous severe storms throughout the area that have the capability to produce dangerous lightening, strong winds, and torrential rain. These storms have the potential to impact the area by spawning destructive tornadoes and possibly flash flooding.

Assumptions

Several assumptions can be made about severe storms and any impact they may have on the healthcare infrastructure. These include:

In sudden impact situations, like severe weather, the earliest that outside assistance can reach an impacted area is highly dependent upon the situation and the geography of the area. This suggests that any area directly impacted by severe weather must be prepared to sustain its own healthcare services for an unknown amount of time before being able to count on regional, state, or federal support.

The principal demand for healthcare following a sudden impact event like severe weather is for conditions that often could be managed on an ambulatory basis. The injuries and conditions for which there will be increased demand include:

- Soft-tissue injuries or lacerations if there is structural damage/tornadoes
- Fractures if there is structural damage/tornadoes
- Psychological/ mental health
- Possible electrocution injuries from lightening
- Drowning

The peak time for demand in surge capacity following such an event is 24 hours. Emergency Departments of local hospitals will be the primary Access Points for people seeking the kind of care required in this type of event.

Should evacuation of any healthcare facility be required following a severe storm, it will probably need to occur in the first 24 hours following the incident. Severe storms can have a generally disruptive impact on a community. This impact includes the potential for significant disruption of services, including: transportation, communication, power, shelter and sanitation.

Impact

The impact that severe weather can have on the healthcare delivery system is dependent on the extent of the disruption generally occurring in a location as well as specific consequence experienced by healthcare facilities.

In order to properly assess the impact of severe storm on the healthcare delivery system, the following factors must be taken into consideration:

- Damage to any healthcare facility. The extent of damage to existing facilities will be a key issue in determining the proper response to a severe storm. The following issues must be determined: Is there any damage to the facility that will require partial or total evacuation? Are there severe weather related injuries to patients or staff at any healthcare impacted that access to the facility is impaired or impossible?
- Damage to the communications infrastructure. Again, normal modes of communication have the potential to be damaged as a result of a severe storm. The ability of the hospital to respond appropriately to a surge situation is dependent on the two-way exchange of important information. Thus, it must be determined immediately the extent to which normal communications are affected and back-up communication systems must be put into operation.
- Damage to transportation channels. A significant risk associated with severe weather is a disruption in transportation. Staff may not be able to reach their usual place of employment. Pre-hospital care may not be able to deliver patients to acute care facilities. Patients may not be able to reach hospitals. Evacuation plans may be disrupted. And, the usual vendors of materials and supplies may not be able to reach the facilities in order to maintain needed supplies.

4.2.2 FLOOD

Often the Metrolina Region experiences flash flooding rather than flooding that can be prepared for. However, there are numerous lakes, rivers, and streams that have the potential to crest and causing damaging flooding that can destroy entire communities. In addition, the Metrolina region is home to Cowens Ford Dam that spills into Lake Norman. The dam alone is an extremely dangerous hazards to those in the Metrolina region.

Assumptions

The following assumptions about floods as they relate to healthcare delivery may be made:

- The Hydrological Service of the National Weather Service will provide watches, warning, and forecasts at least 24 hours prior to actual flooding. These coupled with detailed maps and historical data will allow exact prediction of the structures affected, percent of population affected, transportation impact, and other key planning factors associated with a rain-driven flood.
- In the case of weather related flooding, the most probable type of health issue will be related to the fact that a significant portion of the population may be displaced. This is apt to result in high need for ambulatory care—especially as of chronic conditions. Many of these concerns may be related to patients being separated from their medications for such conditions. Flooding related to a sudden breach of the dams may result in injuries of a different nature and require more acute care response. These injuries could include near drowning events, fractures, soft tissue injuries, etc.

Impact

As with severe weather, the nature and extent of the impact of flooding will depend upon the direct impact on healthcare facilities. The following issues need to be assessed and evaluated in order to determine the extent of surge and the proper response:

- A rain-driven flood will result in internally displaced persons, non-surge levels of routine trauma, and a potentially prolonged need for shelter medicine. A dam-failure-based flood will add near drowning and hypothermia to the trauma- oriented earthquake scenario.
- The extent of damage to existing facilities. The impact of flooding on the usability of a building or facility may not be as directly ascertained or as evident as in earthquake. It must be determined if there is any flooding of the buildings themselves. Also, the availability of power and potable water need to be assessed.
- The extent of damage to transportation routes. This is a key element of the assessment of surge needs related to flooding. It needs to be determined what routes are passable to and from a facility. Can the facility be reached by Emergency Services and can patients be transported in or out of the facility? To what extent is staff able to reach a facility?
- Anticipated length of the crisis. Especially in situations in which flooding is caused by inclement weather, it may well be possible to anticipate the length of a surge crisis by accessing the weather report. This kind of information is essential in determining the type of surge response that is most appropriate.

4.2.3 MAN-MADE DISASTER

Man-made disasters include chemical, biological, radiological, nuclear, or explosive (bombing) attacks (CBRNE) of intentional (i.e., terrorist) origins or accidental etiology (e.g., industrial accident). Obviously, these are very different in nature, but for the sake of brevity are treated together here.

Assumptions

Clearly, the range of possible events that can be grouped in this category is huge and defies easy classification. However, certain assumptions can be made. Among these are:

- CBRNE-based events are likely to produce high number of the “worried well” as well as actual casualties and mortalities.
- Explosive incidents are likely to be more localized than other types of disasters—although it could involve several discrete locations, and would likely require the rapid mobilization of ambulances and would require other modes of transportation for less seriously injured persons. There will be a high demand for treatment of soft tissue injuries, lacerations, burns, and exacerbations of chronic conditions. In short, the highest demand will be for Emergency Department care. Those that are severely injured are likely to need emergency surgery and Intensive Care.
- Any terrorist incident is also a law enforcement event, and appropriate coordination will be required. Even in a surge scenario, the scene of a CBRNE is also a crime scene, and patients may be involved in the collection of evidence. Any incident involving bioterrorism, radiological, or nuclear materials will involve multiple and diverse state and federal agencies.
- Bioterrorism and chemical incidents are likely to increase the need for mutual aid and for involvement of the state’s Department of Public Health.

Impact

Of course, the impact of an event of this sort is completely dependent on the nature of the event, the size of the event, and the nature of the injuries. Given the above assumptions, the most likely impact would include:

- A significant need for ED services and/or field triage. It is likely that the ED closest to the event will be overwhelmed with injuries. This will require the diversion of less emergent or non-emergent patients to another resource. ED staff of local hospitals and/or paramedics may be called upon to provide field triage services.
- A significant need for surgical and ICU services. This may require the local hospital(s) to send some ICU patients to step-down units or to other sites of care. Also, this could require some alternate care site capable of meeting the surgical/ICU needs.
- If the event were to cause significant disruption to transportation channels, it could require surge capacity responses dealing with the inability of staff to reach places of employment or of patients to access hospitals.
- Potentially large opportunities for cohorted patient care (all patients with respiratory difficulties, or all patients with minor soft tissue injuries may be grouped).

4.2.4 PANDEMIC INFLUENZA

Pandemic influenza presents significantly different challenges than the other risks discussed in this plan. In contrast to the other scenarios, pandemic does not have a single or identifiable point of impact. Also, the impact of the pandemic is, necessarily, global—the Metrolina region will be one of many areas trying to meet the medical surge associated with this crisis. National and State plans for dealing with pandemic influenza have been developed and will be operative. This plan attempts to look at the issues that are specific to planning for pandemic in the region.

Assumptions

Pertinent assumptions about Pandemic Influenza and medical surge in the Metrolina region include:

- It is probable that the Metrolina Region will have some warning of the impending arrival of pandemic influenza in the area. Thus, local plans will likely be activated before the occurrence of cases of pandemic influenza in the region
- The emergence of pandemic influenza will be tracked closely by international organizations (e.g., WHO), federal government agencies (CDC), and the State of North Carolina. These agencies and the national press will be alerting local authorities and the local populace about the risks of influenza.
- Due to the fact that influenza is a serious respiratory illness, it is assumed that there will be a need for ventilators and medical supplies and capacities to support large numbers of seriously ill patients.
- It is assumed that large numbers of health care providers and other staff will be impacted by the illness—either ill themselves or caring for seriously ill family members.
- In contrast to other risks, there is little if any risk to the physical infrastructure. Buildings will remain intact and the transportation and communication channels should remain unaffected. Thus, the greatest impact on the system will come from staffing needs, supplies, and the need for space presented by large numbers of ill patients and need to cohort care.
- It is assumed that a pandemic influenza situation will be such that home care is encouraged and, unless absolutely necessary; many patients will be discouraged from

seeking care at a healthcare facility so as to retard the spread of the illness in the community.
- Pandemic influenza may require the use of isolation and quarantine as tools to protect citizens from exposure to the virus.
- Due to the global nature of a pandemic, the ability to rely on outside assistance and resources will be limited as other communities will be similarly affected.

