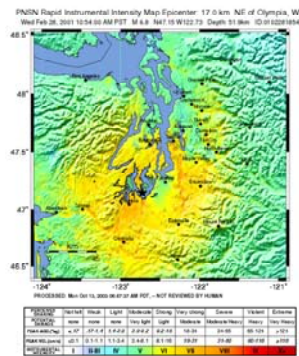


Region 6 – King County



Long Term Care Mutual Aid Plan (LTC-MAP) for Evacuation and Resources / Assets

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Sponsored by: Public Health - Seattle and King County and the King County Healthcare Coalition

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**King County (Region 6)
Long Term Care Mutual Aid Plan
(LTC-MAP)
for Evacuation and Resources / Assets**

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RESOURCE REQUIREMENTS – TO AVOID EVACUATION

Region 6: Individual Facility in Need of Resources

Disaster Struck Facility:

1. Call 911 (or non-emergency number) notifying appropriate local emergency responders of the situation
2. Implement internal disaster notification. Activate Command Center (**required** if requesting assistance) and Establish Incident Action Plan
3. Notify Public Health Duty Officer (24/7 #: [REDACTED]) to activate HM Area Command and other local/county resources
4. Communicate with DSHS to inform them of the situation (CRU Hotline: [REDACTED])
5. Assign a Liaison Officer to report to the HM Area Command location or appropriate EOC to support coordination of supplies, equipment, etc.

911: Notify the Local Emergency Manager

Health & Medical Area Command (HM Area Command)

1. Utilize WATrac to alert King County healthcare facilities and critical partners of the incident
2. Verifies the local Emergency Manager / Municipality is aware of the incident
3. Activates the LTC-MAP Coordinating Team to support communication and coordination with the member facilities.
4. Notifies the Washington State DSHS for the Disaster Struck Facility(ies), if requested by Disaster Struck Facility
5. If necessary, recommend City of Seattle or KC ECC request a State Mission number from the State Emergency Management Division

Medical Needs

Non-medical Needs

HM Area Command

Work through the HM Area Command for all medical needs. This includes staff, supplies, pharmaceuticals, medical equipment, Strategic National Stockpile (SNS) requests, and blood distribution

- HM Area Command will work with other organizations via phone, fax, e-mail and WATrac to identify available resources

LOCAL EOC / COUNTY EOC

Work through the local EOC for all non-medical needs. This includes generators, HVAC units, transportation (i.e. box trucks), etc.

- Directly deal with the KC ECC if the Local EOC is unable to assist due to resource limitations
- If additional assistance is needed, inform the HM Area Command of the situation and seek resource coordination support

NEED SUPPLIES AND EQUIPMENT

1. Call your facility's suppliers
2. Work with the local EOC and, if necessary, the KC ECC, to address other supplies and equipment requests
3. Work with the HM Area Command to secure vendors listed in the LTC-MAP

See supply and equipment availability from member facilities within your LTC-MAP

1. Fax request form to supplier to use as identification at police roadblocks (access may still be denied)
2. Communicate with the appropriate EOC to inform them of supplier access needs
3. Consider security needs, as necessary, for transportation of pharmaceutical and supplies

NEED TRANSPORTATION FOR INCOMING SUPPLIES:

1. Work with the local or KC ECC to secure transportation resources
2. If the local EOC or KC ECC is overwhelmed by the complexity or magnitude of the disaster, all requests will be coordinated through the HM Area Command will in turn work with the appropriate EOC to coordinate resources.
 - a. Transportation help may be secured from facilities within your LTC-MAP for box trucks or other transportation vehicles that may be available
 - b. Request may be filled from outside of King County based on the magnitude of the incident

NEED STAFF

1. Conduct staff callbacks within your facility and secure staff critical to your operations
2. Call your facility's staffing personnel vendors (i.e. Nurse relief teams, staffing agencies)
3. Work with the HM Area Command to secure staff from other LTC-MAP member facilities or via the Medical Reserve Corp (MRC)
4. Work with the appropriate EOC to address non-medical staff (i.e. damage assessment team, food service support, etc.)