Impact

The impact of pandemic influenza will be enormous on all aspects of the healthcare delivery system:

- Staffing at all levels of healthcare delivery—outpatient clinics, long-term care facilities, and hospitals will be significantly impacted. Many employees, of all professional levels, will be unwilling or unable to come to work as scheduled. The usual sources of augmenting the workforce will be similarly impacted and will not be able to fully meet the needs.
- Cohorting of patients (i.e., grouping patients and caregivers known to be infected with influenza) in order to contain the infection will have to be implemented at most, if not all, healthcare facilities. This will require significant demand on space within an existing facility.
- Impact of pandemic influenza is likely to be so overwhelming, in terms of patients ill and decreased resources of staff that broad measures will need to be taken to decrease workload across healthcare facilities. This may include the discharge of patients early, cancellation of scheduled elective or non-emergency surgeries, increased reliance on home care nursing, altered standard of care for hospitalized patients (e.g., decrease in required paperwork and other charting), and other measures.

5. COMPREHENSIVE SURGE RESPONSE PROCESS

The response process described below is intended to be a description of a generic process for the assessment of and response to a medical surge scenario. Regardless of the scenario, this plan will serve as an approach to gathering pertinent information, assessing relevant factors, and choosing the option that best responds to the exigencies presented.

The graphic below (Figure 1) illustrates the steps in flow chart form. Each step is then described in more detail below.

A surge response for pandemic influenza is considered as a special case in Attachment D. Due to the likely lead time, duration, and staging of a pandemic, greater planning and a staged response are possible.

1. Indication of a potential surge	For Pandemic, see Attachment E For an overall surge quick response, guide supporting development of an Emergency Action Plan, see Attachment D
2. Preliminary Information Gathering	Consider issuing warning to partners
3. Activation of Medical Surge Plan	Activate plan, emergency operations center, and mutual aid resources
4. Comprehensive Situation Assessment	See Attachment K, Situation Reporting and Appendix J, Facility Status Report
5. Evaluate Response Options	See Figure 2, Surge Response Options
6. Plan Surge Response	
7. Implement Surge Response	See Attachment G, Job Action Sheet for Implemetning Surge Response
8. Monitor/Evaluate Surge Response	See Attachment H, Job Action Sheet for Monitoring Surge Response
9. Stand-down and Recovery	See Attachment I, Job Action Sheet for Recovery from Surge

5.1 Step 1 - Indication of a Surge Problem

See Attachment C, Surge Quick Response Guide for a general, summary-level job aid supporting Emergency Action Plan development for overall surge response.

Information regarding situations that may present medical surge conditions can come to the attention of the MHPC coordinator, MHPC staff, the MHPC program, or public health staff in different ways; if the RHSC/HISS is activated, information will flow to the other regional partners as deemed appropriate. Several of these are described below.

In each case, when this information comes to MHPC, it will trigger the gathering of further information as described in subsequent sections.

Existing Partners/Relationships

- Healthcare facilities can become aware of surge situations, either through their own perceived needs or other conditions that signal surge conditions.
- Healthcare facilities may request resources of MHPC, thus indicating increased demand for services.
- In routine communications between MHPC staff and healthcare facilities, information may be shared that raises the index of suspicion that an event may be occurring requiring surge resources.

Local Law Enforcement

- The EOC Liaison or MHPC staff may be alerted to surge problems by local law enforcement (sheriff, local police) consistent with existing emergency operations plans.
- Communication from local law enforcement regarding events that have or may have impacted local structures and/or transportation routes can signal the possibility of a surge situation, requiring further investigation.

External Sources (State/Federal)

- State and/or Federal authorities may communicate directly with the ESF8 Desk or County Emergency Management, thus sharing information about disaster events and/or risks.
- County Emergency Management may inquire directly of State and/or Federal officials about events and risks.

General Awareness

- Information may come to the EOC Liaison or MHPC staff in an informal manner, e.g., through news reports on broadcast media, word of mouth, e-mail notification, etc.
- Actual experience of an event, e.g., feeling an earthquake, can signal the MHPC Coordinator of the need for further investigation of an event.

Field Reports from EMS

- EMS Agencies in the Metrolina Counties may be the first indication of a surge problem. Such a problem would present as a multi- casualty incident, and would likely trigger activation of the agency's MCI management plan.

- Note: Pandemic influenza represents an unique surge situation due to the ability to predict and track a pandemic (i.e., it is not a sudden event). See Appendix E, Pandemic Influenza Surge Response, as a condition-specific adjunct to this step-by-step process.
- Consider issuing a preliminary warning to health care partners and emergency medical services providers now. See Appendix C for list of contact information.

5.2 Step 2 - Preliminary Information Gathering

As noted above, information about events that may require medical surge response can come to the MHPC staff in different ways. Whenever such information is received, there are immediate issues that can be assessed that will help direct the planning and response process.

This initial information gathering is not meant to be comprehensive nor should it be the basis for decision making regarding the response plan. Rather, it represents the first "quick look" at the situation and will serve as an informal basis for understanding the event and the needs it presents, including the need for more formal information gathering.

This quick assessment may include the following:

- What is the nature of the event—i.e., earthquake, explosion, flood?
- Are there any known or anticipated sequence of the event that may pose continued risk—e.g., aftershock, further explosion, etc?
- Are there known events happening elsewhere in the State or nation that could impact locally?
- What is known of the immediate impact?
    - Are any structures known to be down?
    - Are there any known injuries?
    - Are there any known power outages?
- What is the known impact on transportation routes?
    - Are the access routes to/from major medical facilities intact?
    - In particular, is there any known issue or problem with a MAJOR highway?
    - Are there any known issues or problems with the routes in/out of the county?
    - Are there any known issues or problems with major routes (including bridges) in neighboring counties?
- Has the County activated its Emergency Operations Center? Has the RHSC/HISS been activated?
- What is the status of the EMS agency, including available personnel, equipment, and ambulances?
- What is the quick look assessment of major medical facilities based on a polling of their status?
    - Are hospitals known to be damaged?
    - Is there an immediate need for evacuation of all or some of the facility?

As soon this preliminary information is gathered, an initial situation report (SIT REP) should be prepared and submitted by the EOC Liaison. The EOC Liaison will prepare a SIT REP within two hours of incident recognition and share that information with the MHPC Coalition Partners, the North Carolina Department of Public Health and, NC Office of Emergency Services HPP Program, local, regional, and state emergency management agencies as indicated.

See Attachment i for details and data elements for the SIT REP.

Updated SIT REPs should be prepared once during each operational period; in response to significant changes in status, prognosis, or actions taken; and in response to requests for updates from the region or state, as communicated by the MHPC program. All SIT REPS will be maintained as part of the incident historical document file.

5.3 Step 3 - Activation of Plan

The activation of the medical surge plan can be taken in steps as the assessment of the situation continues. Immediately, the following steps may be taken:

- Consider activation of the RHSC/HISS. Further consideration of surge response will require significant resources.
- Notify the county Operations Area Emergency Operations Center (Op Area EOC) and NCOEMS Shift Duty Officer
- Alert major healthcare facilities and skilled nursing facilities of the event and of the intention to activate the surge plan.
- Contact information for the major medical facilities and SNFs can be found in Attachment B, Emergency Contact Information.
- Convene a meeting or teleconference with relevant authorities and health care partners for action planning and assessment.
- Assess impact/readiness of facilities considered for possible use as Alternate Care Sites and alert those sites.
- Contact information for facilities that may be used as ACS can be found in Attachment B, Emergency Contact Information.
- Follow general steps as outlined in the Job Action Sheet (see Attachment C, Quick Response Guide).
- File an updated SIT REP (or initial, if not yet submitted. The SIT REP will include healthcare facility system status. Situation reporting will be handled by the EOC Liaison
- Consider requesting mutual aid.

5.4 Step 4 - Comprehensive Situation Assessment

Gather specific information that is needed to inform the process of responding to the surge needs. Assessment is critical to initiating the appropriate surge response. Assessment will cover:

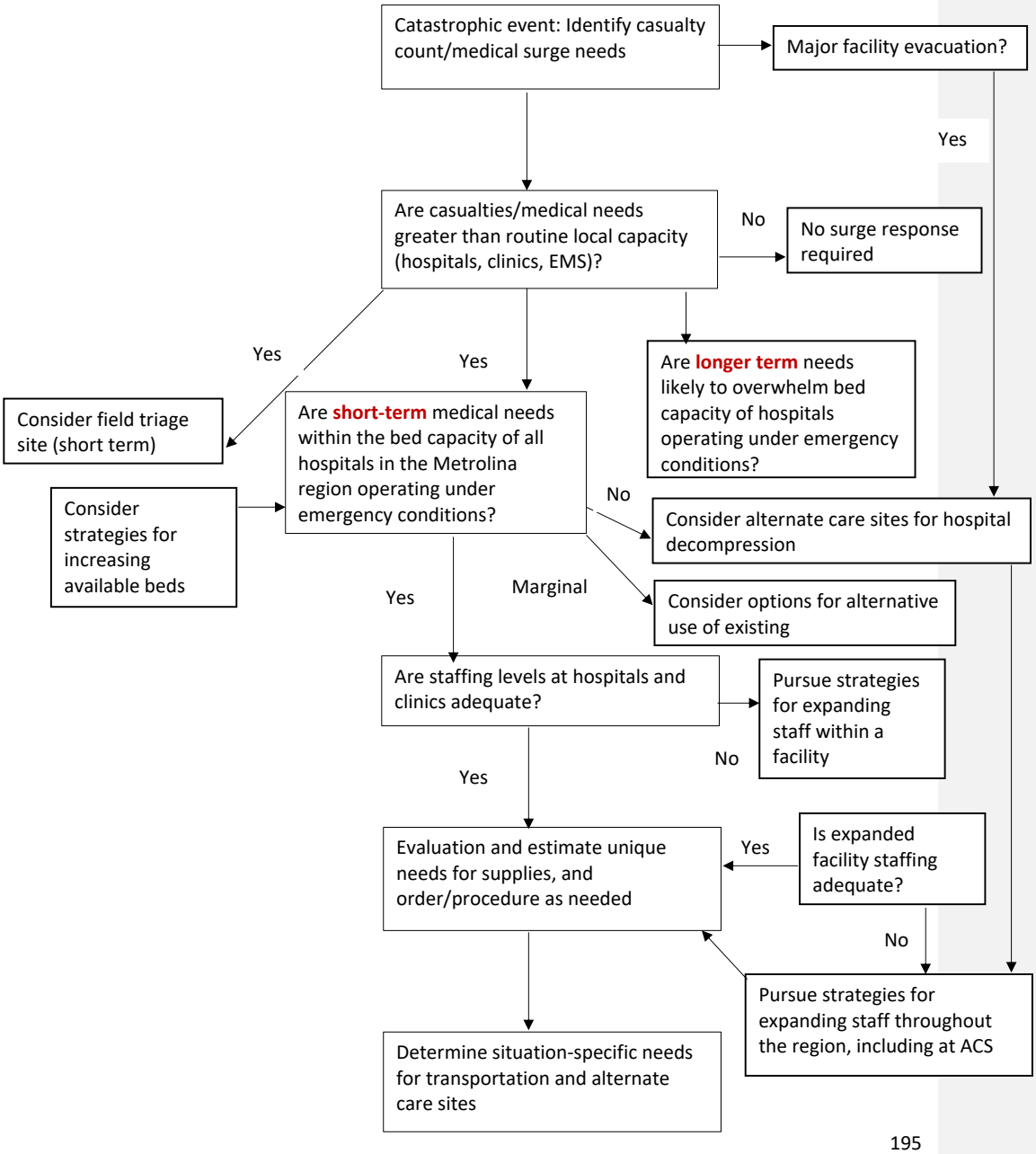
- The nature and magnitude of the incident, Casualty counts (immediate and projected), and status of hospitals, emergency medical services, public health, and transportation.
- See Attachment H, Facility Status Report, for the department's facility status reporting tool, and Attachment I for comprehensive SIT REP instructions.

5.5 Step 5 - Evaluate Response Options

Response to surge conditions require management and creative allocation of space, staffing, and supplies to meet the needs presented by the event. Each event will require unique responses. Figure 2, Surge Response Options, presents an algorithmic approach to evaluating options. These options are then detailed in the text that follows. Another way of considering this text is as a "cookbook" of options. As a job aid during an emergency, planners are urged to review the list of options as they consider strategies and tactics available for the crafting of a particular surge response.

See Figure 2 on the next page

Figure 2 - Surge Response Options



Options for Increasing Available Space
Strategies for increasing available space within facilities:

- Rapid discharge of patients not yet admitted to a hospital. This can include all outpatients and Emergency Department patients who are able to continue care at home or in an alternative setting.
- Rapid discharge of inpatients that can safely continue care at home or in another facility (consider facility capable of providing lower acuity care).
- Cancellation of all non-emergent procedures. In particular, procedures and surgeries that are elective or can be safely postponed for a short period of time should be considered for cancellation.
- Reduction in the use of technology that may be needed to meet surge capacity needs. Special attention should be paid to reducing the use of imaging, laboratory testing and other ancillary services.
- Reducing the critical care population by transferring some critical care patients to other beds. Consideration may be given to placing some ventilator patients on monitored step-down units and using pulse oximetry with alarms in lieu of some cardiac monitoring.
- Increasing the number of beds in non-critical care rooms. Institutions can consider the prudent increase of beds by converting single rooms to double and double rooms to triple.
- Conversion of some rooms or wards to negative pressure or isolated from the ventilation system to allow for cohorting of infected patients in influenza and other infectious disease scenarios.
- Conversion of non-patient care areas to use for less acute patients. For example, consideration can be given to placing cots, gurneys, or beds in a non-patient care area (e.g., gymnasium, multi-purpose room) for the provision of non-critical care.
- Transfer of patients (if transportation available) to institutions outside of the county and/or affected area.
- Increase the use of home care nursing facilities in order to facilitate early discharge and reduce the need for hospitalization of chronically ill patients.

Strategies for Alternative Use of Existing Space

- Consider use of existing outpatient facilities for the delivery of ambulatory care for “worried well” and displaced populations

Strategies for Increasing Space through use of Field Treatment Site/Alternate Care Sites

- Several options are available for Alternate Care Sites including:
  - Ambulatory Care for displaced populations and worried well
  - Overflow for urgent care patients
  - Use of facilities for decompression of acute care facilities
  - Cohorting of patients in pandemic situation

Options for Increasing Staffing Capacity

<u>Strategies for Expanding Staff within a Facility</u>

- Call in lists of available personnel. Facilities will have call-in lists of all available personnel (employees and volunteers). It is recommended that these lists capture as much information as possible as to the availability and method of contact. In particular, the residence information of each person will be captured and sortable by zip-code in order to facilitate determining which personnel may be most impacted by disruptions in transportation channels.
- Changes in scheduling. Facilities will have plans in place that allow for the changing of shift schedules to meet the needs presented by a medical surge event.
- Changes in Staff Assignments. Facilities should allow for changes to assignments in order to increase available staff. Such changes should include shifting site assignments within the facility and changing patient/staff ratios. The use of administrative personnel to perform patient care duties should be considered

Strategies for Expanding Staff throughout the County

- Reallocation of personnel among healthcare facilities. The major healthcare providers in Napa County have entered into a Mutual Aid Agreement that ensures mutual support in emergency situations. That help will include the reallocation of staff. Possible approaches here include:
    - Request mutual aid staff from less impacted facilities to supplement inpatient care at an acute care facility.
    - Request mutual aid staff from less impacted facilities to staff satellite clinics or other ACS to support ambulatory care efforts at those sites.
    - Strategic use of staff with particular skills or resources (e.g., allocation of staff with particular language skills to sites requiring them).

- Increased/altered use of home care resources. In order to decrease the demand on ambulatory care facilities and acute care facilities, existing home care resources may be utilized beyond current capacity. This may require a sharing of home care resources among facilities and an altered approach to some visits. The following may be considered:

- Adding unscheduled visits to chronically ill patients in an effort to prevent unnecessary exacerbations.
- Access/activate Napa County Medical Volunteer Registry.
    - Registry can be used to call on registered nurses and physicians to supplement staffing at existing facilities, ambulatory care clinics, field treatment sites, and alternate care sites.
- Out of County Resource or out of Coalition Resources
- Other resources may be accessed through the MHPC function for increased staffing capacity, including:
    - North Carolinas Disaster Healthcare Volunteers (the Emergency System for Advanced Registration of Volunteer Health Professionals),
    - Resources from neighboring counties with whom the Metrolina Region has MOUs, North Carolina State Medical Assistance Teams (SMATs), and
    - Disaster Medical Assistance Teams (DMATS).

Options for Increasing Available Supplies

- Each healthcare facility should have as part of its emergency plan, a cache of emergency supplies. These supplies should be coordinated with the RHSC/HISS to

ensure that at time of emergency, the Logistics Specialist will know of available supplies that can be used at the individual facility or, if necessary, at other facilities, e.g., Alternate Care Sites.
- The Coalition maintains a limited cache of supplies and stores it specifically for use at ACS or Field Treatment sites as necessary
- Individual facilities and the county should seek MOUs with commercial supply companies for supply chain continuity.

Options Relating to Transportation

- Several options are available for both patient and non-patient (e.g., volunteer) transportation. Specific contact information for these resources is found in Attachment B.
- Routine Emergency Medical Response

Transportation options owned by healthcare facilities:
–MedCenter Air – Atrium Health
-Critical Care Transport – Novant Health

5.6 Step 6 - Plan Surge Response

The specific nature of an event and a review of the options presented in Step 5, will lead to a determination of the proper approach to a plan for surge. Those determinations need to be made and documented in an Emergency Action Plan (EAP). The following check list can guide completion of the EAP:

- Coordinate planning efforts with Acute Care Hospitals
- Communicate with involved healthcare partners (see Emergency Contact Information, Attachment B):
  - Convene meeting of involved partners for communication and distribution of plan
  - Determine plan for continued regular meetings of involved partners

- Determine plan for regular communication with involved partners Utilizing efforts in Step 6, determine the following:
  - Specific level of evacuation needed for any health care facility ○ Location for receiving of evacuees
  - Site and concept of operations for any Field Treatment Site
    - Determine security requirements for FTS
    - Communicate with local authorities and/or any contracted security resources
  - Site and concept of operations for any Alternate Care Site
    - Determine security requirements for ACS
  - Communicate with local authorities and/or any contracted security resource

- Type and number of additional staffing required

- Plan(s) for obtaining staffing resources
  - Determine specific requests to be made of Napa County Medical Volunteer Registry
  - Determine which staffing requests will be made of any Mutual Aid Agreements (both within county and outside)

- Determine what requests will be of outside resources (ESAR- VHP, SMAT, etc.)