NOTES:

1. Fax request form to other facilities to use as identification for staff at police roadblocks. If from another healthcare facility, ensure they have their facility ID and one other form of acceptable identification (access may still be denied)
2. Communicate with EOC to inform them of staff access needs

Legend

DSHS – Department of Social and Health Services
EOC – Emergency Operations Center
EMS – Emergency Medical Services
HM Area Command – Health & Medical Area Command (Public Health)
Hospital Control – Hospital Control (Harborview)
KC ECC – King County Emergency Coordination Center
LTC-MAP – Long Term Care Mutual Aid Plan

REGION 6 ACTIONS

DISASTER OCCURS FORCING EVACUATION – PATIENT LIFE SAFETY IS PRIORITY

Disaster Struck Facility (DSF):

1. Call 911
2. Implement internal disaster notification. Activate Command Center (**required**) and Establish Incident Action Plan
3. Notify Public Health Duty Officer (24/7 #: [REDACTED]) to activate HM Area Command and other local/county resources
4. Communicate with DSHS to inform them of the situation (CRU Hotline: [REDACTED])
5. Assign a Liaison Officer to report to the HM Area Command to assist in resource coordination and communications (if applicable)
6. Continue to follow your facility's internal Emergency Management / Emergency Operations Plan

911: Notify the Local Emergency Manager

Health & Medical Area Command (HM Area Command)

1. Utilize WATrac to alert King County healthcare facilities and critical partners of the incident
2. Ensure Hospital Control is provided with a notification of the incident
3. Verifies the local Emergency Manager / Municipality is aware of the incident
4. Activates the LTC-MAP Coordinating Team to support communication and coordination with the member facilities.
5. Notifies the Washington State DSHS for the Disaster Struck Facility(ies), if requested by Disaster Struck Facility
6. If necessary, recommend City of Seattle or KC ECC request a State Mission number from the State Emergency Management Division

TRANSPORTATION FOR EVACUEES

1. Fire / EMS provide on-site transportation for patients (primary responsibility will focus around private ambulance / transport groups)
2. HM Area Command will coordinate patient placement with DSF
3. LTC-MAP member facilities provide transportation vehicles to assist the DSF
 - a. Vehicles should be Staged with other EMS and non-EMS transport vehicles

If additional non-EMS transportation resources are needed and requests escalate above the capacity of local EOC:

4. Evacuating Facility notifies HM Area Command
5. HM Area Command requests assistance from the KC ECC to mobilize transit agencies and private transportation contractors

Legend

DSF – Disaster Struck Facility
DSHS – Department of Social and Health Services
EOC – Emergency Operations Center
EMS – Emergency Medical Services
HM Area Command – Health & Medical Area Command (Public Health)
Hospital Control – Hospital Control (Harborview)
KC ECC – King County Emergency Coordination Center
LTC-MAP – Long Term Care Mutual Aid Plan

NEED TO EVACUATE

Disaster Struck Facility (DSF) Actions:

1. Slow Evacuation – Move patients to Stop Over Point OR transfer directly to Patient Accepting Facilities
 - a. *If an extended period of time is available to evacuate and the facility has extensive damage (e.g. will not reopen in short term), all efforts will be coordinated with **DSHS** and local nursing homes to place all patients in open beds
2. Fast Evacuation – Move patients to Stop Over Points and subsequently to Patient Accepting Facilities:
 - Establish Unified Command with local / on-site Emergency Response Agencies
 - Implements census reduction (on-site patient reduction) / rapid discharge plan to minimize number of patient transfers
 - Send Medical Record / Chart and tracking forms (and staff/equipment, as necessary)
 - Track patients with *Resident Evacuation Tracking Form/Tag and Patient / Medical Record & Equipment Tracking Sheet*
 - Evaluate the necessity of transferring controlled substances with patients
 - Disaster Struck Facility notifies each patient's responsible party and physician (utilizing Regional Call Center support and Patient Accepting Facility Support if the facility is overwhelmed)

SINGLE FACILITY EVACUATION

DSF, EMS/Emergency Responders (Police/Fire) and HM Area Command Actions:

1. Contact each Patient Accepting Facility --- Responsibility of DSF with support from other agencies when available. DSHS will support this communication as applicable
2. DSF advises EMS of number and type of patients being sent, to which facility and required transport needs. Follow the **Facility Information Report** and **Special Care Categories**.
 - a. Must provide EMS the # of patients needing Critical Care Transport, ALS or BLS ambulance, bus or wheelchair van (in aggregate)
3. Consider activation of an off-site Reunification Center for patients qualified for discharge
4. Health & Medical Area Command should coordinate a Regional Call Center with the KC ECC if Disaster Struck Facility is overwhelmed
5. Ongoing communications will be distributed via WATrac

MULTIPLE FACILITY EVACUATION

HM Area Command:

- Coordinate with each DSF.
- Communicate with appropriate EOCs and KC ECC and work with DSHS to coordinate placement of patients within Region 6 and in other Regions that are on Alert
- Notify facilities of the numbers/types of patients they will be receiving
- Consider activation of other Stop Over Points & Alternate Care Facility (ACF)
- Activate, through DSHS / DOH, other WA Regions as necessary