- Additional medical supplies that will be needed and source of those supplies

- Additional transportation resources will be required and source of those resources Plans will include decisions reached on transportation of patients, staffing resources, and supplies

- Draft Emergency Action Plan for surge response including items determined above

5.7 Step 7 - Implement Surge Response

Implementing the surge response will follow directly from the planning considerations outlined above. See Attachment E: Job Action Sheet for Implementing Surge Response. This is a general purpose checklist for any surge response.

Using the Standard Emergency Management System (SEMS), the planning and logistics branches of the HHSA DOC, and if needed, the Op Area EOC, will assist in implementing the surge response. Updated SIT REPs will be submitted each operational period.

5.8 Step 8 - Monitor/Evaluate Surge Response

Daily situation analysis to monitor the event which prompted the surge response, and to evaluate the response itself, will be conducted using RHSC/HISS, Op Area EOC or public health-based resources. This analysis will also monitor for indications that the event is over, or that the surge response will be discontinued. Updated SIT REPs will be submitted each operational period.

See Attachment F, Job Action Sheet for Monitoring Surge Response, a general purpose checklist for evaluating the progress of the surge event.

5.9 Step 9 - Stand-down and Recovery from Surge Response

At some point, the surge response will no longer be needed. See Attachment G, Job Action Sheet for Recovery from Surge for a checklist of relevant actions. A final SIT REP will be completed at the appropriate time.

6. ATTACHMENT A: SURGE DEFINITIONS

What is Surge?

A. What it is:
The Agency for Healthcare Research and Quality (AHRQ) has defined surge capacity in this way:

"Surge capacity is a healthcare system's ability to expand quickly beyond normal services to meet an increased demand for medical care in the event of bioterrorism or other large-scale public health emergencies."

- Key elements of this definition that are noted and affirmed in this plan include the focus on the healthcare system and the recognition that surge refers to situations that have placed demand beyond normal services. This understanding is further supported by State of California emergency planners who have used "surge" to refer to: "an overwhelming increase in demands for medical care services arising out of a moderate to severe emergency."
- Thus, the understanding of this plan is that it will be activated only in situations in which the ability of the county's healthcare system to provide appropriate care is threatened. It is also understood that some stresses occur in a healthcare system on a regular, daily basis. These stresses, while sometimes placing a temporary, extraordinary demand on a portion of the system, do not necessarily exceed the normal services that are provided within that system.
- Specific situations that will trigger the activation of this plan are discussed above. In general, the Healthcare Preparedness Coordinator/On-Call Staff will monitor any situation that places significant stress on individual healthcare providers within the county and on the county's healthcare system in general. Then, consistent with the description in state surge planning documents, a surge event will be proclaimed when the Healthcare Preparedness Coordinator:

"using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess of demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status."[i]

B. What It Is Not

As is made clear in the above section, not all stress on a portion of the healthcare delivery system results in a surge condition. Indeed, even those events that may seriously stress a single portion of the system may be dealt with in the context of routine operations.

Thus, a situation could occur that places extraordinary stress on the Emergency Department of a local hospital—e.g., a multi-vehicle accident involving a large number of injuries. This even may cause the local hospital to take actions to decrease the impact of the event on their ability to provide care. Actions that the facility may take include internal shifting of personnel resources and a request to divert ambulances to other facilities.

While such a situation does not reach the level of a "surge" event, it demonstrates the progression to such a situation. The facility could (and should) inform local officials of the impact on their capacity to provide care. The Health Officer, taking into account this information and all other that may be coming to her, may determine that the overall capacity to provide care within the county is being jeopardized. At that point, the Healthcare Preparedness Coordinator may activate some or this entire plan.

7. ATTACHMENT B: EMERGENCY CONTACT INFORMATION

Hospitals	***EMS Agencies***	***Emergency Management***	***Public Health***
Carolinas Healthcare System - Anson **2301 U.S. Highway 74 W** **Wadesboro, NC 28170** **(704)994-4500**	**Anson County EMS** **605 McLaurin St** **Wadesboro, NC 28170** **(704) 694-5342**	**Anson County Office of Emergency Management** **2230 Country Club Rd** **Wadesboro, NC 28170** **(704) 994-3272**	**Anson County Health Dept** **110 W Ashe St** **Wadesboro, NC 28170** **(704) 694-5188**
Carolinas Healthcare System Blue Ridge - Morganton **2201 South Sterling St** **Morganton, NC 28655** **(828) 580-5000** **Carolinas Healthcare System Blue Ridge – Valdese** **720 Malcom Blvd** **Valdese, NC 28690** **(828) 580-5000**	**Burke County EMS** **200 Avery Avenue** **Morganton, NC 28680** **(828) 433-6609**	**Burke County Emergency Management** **200 Avery Ave** **Morganton, NC** **(828) 433-6609**	**Burke County Public Health** **700 East Parker Rd** **Morganton, NC 28655** **(828) 764-9150**
Carolinas Healthcare System – Northeast **920 Church St. North** **Concord, NC 28025**	**Cabarrus County EMS** **31 Willowbrook Dr** **Concord, NC 28027** **(704) 920-3000**	**Cabarrus County Office of Emergency Management** **30 Corban Ave SE** **Concord, NC 28025** **(704) 920-2143**	**Cabarrus Health Alliance** **300 Mooresville Rd** **Kannapolis, NC 28081** **(704) 920-1000**

(704) 403-3000			
Catawba Valley Medical Center 810 Fairgrove Church Rd Hickory, NC 28602 (828) 326-3000 Frye Regional Medical Center 420 N. Center Street Hickory, NC 28601 (828) 315-5000	**Catawba County EMS 100-A Southwest Blvd Newton, NC 28658 (828) 465-8234**	**Catawba County Office of Emergency Management 100 SW Blvd A Newton, NC 28658 (828) 465-8233**	**Catawba County Health Department 3070 11th Avenue Dr SE Hickory, NC 28602 (828) 695-5800**
Carolinas Healthcare System – Cleveland 201 E. Grover St Shelby, NC 28150 (980) 487-3000 Carolinas Healthcare System – Kings Mountain 706 W. King St Kings Mountain, NC 28086 (980) 487-5000	**Cleveland County EMS 100 Justice Pl Shelby, NC 28150 (704) 484-4822**	**Cleveland County Office of Emergency Management PO Box 2232 Shelby, NC 28151 (704) 484-4841**	**Cleveland County Public Health 200 South Post Rd Shelby, NC 28152 (980) 484-5100**
Caromont Regional Medical Center 2525 Court Drive Gastonia, NC 28054 (704) 834-2000	**Gaston County EMS 615 N Highland St Gastonia, NC 28052 (704) 866-3300**	**Gaston County Office of Emergency Management 615 N Highland St Gastonia, NC 28052 (704) 866-3350**	**Gaston County Health Department 991 W Hudson Blvd Gastonia, NC 28052 (704) 853-5000**

Lake Norman Regional Medical Center **171 Fairview Road** **Mooresville, NC 28117** **(704) 660-4000**	**Iredell County EMS** **400 S Meeting St** **Statesville, NC 28677** **(704) 878-3025**	**Iredell County Office of Emergency Management** **349 N Center St** **Statesville, NC 28687** **(704) 872-7468**	**Iredell County Health Department** **318 Turnersburg Hwy** **Statesville, NC 28625** **(704) 878-5300**
Carolinas Healthcare System – Lincoln **433 McAlister Rd** **Lincolnton, NC 28092** **(980) 212-2000**	**Lincoln County EMS** **720 John Howell Memorial Dr** **Lincolnton, NC 28092** **(704) 736-9385**	**Lincoln County Emergency Management** **1 Court Square** **Lincolnton, NC 28092** **(704) 736-8530**	**Lincoln County Department of Public Health** **115 W Main St** **Lincolnton, NC 28092**
Carolinas Medical Center **1000 Blythe Blvd** **Charlotte, NC 28203** **(704) 355-2000** **Carolinas Medical Center – Mercy** **2001 Vail Ave** **Charlotte, NC 28207** **(704) 304-5000** **Carolinas Healthcare System – University** **8800 N Tryon St** **Charlotte, NC 28262** **(704) 863-6000** **Carolinas Healthcare System – Pineville** **10628 Park Road** **Charlotte, NC 28210**	**Mecklenburg County EMS** **4525 Statesville Rd** **Charlotte, NC 28269** **(704) 943-6000**	**Mecklenburg County Office of Emergency Management** **500 Dalton Ave** **Charlotte, NC 28206** **(704) 336-2412**	**Mecklenburg County Department of Public Health** **249 Billingsly Rd** **Charlotte, NC 28211** **(704) 336-4700**