PATIENT ACCEPTING FACILITY

1. Activate internal plans to receive evacuated patients
 - a. Identify patient intake areas and communicate this information when informed of the number of incoming patients
 - b. Prepare to initiate Census Reduction & Surge Plan
2. Provide, if requested, a transportation vehicle to pick up the patients at the DSF – do not send a vehicle unless requested and a Staging or Pick-up location is provided
3. Assume provision of all staff and equipment required for evacuated patients until Disaster Struck Facility's staff and equipment arrive
4. Notify Disaster Struck Facility or other designated group when patients have been received (CRITICAL STEP) – Use *Influx of Patients form* and cross-reference with *Patient / Medical Record & Equipment Tracking Sheet*
5. Start a new Medical Record / Chart for the patient and clearly delineate the end point in the existing Medical Record / Chart

ADDITIONAL REGION 6 ACTIONS

Incapable of Handling Patient Volume

REGIONAL EVACUATION:

HM Area Command and KC ECC:

1. Communicate with the State EOC / ESF 8
2. Advise appropriate agencies what level of Statewide Mobilization of Fire Resources should be activated across Washington for additional EMS units and emergency staff
3. **Prioritize facility evacuation locations with the State EOC / ESF 8 and LTC-MAP Coordinating Team**
4. Request the activation of the Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (hospitals) to support surge capacity needs

Activation: Adjacent Region Beds

- PRIORITY EVACUATION REGIONS (see Patient Placement):**
1. Region 5
 2. Region 1
 3. Region 2
 4. Region 3
 5. Greater Portland, OR area
 6. Region 9

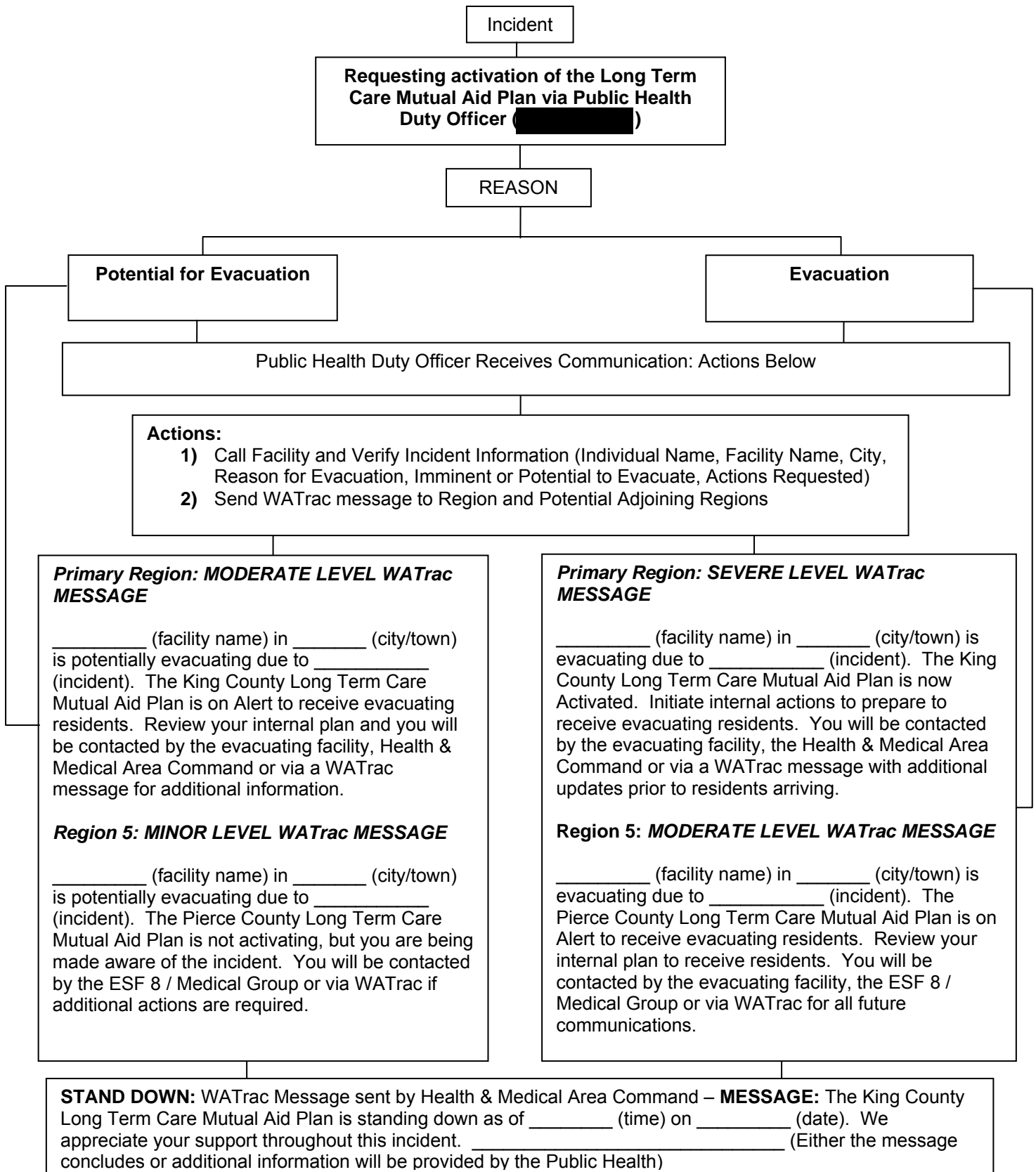
Activation: Stop Over Points and Alternate Care Facilities
(commencing, as necessary, with early phase of evacuation)