(704) 667-1000 **Novant Health – Huntersville** **10030 Gilead Rd** **Huntersville, NC 28078** **(704) 316-4000** **Novant Health – Matthews** **1500 Matthews Township Pkwy** **Matthews, NC 28105** **(704) 384-6500** **Novant Health – Presbyterian** **200 Hawthorne Lane** **Charlotte, NC 28204** **(704) 384-4000**			
Sandhills Regional Medical Center **1000 West Hamlet Ave** **Hamlet, NC 28345** **(910) 205-8000**	**Richmond County EMS** **1401 Fayetteville Rd** **Rockingham, NC 28380** **(910) 997-8238**	**Richmond County Office of Emergency Management** **1401 Fayetteville Rd** **Rockingham, NC 28380** **(910) 997-8200**	
Scotland Memorial Hospital **500 Lauchwood Dr** **Laurinburg, NC 28352** **(910) 291-7000**	**Scotland County EMS** **1403 West Blvd** **Laurinburg, NC 28352** **(910) 276-1313**	**Scotland County Office of Emergency Management** **1403 West Blvd** **Laurinburg, NC 28352** **(910) 276-1313**	**Scotland County Public Health** **1405 West Blvd** **Laurinburg, NC 28352** **(910) 277-2454**

Carolinas Healthcare System – Stanly 301 Yadkin St Albemarle, NC 28002 (704) 984-4000	**Stanly County EMS 201 South Second St Albemarle, NC 28001 (704) 986-3650**	**Stanly County Office of Emergency Management 201 South Second St Albemarle, NC 28001 (704) 986-3650**	**Stanly County Public Health 1000 N 1st St Albemarle, NC 28001 (704) 986-3845**
Carolinas Healthcare System – Union 600 Hospital Dr Monroe, NC 28112 (980) 993-3100	**Union County EMS 1403 Dove St Monroe, NC 28112 (704) 226-2001**	**Union County Office of Emergency Management 500 N Main St Monroe, NC 28112 (704) 283-3536**	**Union County Health Department 1224 W Roosevelt Blvd Monroe, NC 28110 (704) 296-4800**

Other HCC Partners

Behavioral Health Services
Alexander Youth Network – 704-366-8712
Children's Hope Alliance – 704-872-4157
Mecklenburg County DSS – 704-336-3000
Behavioral Health Charlotte/Davidson – Atrium Health -704-358-2700/704-801-9400
Metrolina Medical Reserve Corps
Dialysis Centers
Fresenius Dialysis – 800-881-5101
Federal Facilities
VA Outpatient Clinic – Charlotte -704-597-3500
Home Health Agencies
Healthy at Home – Atrium Health – 828-879-9050
Local Public Safety Agencies
Cabarrus County Sheriff Department – 704-920-3000
Non-Governmental Organizations
Red Cross – 704-376-1661
Outpatient Health Care Delivery
Schools and Universities
University of North Carolina – Charlotte – 704-687-8622
Central Piedmont Community College – 704-330-2722
Long-Term Care Facilities
PACE of the Southern Piedmont – 704-877-3840

Senior TLC – PACE Organization – 704-874-0600
Jessie Helms SNF – Atrium Health – 704-993-3280
Sardis Oaks SNF – Atrium Health – 704-365-4202
Huntersville Oaks – Atrium Health – 704-863-1000
Cleveland Pines SNF – Atrium Health – 980-487-1500
Stanly Manor SNF – Atrium Health – 704-982-0770
5-Star Senior Living (The Laurels: 704-974-8050) (Summit Place: 704-525-5508) (Legacy Heights: 704-544-7220
Aldersgate – 704-532-7000
Brian Center – Gastonia – 704-866-8596
Autumn Care Shelby – 704-482-5396
Brookdale Shelby – 704-481-0150
Clear Creek Nursing and Rehab – 704-545-2377
Covenant Village – 704-867-2319
House of Peace Family Care – 704-620-4131
Lakewood Care Center – 704-483-7000
Lincolnton Rehabilitation Center – 704-732-1138
Monroe Rehabilitation – 704-283-8548
Peak Resources – (Cherryville: 704-435-6029) (Shelby: 704-482-5396)
Royal Park of Matthews – 704-940-8300
Sharon Towers – 704- 553-1670
Southminster – 704-551-6800
Stanly Total Living Center – 704-263-1986
Summit Place of Mooresville – 704-779-2712
The Pines at Davidson – 877-675-5413
Trinity Ridge – 828-322-6995
White Oak Manor – (Shelby: 704-482-7326) (Kings Mountain: 704-739-8132) (Rutherfordton: 828-286-9001)
Hospice Agencies
Scotland Regional Hospice – 910-276-7176
Hospice of Cleveland County – 704-487-4677
Hospice of Burke County – 828-879-7296
Hospice and Palliative Care Charlotte Region – 704-375-0100
Novant Hospice – 704-384-6478
Hospice of Union County – Atrium Health – 704-292-2100
Hospice of Cabarrus County – Atrium Health – 704-935-9434
Catawba Regional Hospice – 828-466-0466
Hospice and Community Care – 803-329-1500
Hospice of Stanly – 704-983-4216
The Carolinas Center – 919-459-5380
Robin Johnson House – CaroMont Hospice – 704-922-4211
Federally Qualified Health Centers

Gaston Family Health Services – 704-853-5079
Medical Examiners
Mecklenburg County Medical Examiner – 704-336-2005

8. ATTACHMENT C: SURGE QUICK RESPONSE GUIDE

This Job Action Sheet provides a high-level overview of surge response for the RHSC/HISS staff and supports development of an appropriate Emergency Action Plan.

To the extent possible, these actions are listed as they should be carried out chronologically. However, some items will require simultaneous action and, therefore, should be delegated in order to allow for the quickest impact possible.

Read the entire Action Check List

Obtain briefing from authorities in County (and State if applicable) as to nature and extent of incident and its impact. Briefings should be obtained from:

- Local police agencies
- North Carolina Highway Patrol

Obtain initial situation analysis from each of the following healthcare facilities/agencies (see Attachment C for contact information):

- All Atrium Health Facilities
- CaroMont Health
- Novant Health
- Lake Norman Regional Medical Center
- Catawba Valley Medical Center

Complete an initial (or updated) SIT REP as indicated in Attachment K. Obtain subsequent situation analyses at:

- 8-12 hours after event
- On regular basis after initial and subsequent determined by exigencies of event

Based on above briefings and analyses, determine what, if any, legal action needs to be taken immediately:

- Determine if Governor has issued proclamation of emergency

Using above briefings and analyses—estimate numbers, types, and location of casualties from events:

- Determine need for evacuation of any facility or portion of facility
- Determine which facilities are capable of receiving casualties or evacuees
- Determine need for and proper location for staging area(s) and/or field treatment facility
- Determine need for additional transportation resources

- Determine need for use of Alternate Care Site and determine which site is appropriate. (see Attachment F)
- Develop an Emergency Action Plan for surge response

9. ATTACHMENT D: PANDEMIC INFLUENZA SURGE RESPONSE

Pandemic influenza (or any other prolonged communicable disease emergency or pandemic) represents a unique surge situation due to the timing and epidemiologically measurable aspects of the event. The following are specific planning considerations based on an influenza pandemic.

Steps to take prior to emergence of pandemic:

- Establish infrastructure that can be utilized for management of surge in case of pandemic. Specific steps to take include:
  - Establishment of Emergency Operations Center and HHSA DOC plans
    - Consider establishment of a Healthcare Leadership Coalition:
      - Made up of directors/leaders of:
        - Hospitals in County or impacted area
        - Major Clinics in County or impacted area
        - Long Term Care facility representatives
        - Emergency Medical Response
        - Law Enforcement Authorities
      - Key roles:
        - Establishment of regular communication in order to recognize emergence of disease in county or region
        - Exchange of information regarding current capacities and needs Establishment of communication methods (e-mail, messaging, telephone, etc) Oversee drilling/testing of preparedness plans
      - Establishment of Public Health Point of Contact:
        - Reporting/monitoring of influenza like illnesses
        - Clarifying agreements with local hospitals
        - Clarifying agreements/MOU with potential ACS
        - Clarifying agreements/MOU with potential Casualty Treatment Areas (CTA)
      - Develop Policies for operations of CTA
        - Plan staffing of CTA
        - Plan supply of CTA
        - Plan Transportation of patients to CTA
        - Develop Policies for operations of ACS
        - Plan Staffing for ACS
        - Plan Supply for ACS
        - Plan Transportation of Patients to ACS and to/from area hospitals

Steps to take during Pandemic Alert Period: (Global Cases/First Confirmed US Cases)

- Generally encourage increased capacity to care for patients at home:
  - Encourage all healthcare institutions/providers to ensure adequate supply of chronic care medications available to patients to encourage care at home.
  - Encourage all healthcare institutions/providers to ensure adequate supply of first aid supplies/bandages/antipyretic medications/ oral electrolyte solutions/ thermometers.
- Establish daily communication with Healthcare Leadership Coalition, if created:
  - Consider planned daily teleconference
- Consider use of regular "listserv" or other e-mail communications Activate RHSC/HISS Communications Plan
- Encourage hospitals to prepare for decreased services:
  - Encourage scheduling of elective procedure within the next few weeks
  - Increase outpatient services for non-urgent services that can be provided in next few weeks:--e.g., employment physicals, annual exams, pre-natal checks)
    - Encourage staff increases for next few weeks
    - Encourage extended hours for next few weeks
    - Encourage communication to patients within systems to utilize these opportunities now. (Consider use of public service announcements to reach general public).
  - Consider creation of "anterooms" and areas within hospitals for cohorting of infectious patients
  - Consider creation of "primary care" vans to go into the community for offering primary care services

Identify Alternate Care Sites (ACS) to be used in upcoming stages.

- Transport county supply cache to site
- Establish plan for staffing of ACS:
  - Activate Volunteer Registry
  - Contact all local facilities and identify those staffing opportunities
  - Access State resources (e.g., SMAT, ESAR-VHP)
  - Establish Incident Command Structure for each of the ACS
- Unpack and inventory cache supplies

Steps to Take in Pandemic Period (Increased and sustained transmission in US Population):

- Assess information about status of the pandemic:
  - Acquire updates from CDC and from State officials
  - Continue daily meetings of Healthcare Leadership Coalition to:
    - Assess local impact
    - Assess status of staffing and patient load at local hospitals
    - Anticipate needs for upcoming period (i.e., current needs and planning 2 weeks, 1 month out)
- Set up and utilize Alternate Care Sites (ACS):
  - Activate agreements with facilities for use as ACS:
  - Instruct pre-hospital personnel to transport casualties to ACS
  - Staff the ACS
- Address staffing issues at local hospitals:

- Encourage hospitals to utilize methods to alleviate staffing pressures such as:
  - Engaging patient families to provide basic care (e.g., feeding/bathing)
  - Activating local, hospital based, volunteer programs to assist with basic patient care, assisting nursing staff with transportation, communications, acquisition of supplies, etc
  - Asking retired nursing personnel to return to work on volunteer basis—those with current licenses can pass medications, take vital signs, etc
  - Using respiratory therapists to do only higher acuity care—e.g., management of ventilators and having nursing personnel provide other respiratory services
  - Consider altering standard for documentation of patient care to allow nursing and other professional staff to do more patient care
  - Consider expanding capacity through schedule alteration—e.g., increasing shift length, changing staffing ratios
  - Encourage all staff to adhere rigidly to PPE precautions so as to decrease risk of becoming ill
- Address space issues at local hospitals:
  - Encourage facilities to activate plans for cohorting of infectious patients
  - Use designated operating room and procedure room space for additional ventilated patient care
  - Encourage hospitals to make timely requests of County Emergency Management and MHPC for assistance in decompression of facility by use of ACS:
    - This should be content of daily communication between MHPC and each hospital.
    - Prior to determination of need for decompression, sites for decompression will be notified
- Address staffing issues at ACS:
  - Contact all healthcare facilities in County

10. ATTACHMENT E: JOB ACTION SHEET FOR IMPLEMENTING SURGE RESPONSE

This job aid assumes surge response planning for a specific incident is completed and is intended to guide emergency action plan (EAP) development for implementing the specific surge response.

This EAP is to be completed by the appropriate HHSA DOC staff.

- Ensure that the RHSC/HISS (and if needed, Op Area EOC) are opened or are being virtually operated
- Determine and communicate the concept of operations/concept of care: what levels of care will be provided, in what settings, and by whom, to relevant partners and staff.
- Develop an emergency action plan spanning all elements of surge response, including:
  - Declaration of public health emergency
  - Requests for mutual aid
  - Communication with partners
  - Concept of operations for specific use of specific facilities:
    - What kinds of patients will be sent to which facilities?

        - Identify types of patients based on case definition or triage scoring
    - Address any transportation issues
    - Establish a comprehensive public information strategy
    - Determine if specific just-in-time training will be required
- Submit SIT REPs per NCOEMS HPP requirements once per operational period
- Implement all appropriate ancillary plans, including general public health and county emergency response, Strategic National Stockpile, mental health, and security plans.
- Centrally coordinate patient transportation issues
- Open any ACS to be used (regardless of field triage, decompression, or other purpose):
    - Communicate with facility managers at ACS
    - Establish incident command system at ACS using HICS and fill all positions
    - Request update on the ACS's readiness to accept surge patients, or projected time when they will be able to accept surge patients
    - Ensure that the following ACS issues have been addressed:
        - Signage in English and Spanish as appropriate directing patients to correct location
        - Clear patient ingress and egress (entrances and exits)
        - Transportation routes determined and communicated
        - Staffing of ACS for first 48 hours, using 12-hour shifts (i.e., first 4 shifts)
        - Power, water, and sanitation (toilets) in working order and with reserve supplies for at least first 48 hours
        - Rules and policies for ACS operation
- Establish communication and coordination within hospitals, clinics, public health staff, and emergency medical services:
    - Convene regular teleconferences during implementation phase
    - Ensure clarity regarding concept of operations for surge response (what kinds of patients are going where and how they are getting there)
    - Hospital managers have prepared overflow capacity
    - Order local hospitals to utilize overflow capacity measures
- Coordinate with County Coroner for overflow measures and morgue arrangements at ACS
- Coordinate with (as appropriate) the FBI, CDC, U.S. Bureau of Alcohol, Tobacco, and Firearms, and Explosives, and the North Carolina Department of Public Health if the event is a bioterrorism, nuclear, radiological, or other weapon of mass destruction-oriented event

11. ATTACHMENT F: JOB ACTION SHEET FOR MONITORING SURGE RESPONSE

This job aid assumes surge response is underway and is intended to guide emergency action plan development for daily monitoring of the specific surge response.

This EAP is to be completed by the appropriate MHPC RHSC/HISS staff.

- Request/obtain the following information on a daily basis:
    - Bed capacity at all facilities (including ACS)
    - Casualty counts by triage tag color/status (untreated patients)
    - Patients waiting to be seen/treated
    - Mortality rate

- Relevant epidemiological data if a communicable disease incident.

Ensure daily communications between public health, health care partners, and EMS partners

- Determine if ACS are meeting needs, based on daily casualty counts and census:
  - Determine if any ACS are still required
- Determine the limiting factor(s) pertinent to surge operations, both at hospitals and alternate care sites (staffing, beds, or specific supplies)
- Project surge response needs for the next 24 hours
- Submit SIT REPs once per operational period
- Monitor declarations of emergency for their continued relevancy
- Monitor physical and mental health of yourself and your staff
- Monitor patient transportation for needs, efficacy, and safety
- If modified treatment protocols, altered clinical care standards, palliative care guidelines, or other care provisions are in effect, review the efficacy and appropriateness of those guidelines. Modify and disseminate as needed.
- Continue liaison with mutual aid sources and revisit mutual aid requests Monitor logistics and supply chains
- Monitor scare supplies and personnel, and re-allocate as needed (e.g., pharmaceuticals, ventilators, burn nurses, etc)
- Determine if the surge response is still required
- Begin developing an exit strategy to close the ACS

12. ATTACHMENT G: JOB ACTION SHEET FOR RECOVERY FROM SURGE

This job aid assumes surge response planning for a specific incident is completed and is intended to guide emergency action plan development for recovery-phase operations.

This EAP is to be completed by the appropriate MHPC RHSC/HISS staff.

- Systematically ensure that all elements of the surge response are returned to normal.
  - If the surge response gives way to an interim, non-normal health care situation (e.g., building repair to a hospital following an earthquake), ensure a smooth transition.
- Close any alternate care sites:
  - Discharge or transfer patients
  - Demobilize staff
  - Arrange for decontamination, clean-up, and resupply of the ACS
- Arrange for resupply of all caches, equipment stores, etc
- Determine the needs for critical incident stress debriefings
- Participate in after action report development

13. ATTACHMENT H: FACILITY STATUS REPORT

FACILITY STATUS REPORT

Date: _____Facility/Provider: _____

Facility operational? No _____ Yes _____ % Open _____

Damages to Facility:

_____
___
_____
___

PATIENT CENSUS:

Number of Ambulatory: _____ Non-Ambulatory: _____ patients at your facility.

Accepting Patients? NO____ YES ____ Estimated Capacity _____ Bed Availability:
(Numbers) ICU _____ Other monitored _____ Other

WebEOC/Continuum Updated? NO____ YES ___
FREQUENCY_____

Staffing Status:
_____ ___

_____
___
_____
___

YOUR CONTACT INFORMATION:

Contact: _____ Contact: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

OUR CONTACT INFORMATION:
Contact: _____
Phone: _____ Fax: _____

14. ATTACHMENT I: SITUATION REPORT

Example provided below

2016-10-01 Hurricane Matthew

Summary:
Rain and periods of winds are expected to affect the region as soon as Friday morning. Rain levels will range between an inch to five inches throughout the Metrolina region. The NC Coast will begin to experience rain and winds early Friday morning through Saturday. Concerns for the coast include large amounts of rain, flooding, and damaging winds.

MHPC Contact Methods:
24 Hour Request Line: **877-262-6397 (Key words Metrolina Preparedness, Disaster)**
On-Call Duty Officer: **980-349-6472**
Email: **MetrolinaHPC@carolinas.org**
VIPER: **VML 79501 (SMRS Home)**
Website: **www.metrolinapreparedness.org**

Situation Report:

- **Weather Forecast:**
  - Now: Mostly sunny, with a high near 80. East northeast wind around 10 mph.
  - 12 hours from now: Mostly clear, with a low around 57. East northeast wind around 7 mph.
  - 24 hours from now: Partly sunny, with a high near 75. North northeast wind 9 to 11 mph.
- **Roads:**
  - Major roads open/closed: All major roads and secondary roads are opened at this time. No flooding reported on roadways. Minor traffic accidents being reported.
  - Assistance from Law Enforcement? None at this time. Local agencies are monitoring.
  - Patient Transport issues/considerations? None at this time. Local agencies are monitoring.
- **Infrastructure/Communications:**
  - Power: No interruptions at this time
  - Cable: No interruptions at this time.
  - Cellular Services: No interruptions at this time.
  - Land Line Phone: No interruptions at this time.
  - VIPER and UASI 800 Systems: No interruptions at this time.