Legend

- DSHS** – Department of Social and Health Services
- EOC** – Emergency Operations Center
- EMS** – Emergency Medical Services
- HM Area Command** – Health & Medical Area Command (Public Health)
- Hospital Control** – Hospital Control (Harborview)
- KC ECC** – King County Emergency Coordination Center
- LTC-MAP** – Long Term Care Mutual Aid Plan

WATrac ACTIVATION ALGORITHM

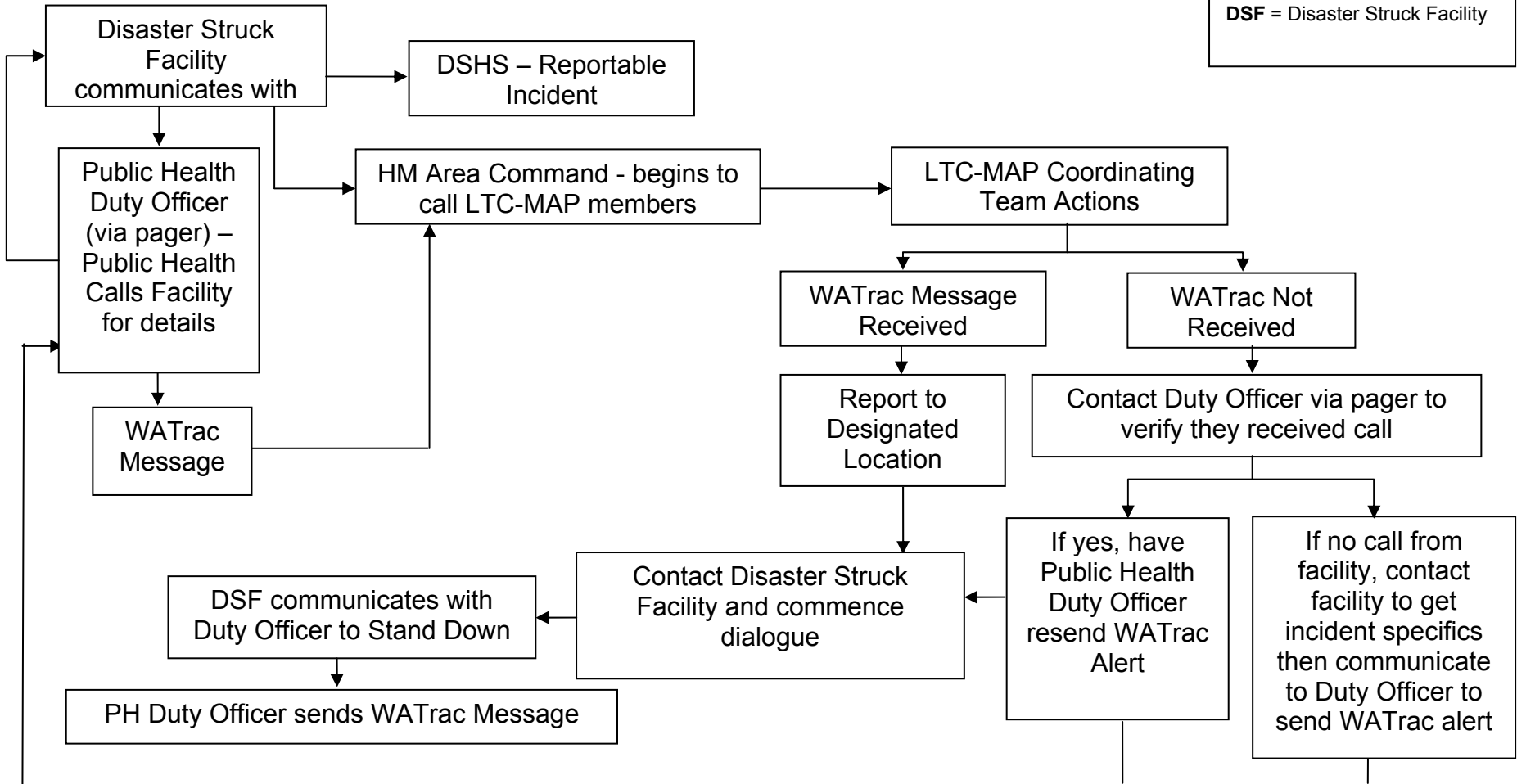
KING COUNTY LONG TERM CARE MUTUAL AID PLAN (LTC-MAP)



WATrac COMMUNICATION LOOP FOR KING COUNTY LTC-MAP

***HM Area Command** = Health & Medical Area Command (Public Health)

DSF = Disaster Struck Facility



SECTION 2: OVERVIEW

Long Term Care Mutual Aid Plans (LTC-MAP) are important so nearby facilities can assist a member Disaster Struck Facility by accepting evacuated patients or helping with needed supplies, staffing, equipment and transportation.

In the past decade, disasters such as the 1998 Northeast Ice Storm, 2001 Nisqually Earthquake, 2001 Tropical Storm Allison's assault on Houston, the multiple fatality nursing home fires of 2003, the Florida hurricanes of 2004, Hurricane Katrina in August 2005, the California Wildfires of 2007/08 and the flooding/ice storms in Washington in December 2008/January 2009 have resulted in such substantial local and regional impact that Mutual Aid Plans must be established to institute a pre-planned methodology for regional disaster planning.

PLAN OBJECTIVE:

1. Voluntary agreement among individual plan members to provide help for each other at the time of a disaster. Refer to the definition of a "disaster" in the Memorandum of Understanding (Annex I).
2. Become an Annex to the Comprehensive Emergency Management Plans for each of the towns and cities where member facilities are located.

PLAN SCOPE:

1. To place and support care of patients evacuated from a Disaster Struck Facility.
2. To provide supplies as needed to a Disaster Struck Facility.
3. To assist with transportation of evacuated patients.
4. To provide staffing support as needed to a Disaster Struck Facility, whether evacuating or the facility is directly affected by the disaster.
5. To provide Stop Over Points and transportation for evacuated patients or to provide supplies from member facilities geographically removed from the region-wide disaster area.

MEMORANDUM OF UNDERSTANDING:

The Memorandum of Understanding (MOU) in Annex I is the Agreement among Region 6 – King County long term care facilities that commit the healthcare facilities to voluntarily provide support to accept evacuated patients and/or provide assistance to Member Facilities with needed supplies, equipment, staffing and transportation.

RESPONSIBILITIES OF PLAN MEMBERS:

Note: Refer to the Memorandum of Understanding in Annex I for additional details.

Following is a list of responsibilities of all plan members:

- Number of Patients Accepted: All members are required to accept a minimum of 10% of their total beds. Type of patients will be those your facility is qualified to care for based on the Facility Information provided to the LTC-MAP.
- Members are required to attend the annual meeting and sign recommitment forms.
- Members are required to participate in all Region 6 long term care drills and exercises.
- Members must notify all participants and the Steering Committee of any changes throughout the year, which may include: changes in administration personnel and phone numbers and temporary changes which affect the number of Patients the Patient Accepting Facility can accommodate due to construction/renovation.
- Members are required to use the plan-specified *Resident Evacuation Tracking Form* (Disaster Tag) and *Patient/Medical Record & Equipment Tracking Sheet*. If evacuating, the Active Medical Record / Chart will be sent with the patient unless the speed of the evacuation forces the facility out to the sidewalk; then the *Resident Evacuation Tracking Form* will be utilized as a stand-alone form for each Patient prior to transport.
- Members are required to have activated their internal disaster plan and Command Center in order to request support from the plan.

It is further understood that this plan is instituted in conjunction with any additional requirements that may be identified by the Washington State Department of Social and Health Services (DSHS), which maintains ultimate regulatory authority over licensed facilities and works with additional state and local agencies to assist and support facilities in times of crisis.