- NCMCN out of service

- **Hospitals:**
  - All hospitals and ED's are currently open
- **EMS:**
  - Agencies maintaining service, no delays noted.
- **MHPC/SMRS Status**
  - MHPC Warehouse
    - Trailers and resources are available for deployment. The following resources are available at this time: SMSS trailer, Resupply trailer, MSU 1 and 2, and Reefer trailer. Currently no resources have been deployed as a result of this incident.
  - Med-1 status
    - Med-1 is available at this time and is able to deploy staff members. At this time, there is a potential for these members to be deployed to the coast.
  - Two Ambulance Strike Teams have been created and assigned for pre-deployment to the coast. They are expected to leave for the coast on morning of October 5th.
  - MHPC Staff coordinating regional info sharing and healthcare resource requests from the Warehouse.
  - *MHPC staff will be reaching out to regional partners and facilities for status requests beginning during the morning of October 5th. Please be prepared to respond to these.*
  - **MHPC can be reached on VIPER at VML 79501**
  - Metrolina SMAT Volunteers:
    - Active, Providers, and Reserve members have been polled for their availability
    - Requests for volunteers to assist at the warehouse for logistics support has been requested

Next SitRep- 10/05/2016 at 0700hrs. Please send any update by 0600hrs: MetrolinaHPC@carolinas.org

INSERT MAP IF APPROPRIATE

15. ATTACHMENT J: MEDICAL FIELD OPERATIONS COORDINATOR JOB ACTION SHEET

MEDICAL FIELD OPERATIONS COORDINATOR
MISSION: Provide coordination between field EMS incident command and the RHS/HISS. REPORT TO: EOC Liaison

RESPONSIBILITIES: Assist the EOC Liaison by ensuring maximum coordination and support between the RHSC/HISS and field emergency medical services incident command organizations during multi-casualty multi-group and multi-branch responses.

WORK LOCATION: Either the EOC or field incident command posts, dependent on event. This position supports on-scene incident response, and is activated when the surge plan is activated, or during a mass casualty incident multi-casualty multi-group or multi-branch responses.

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√	MEDICAL FIELD OPERATIONS COORDINATOR CHECKLIST
	Receive appointment and obtain briefing from the Operations Section Chief. Read the checklist. Maintain activity log.
	Upon deployment to the incident location(s), check in to the incident command post and obtain a briefing on the extent of the incident from the incident commander (IC).
	Assess incident situation, incident facts, probabilities, priorities, limitations, constraints, and objectives.
	Maintain contact with the EOC Liaison
	Ensure situation reporting and resource requests from the field incident command system to the DOC is accomplished effectively and efficiently each operational period and more frequently as indicated by incident circumstances. Ensure the EOC Liaison is appropriately aware of how the MCI/field response relates to any broader county surge response.
	Keep the EOC Liaison informed on issues dealing with assisting agencies, cooperating agencies, stakeholders, and situation status.
	Provide assistance and information to field incident command Section Chiefs as required.
	Maintain documentation of response costs, including equipment; overtime labor hours, and mileage.
	At a shift change, provide a detailed status report and all written materials to replacement staff.
	Maintain documentation of response costs, including equipment; overtime labor hours, and mileage.
	Provide the Documentation Unit with all logs and documentation that has been generated in the DOC/EOC. Submit all forms and documentation used during the event.
	Attend the DOC/EOC operations critique and prepare an after-action report with recommendations for your DOC/EOC position.

Patient Care
Strategies for Scare Resource Situations
Metrolina Healthcare Preparedness Coalition

Table of Contents

Instructions

Potential Trigger Events:	○ Mass Casualty Incident (MCI) ○ Infrastructure damage/loss ○ Pandemic/Epidemic	○ Supplier shortage ○ Recall/contamination of product ○ Isolation of facility due to access problems (flooding, snow, etc)

How to use this card set:

1. Recognize or anticipate resource shortfall
2. Implement appropriate incident management system and plans; assign subject matter experts to the problem
3. Determine degree of shortfall, expected demand, and duration; assess ability to obtain needed resources via local, regional, or national vendors/partners
4. Find category of resource on index
5. Refer to specific recommendations on card
6. Decide which strategies to implement and/or develop additional strategies appropriate for the facility and situation
7. Review strategies every operational period or as availability (supply/demand) changes

Core strategies to be employed (generally in order of preference) during, or in anticipation of a scarce resource situation are:

1. Prepare: pre-event actions taken to minimize resource scarcity
2. Substitute: use an essentially equivalent device, drug, or personnel for one that would usually be available
3. Adapt: use a device, drug, or personnel that are not equivalent but that will provide sufficient care
4. Conserve: use less of a resource by lowering dosage or changing utilization practices
5. Re-use: re-use (after appropriate disinfection/sterilization) items that would normally be single-use items
6. Re-allocate: restrict or prioritize use of resources to those patients with a better prognosis or greater need

Capacity Definitions

Conventional Capacity – The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan	***Contingency Capacity*** – The spaces, staff, and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These spaces or practices may be used temporarily during a major MCI or on a more sustained basis during a disaster.	***Crisis Capacity*** – Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster. Crisis capacity activation constitutes a significant adjustment to standards of care.

Oxygen

Strategies for Scare Resource Situations

Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Inhaled Medication ○ Restrict the use of Small Volume Nebulizers when inhaler substitutes are available ○ Restrict continuous nebulization therapy ○ Minimize frequency through medication substitutions that results in fewer treatments	Substitute & Conserve			
High-Flow Applications ○ Restrict the use of high-flow cannula systems as these can demand 12 to 30 LPM flows ○ Restrict the use of simple and partial rebreathing masks to 10 LPM max ○ Restrict use of Gas Injection Nebulizers as they generally require oxygen flows between 10 and 75 LPM ○ Eliminate the use of oxygen-powered venture suction systems as they may consume 15 to 50 LPM	Conserve			
Air-Oxygen Blenders ○ Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender use. This can amount to an additional 12 LPM. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets ○ Disconnect blenders when not in use	Conserve			
Oxygen Conservation Devices ○ Use reservoir cannulas at ½ the flow setting of standard cannulas ○ Replace simple and partial rebreather mask use with reservoir cannulas at flowrates of 6-10 LPM	Substitute & Adapt			
Oxygen Concentrators if Electrical Power is Present ○ Use hospital-based or independent home medical equipment supplier oxygen concentrators if available to provide low-flow cannula oxygen for patients and preserve the primary oxygen supply for more critical applications	Substitute & Conserve			
Monitor Use and Revise Clinical Targets ○ Employ oxygen titration protocols to optimize flow or % to match targets for SPO2 or PaO2 ○ Minimize overall oxygen use by optimization of flow ○ Discontinue oxygen at earliest time possible	Conserve			
Expendable Oxygen Appliances ○ Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small and large-bore tubing, and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection, or irradiation may be suitable.	Re-use			
Oxygen Reallocation	Re-allocate			

○ Prioritize patients for oxygen administration during severe resource limitations				

Staffing

Strategies for Scare Resource Situations

Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Staff and Supply Planning ○ Assure facility has process and supporting policies for disaster credentialing and privileging including degree of supervision required, clinical scope of practice, mentoring and orientation, and verification of credentials ○ Encourage employee preparedness planning (www.ready.gov and other resources). ○ Cache adequate personal protective equipment (PPE) and support supplies. ○ Educate staff on institutional disaster response. ○ Educate staff on community, regional and state disaster plans and resources. ○ Develop facility plans addressing staff 's family / pets or staff shelter needs.	Prepare			
Focus Staff Time on Core Clinical Duties ○ Minimize meetings and relieve administrative responsibilities not related to the event ○ Reduce documentation requirements ○ Cohort patients to conserve PPE and reduce staff PPE donning/doffing time and frequency ○ Restrict elective appointments and procedures	Conserve			
Use Supplemental Staff ○ Bring in equally trained staff (burn or critical care nurses, Disaster Medical Assistance Team, other health system or Federal sources) ○ Equally trained staff from administrative positions (nurse manager)	Substitute			
○ Adjust personnel work schedules (longer but less frequent shifts, etc) if this will not result in skill/PPE compliance deterioration ○ Use family members/lay volunteers to provide basic hygiene and feeding – releasing staff for other duties	Adapt			
Focus Staff Expertise on Core Clinical Needs ○ Personnel with specific critical skills (ventilator, burn management) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals ○ Have specialty staff oversee larger numbers of less-specialized staff and patients ○ Limit use of laboratory, radiographic, and other studies, to allow staff reassignment and resource conservations ○ Reduce availability of non-critical laboratory, radiographic, and other studies	Conserve			
Use Alternative Personnel to Minimize Changes to Standard of Care ○ Use less trained personnel with appropriate mentoring and just-in-time education ○ Use less trained personnel to take over portions of skilled staff workload for which they have been trained	Adapt			

○ Prove just-in-time training for specific skills ○ Cancel most sub-specialty appointment, endoscopies, etc, and divert staff to emergency duties including in-hospital or assisting public health at external clinics/screens/dispensing sites.				