1. This plan covers different levels of care. Due to this, the concept is that facilities should evacuate to like-to-like levels of care or up a level of care. During an evacuation, the following evacuation protocols should be instituted (example only as other levels of care are present within Member facilities):
 - a. **Nursing Homes** would evacuate to other Nursing Homes. If additional bed availability is necessary, Nursing Homes could evacuate to regional hospitals as a last resort with the goal being a potential unit to be opened for the nursing home and their staff to care for the patients.
 - b. **Dementia Secured Units** would evacuate to other Nursing Homes with Dementia Secured Units.
 - c. **Ventilator Beds** evacuate to other facilities capable of handling vents or higher level of care. This would include Long Term Acute Care (LTAC) facilities and Acute Care hospitals.
 - d. If it is required to evacuate to a healthcare facility that does not provide the equivalent level of care, staff from the Disaster Struck Facility should attempt to relocate to the Patient Accepting Facility or teams from other healthcare facilities should be appropriately redeployed as necessary with

6. It is the intent of this plan to evolve over time and be an inclusive plan. This plan was designed in conjunction with Region 5 – Pierce County and will integrate with their LTC-MAP. This plan will also incorporate reviewing opportunities to partner with and include other Regions in Washington (Region 1 to 4 and 7 to 9), adjacent states and British Columbia into future planning to ensure the boundaries between states and countries do not limit the ability to manage regional evacuations and resources or assets in a disaster.
7. In disaster response planning, Member Facilities should not rely solely on this LTC-MAP for Evacuation and Resources/Assets. After a flood, earthquake, ice storm or other substantial regional/state-wide disaster, the facilities may not receive support from vendors, first responder agencies and/or emergency management based on the severity of the disaster and prioritization of infrastructure resources. Prioritization criteria for which any given facility receives resources is incident specific with an emphasis on the impact to the community or region based on a facility being unable to sustain operations.

Therefore, this plan does not replace the requirement for healthcare facilities to have in place:

- *Internal Incident Command Systems (ICS) that are compliant with the National Incident Management System (NIMS)*
- *Full building evacuation plans to safely transport the Patients to the sidewalk*
- *Communications plan*
- *Influx of Patients / Surge Capacity Plan*
- *Isolation/rationing plans when supplies, equipment, staffing or other resources will not allow a facility to stand alone for a 96 hour period or greater.*

8. Since regional evacuation assets are vulnerable to natural and technological disaster events, they may be overwhelmed in a disaster, requiring the activation of this plan. The King County Healthcare Coalition, Public Health - Seattle & King County, King County Government departments, cities and special purpose districts can only attempt to make every reasonable effort to support this plan based on the situation, information, and resources available at the time of the disaster.

SECTION 3: ACTIONS OF

- **DISASTER STRUCK FACILITY (DSF)**
- **PATIENT ACCEPTING FACILITY (PAF)**

If a disaster forces a facility to fully or partially evacuate, other facilities within the plan receive and care for the **evacuated patients**. It is the intent of this plan to be able to absorb within the region the evacuation of the largest two (2) facilities in Region 6.

For all communications, see *PLAN ACTIVATION & COMMUNICATIONS*, in Section 4, for activation protocols.

**If an extended period of time is available to evacuate and the facility has extensive damage (e.g. will not reopen in the short term), all efforts will be coordinated with Health & Medical Area Command and DSHS to only place patients into open beds and avoid using the surge capacity plans (if possible).*

Disaster Struck Facility

To minimize the number of patients transferred to other healthcare facilities:

1. Activate **census reduction plans** as time permits.
 - a. Discharge to Home - Identify patients who could be discharged, whereby the patients would either be discharged home, if the family or responsible party is able to pick them up, or moved to an off-site *Family Reunification Center*.
 - The Incident Commander at the scene for Fire / EMS / Police, should work to identify a location in close proximity where the patients can be brought to (outside of the police perimeter) for families to pick up the patients ready for discharge
 1. The healthcare facility should have a staff member at the Family Reunification Center to support filling out the *Patient / Medical Record and Equipment Tracking Sheet* and other patient & family interactions.
 - b. Stop Over Points will be utilized for slow out or fast-out emergencies for long-term care facilities.

NOTE: It is 25 degrees outside and there is snow falling – if you are forced to evacuate to the sidewalk, where can you go right away to shelter your patients? These conditions assume that it is unsafe to keep the patients in unprotected space (i.e. parking lot) while full transportation resources are mobilizing and Patient Accepting Facilities are being informed of the evacuation.

2. **Stop Over Point:** Stop Over Point means a facility or facilities that are in a suitable location to be utilized for a slow or fast-out evacuation for an isolated, local or regional disaster. The person in charge of the facility at the time of the disaster will alert the Stop Over Point (in a fast evacuation, otherwise move to #3) that a disaster has occurred. Identify yourself and the problem. This will provide advance warning to the Stop Over Point to begin preparation. The intent is to use this site in the event the facility is:
 - Quickly forced to the sidewalk in adverse conditions and sheltering is necessary for the patients prior to relocation to other healthcare facilities or to home
 - Evacuated from the facility, yet the facility should be able to reopen in a short period of time (hours instead of days)
 - It is safer to move the patients to a Stop Over Point instead of distributing them at greater distances due to regional disaster conditions.

The Disaster Struck Facility will:

- a. Have a staff member present as patients arrive at the Stop Over Point.
 - b. Have CPR ability available at the Stop Over Point. Increase staffing appropriately as more patients arrive.
 - c. Be responsible for the transportation of staffing, supplies, pharmaceuticals and equipment, in coordination with the appropriate EOC.
 - d. Along with support from the local EOC / King County ECC and Health & Medical Area Command, manage the set-up, activation, operations and demobilization of the Stop Over Point. In the event that the staff from the Disaster Struck Facility are unable to provide the full resources necessary to support the Stop Over Point, staff may be requested from other facilities inside Region 6 and outside the area to provide additional staffing support.
 - e. Alternate Care Facilities may be activated in King County through the appropriate agencies to support a long term and large scale disaster.
3. **Prior to actual transfer of patients** from the Disaster Struck Facility or the Stop Over Point, in the event of a slow evacuation, the person in charge of the facility or designee at the time of the disaster should notify the Patient Accepting Facilities of the following specific information:
 - a. Specific number and type of patients (i.e. wheelchair, stretcher, ambulatory, special needs patients, etc.) being transported to them.
*Follow the **Facility Information Report and Special Care Categories - Aggregate** which describes the type of care which each facility is qualified to render as well as the number of patients they have agreed to accept.
 - b. The number of supporting personnel they can expect to receive.
 - c. The approximate time of arrival.

NOTE 1: Always evacuate like-to-like or up a level of care (see *Overview*). Evacuate within your Regional LTC-MAP first. If the Regional LTC-MAP is overwhelmed, request help from other regions through Health & Medical Area Command.

NOTE 2: If a patient has a significant medical emergency, utilize the standard process of transporting via EMS to a hospital.

NOTE 3: *If there is considerable damage to the facility (substantial fire or flood damage) and the facility will not be reopening in the short term, work with Health & Medical Area Command and DSHS to find longer term placement for patients within open beds. Use the “Open Space” approach of the Mutual Aid Plan only if a “Holding Area” or secondary Stop Over Point is necessary to protect the patients.*

NOTE 4: Each plan member should pre-select evacuation sites for the LTC-MAP and determine the total number of facilities to handle your total patient population and type of care.

4. Be familiar with the function and extent of community emergency services such as Police, Fire and EMS, Local Emergency Operations Center, Red Cross, Salvation Army, etc. and advise them of your needs.
 - a. Be familiar with the functions of the Health & Medical Area Command to ensure there is effective communication and coordinated efforts.
 - b. Attempt to have an individual sent to the local Emergency Operations Center to improve communication for resources and support.
5. **Send Staff:** Send nursing personnel and supplemental staff to Patient Accepting Facilities as soon as possible. Nurses will take federally controlled substances (if necessary) and Active Patient Record / Charts (if they did not initially accompany the patients).

Notify attending physicians and responsible parties. If possible, send useable mattresses, wheelchairs, and other equipment with patients. Use your facility vehicles or request transport help from the Local Emergency Operations Center (EOC) of the King County Emergency Coordination Center (ECC). Administration must work closely with Patient Accepting Facilities throughout the process.

6. **Responsibility of patient tracking:** Use the plan specific *Patient/Medical Record & Equipment Tracking* Sheet which follows the patient as they pass through the holding area, Stop Over Point, and finally the Patient Accepting Facility. Send or make available sufficient patient medical information to ensure proper care. *Resident Evacuation Tracking Form / Tag* should record pertinent medical information. Include copy of the physician orders, medication sheets and advanced directives. This will provide a quick review of the patient.

Consider including wrist bands (photo if possible) for patients to match with the *Resident Evacuation Tracking Form / Tag* and *Patient/Medical Record & Equipment Tracking Sheets*.

The *Resident Evacuation Tracking Form / Tag* may be completed before leaving the Disaster Struck Facility or at the Stop Over Point, and must accompany the patient at the time of transfer to Patient Accepting Facilities. At the time that a patient is transferred, the anticipated destination is entered on the *Resident Evacuation Tracking Form / Tag* and the *Patient/Medical Record & Equipment Tracking Sheet*. The top page of the *Resident Evacuation Tracking Form / Tag* is retained by the Disaster Struck Facility and copies of the *Patient/Medical Record & Equipment Tracking Sheet* are made to accompany the final patient going to a specific Patient Accepting Facility.