Blood Products

Strategies for Scare Resource Situations

Category	*Recommendations*	*Healthcare Facility*	*Blood Center*	*Strategy*	*Conventional*	*Contingency*	*Crisis*
All Blood Products	○ Increase donations if required, and consider local increase in frozen reserves ○ Increase O positive levels ○ Consider maintaining a frozen blood reserve if severe shortage ○ Increase recruitment for specific product needs		✓	Prepare			
	○ Consider adjustments to donor HGB/HCT eligibility		✓	Adapt			
	○ Relax travel deferrals for possible malaria and BSE		✓	Prepare			
Packed Red Blood Cells	○ Use cell-saver and auto-transfusion to degree possible	✓		Re-use			
	○ Limit O negative use to women of child-bearing age ○ Use O positive in emergency transfusion in males or non-child bearing females to conserve O negative	✓		Conserve Adapt			
	○ Change donations from whole blood to 2x RBC		✓				
	apheresis collection if specific shortage of PRBCs ○ More aggressive crystalloid resuscitation prior to transfusion in shortage situations	✓		Conserve			
	○ Long-term shortage, collect autologous blood pre-operatively and consider cross-over transfusion	✓		Conserve Conserve			
	○ Enforce lower hemoglobin trigger for transfusion	✓					
	○ Consider limiting high- consumption elective surgeries	✓		Conserve			
Fresh Frozen Plasma	○ Though not true substitute, consider the use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states	✓		Substitute			

	○ Consider reduction in red cell: FFP ratios in massive transfusion protocols in consultation with blood bank medical staff	✓		Conserve			
	○ No anticipatory use of FFP in hemorrhage with documented coagulopathy	✓		Conserve			
	○ Obtain FDA variance to exceed 24 collections per year for critical types		✓	Adapt			
Platelets	○ Though not true substitute, consider use of desmopressin (DDAVP) to stimulate improved platelet performance in renal and hepatic failure patients	✓		Substitute			
	○ May use leukoreduced whole blood pooled platelets		✓	Adapt			
	○ Convert less needed ABO Whole Blood to Apheresis		✓	Adapt			
	○ Transfuse platelets only for active bleeding, further restrict to life-threatening bleeding if required by situation	✓		Conserve			
	○ No prophylactic use of platelets	✓					
	○ Accept female platelet donors without HLA antibody screen	✓					
	○ Apply for variance of 7 day outdate requirement	✓					

Hemodynamic Support and IV Fluids

Strategies for Scare Resource Situations

Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Cache additional Intravenous (IV) Cannulas, Tubing, Fluids, Medications, and Administration Supplies	Prepare			
Use Scheduled Dosing and Drip Dosing When Possible ○ Reserve IV pump use for critical medications such as sedatives and hemodynamic support	Conserve			
Minimize Invasive Monitoring ○ Substitute other assessments of central venous pressure ○ When required, assess CVP intermittently via manual methods using bedside saline manometer or transducer moved between multiple patients as needed	Conserve			
Emphasize Oral Hydration Instead of IV Hydration When Possible	Substitute			
Provide Nasogastric Hydration Instead of IV Hydration When Practical ○ Patients with impediments to oral hydration may be successfully hydrated and maintained with nasogastric (NG) tubes ○ For fluid support, 8-12F tubes are better tolerated than standard size tubes	Substitute			
Substitute Epinephrine for Other Vasopressor Agents	Substitute			
Re-use CVP, NG, and Other Supplies After Appropriate Sterilization/Disinfection ○ Cleaning for all devices should precede high-level disinfection or sterilization ○ High-level disinfection for at least twenty minutes for devices in contact with body surfaces ○ Sterilize devices in contact with bloodstream and mucous membranes	Re-use		(Disinfection – NG, etc)	(Sterilization – central line, etc)
Intraosseous/Subcutaneous (Hypodermoclysis) Replacement Fluids ○ Consider as an option when alternative routes of fluid administration are impossible/unavailable ○ Intraosseous before percutaneous Intraosseous ○ Intraosseous infusion is not generally recommended for hydration purposes but may be used until alternative routes are available. Intraossuesous infusion requires pump or pressure bag. Rate of fluid delivery is often limited by pain of pressure within the marrow cavity Hypodermoclysis ○ Cannot correct more than moderate, dehydration via this technique ○ Many medications cannot be administered subcutaneously ○ Common infusion sites: pectoral chest, abdomen, thighs, upper arms	Substitute			

Consider Use of Veterinary and Other Alternative Sources for IV Fluids and Administration Sets	Adapt			

Medication Administration

Strategies for Scare Resource Situations

Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Cache/Increase Supply Levels ○ Patients should have at least 30 days supply of home medications and obtain 90 days supply if pandemic, epidemic, or evacuation is imminent ○ Examine formulary to determine commonly-used medications and classes that will be in immediate/high demand ○ Increase supply levels or cache critical medications – particularly for low-cost items and analgesics ○ Key examples include ○ Analgesia: morphine, other narcotic and non-narcotic class – injectable and oral ○ Sedation: particularly benzodiazepine (lorazepam, midazolam, diazepam) injectables ○ Anti-infective: narrow and broad spectrum antibiotics for pneumonia, skin infections, open fractures, sepsis, select antivirals ○ Pulmonary: metered dose inhalers, oral steroids ○ Behavioral Health: haloperidol, other injectable and oral anti-psychotics, common anti-depressants, anxiolytics ○ Other: sodium bicarbonate, paralytics, induction agents, atropine, pralidoxime, epinephrine, local anesthetics, insulin, common oral anti-hypertensive and diabetes medications	Prepare			
Use Equivalent Medications ○ Obtain medications from alternate supply sources ○ Pulmonary: metered dose inhalers instead of nebulized medications ○ Analgesia/Sedation: Consider lorazepam for Propofol substitution ○ Anti-infective: Cephalosporins, gentamicin, clindamycin substitute for broad-spectrum antibiotic/Target therapy as soon as possible based upon organism identified ○ Other: beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives	Substitute			
Reduce Use During High Demand ○ Restrict use of certain classes if limited stocks likely to run out ○ Decrease dose; consider using smaller doses of medications in high demand/likely to run out ○ Allow use of personal medications (inhalers, oral medications) in hospital	Conserve			
○ Do without – consider impact if medications not taken during shortage	Conserve			
Modify Medication Administration ○ Emphasize oral, nasogastric, subcutaneous routes of medication administration ○ Administer medications by gravity drip rather than IV pump if needed	Adapt			

○ Consider use of select medications beyond expiration date ○ Consider use of veterinary medications when alternative treatments are not available	Adapt			
Restrict Allocation of Select Medications ○ Allocate limited stocks of medications with consideration of regional/state guidance and available epidemiological information	Re-allocate			
○ Allocate limited stock to support other re-allocation decisions	Re-allocate			

Nutritional Support

Strategies for Scares Resource Situations

Recommendations	*Strategy*	*Conventional*	*Contingency*	*Crisis*
Food ○ Maintain hospital supply of inexpensive, simple to prepare, long-shelf life foodstuff as contingency for at least 96 hours without resupply, with additional supplies according to hazard vulnerability analysis. Access existing or devise new emergency/disaster menu plans ○ Maintain hospital supply of at least 30 days of enteral and parenteral nutrition components and consider additional supplies based on institution-specific needs. Review vendor agreements and their contingencies for delivery and production, including alternate vendors. Note: A 30-day supply based on usual use may be significantly shortened by the demand of a disaster	Prepare			
Water ○ Stock bottled water sufficient for drinking needs for at least 96 hours if feasible (for staff, patients and family/visitors), or assure access to drinking water apart from usual supply. Potential water sources include food and beverage distributors. ○ Ensure there is a mechanism in place to verify tap water is safe to drink ○ Infants: assure adequate stocks of formula and encourage breastfeeding	Prepare			
Staff/Family ○ Plan to feed additional staff, patients, and family members of staff/patients in select situations	Prepare			
Planning ○ Work with stakeholders to encourage home users of enteral and parenteral nutrition to have contingency plans and alternate delivery options. Anticipate receiving supply requests from home users during periods of shortage. Work with vendors regarding their plan for continuity of services and delivery ○ Identify alternate sources of food supplies for the facility should prime vendors be unavailable. Consider additional food supplies at hospitals that do not have food service management accounts ○ Determine if policy on family provision of food to patients is in place, and what modifications might be needed or permitted in a disaster	Prepare			
○ Liberalize diets and provide basic nutrients orally, if possible. Total parenteral nutrition (TPN) use should be limited and prioritized for neonatal and critically ill patients	Substitute			
○ Non-clinical personnel serve meals and may assist preparation ○ Follow or modify current facility guidelines for family donation of meals to patients ○ Anticipate and have a plan for the receipt of food donations. If donated food is accepted, it should be non-perishable, prepackaged, and in single serving portions	Adapt			
○ Collaborate with pharmacy and nutrition services to identify patients appropriate to receive parenteral nutrition support vs enteral nutrition. Access premixed TPN/PPN solutions from vendor if unable to compound. Substitute oral supplements for enteral nutrition products if needed	Substitute & Adapt			
○ Eliminate or modify special diets temporarily				

○ Use blenderized food and fluids for enteral feedings rather than enteral nutrition products if shortages occur	Adapt			