7. Medications and Charts

- a. Send the patient's prescribed medications and Active Patient Record/ Chart, including insurance information, to the Patient Accepting Facility with the patient.
 - b. If either facility is unwilling to send or receive medications, the Patient Accepting Facility will obtain and provide essential medications.
 - c. Federally controlled substances will be brought to the patient accepting facilities, if necessary, when nurses from the Disaster Struck Facility arrive. If the federally controlled substances are going to be left at the Patient Accepting Facility and not administered by said nurse, a count and sign-off would take place at the Patient Accepting Facility.
8. Provide patient transportation to Patient Accepting Facilities from Stop Over Point (see Attachment A). Patient Accepting Facilities may use their own handicapped accessible vehicles to pick up evacuated patients. Transportation and lodging for staff evacuating with patients will also have to be considered, especially if out of region.

NOTE: STAFF MUST WEAR FACILITY I.D. BADGES TO GET THROUGH POLICE ROADBLOCKS AND FOR ACCESS TO RECEIVING FACILITIES.

9. Understand that the staff of the Disaster Struck (evacuating) Facility will be under the administrative direction of the Patient Accepting Facilities.
10. Remember to record destination of patients and staff prior to leaving the facility or the facility's Stop Over Point. You are responsible for patient and staff tracking.
11. **Notification of Family / Primary MD:** Contact patients' responsible parties and physicians as appropriate. Once the Patient Accepting Facility has confirmed receipt of the patient, they will typically take over communications with the family as of that time. This should be agreed upon by both parties.
- a. If the resources of the Disaster Struck Facility are overwhelmed, the utilization of a centralized Regional Call Center should be reviewed through the Health & Medical Area Command in consult with the King County ECC. This would also be a location to receive the *Patient/Medical*

Records and Equipment Tracking Sheet and *Resident Evacuation Tracking Form* information (either by fax, in paper copy, e-mail, or by courier) and proactively provide status information to families or responsible party and the patient's attending or personal physician. This Regional Call Center phone number is broadcast via Television, Radio, hospital operators and recorded messages in order to direct all phone traffic to the appropriate location.

12. Contact each Patient Accepting Facility to notify them of your Command Center contact information so as to facilitate communication in cases where the Disaster Struck Facility has already evacuated (see Section 4, Communications.)
 - a. These actions may be managed for the facility by the Health & Medical Area Command.

ACTIONS OF THE PATIENT ACCEPTING FACILITIES

For quick checklist see Section I, Algorithms

1. YOU MUST HAVE AN INTERNAL PLAN TO APPROPRIATELY RECEIVE AND CARE FOR PATIENTS: This plan is an Influx of Patients Plan or Surge Capacity Plan to support the pre-planning efforts with the appropriate amount of supplies, equipment, staffing and other resources necessary to manage 10% over the licensed bed capacity.
 - a. There are two options with regards to the charts. When the Active Patient Record / Chart arrives with the patient, a review is conducted of the records along with an assessment of the patient and the facility begins documents in the following manner:
 - i. Start a new chart for each newly accepted patient, clearly noting the time in the existing chart to delineate where the documentation ended.
 - ii. If using the existing chart, clearly delineate when and where the Patient Accepting Facility began documenting in the chart.*

** When/If the determination is made that the patient will not be returning to the Disaster Struck Facility, the Patient Accepting Facility will begin a new chart for the patient.*

2. When evacuated patients arrive at your site, you agree to temporarily provide supportive coverage until the Disaster Struck Facility can provide their patients with coverage. If the physician is unable to follow the patient, the Medical Director/designee of the Patient Accepting Facility will assume responsibility on an interim basis. When evacuating out of the region or a large scale disaster, this is likely to happen.
3. **Patient Care Responsibility:** Once received and/or admitted, the patient is under the care of the Patient Accepting Facility's admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g. equipment, blood products) along with the patient if requested and if possible. When the situation that led to evacuation has been resolved and it is safe and practical to do so, patients may be returned and must be accepted at the Disaster Struck Facility.
4. Patients will go to open areas (primary focus is open beds*) of the Patient Accepting Facility. In the initial phase of the disaster, staff and equipment will be provided by the Patient Accepting Facility; if more supplies are needed, contact vendors listed in the plan. As soon as possible, the Disaster Struck Facility will send staff and equipment.

** Beds with a confirmed admission may be held open for an incoming patient.*

5. Agree to arrange for or provide all beds, linens, and other equipment, supplies and food (see Section 7). NOTE: Call any supporting vendors or agencies prior to exhausting all options in the plan.
6. Establish a Command Center and a person responsible for coordinating efforts and facilitating communication (Liaison Officer).
7. Upon arrival of patients, assume administrative direction for displaced patients and staff. Continue tracking of the patients, staff, medical records and equipment as applicable.
8. Notify Disaster Struck Facility of arrival of their patients, giving names and conditions. Inform the Disaster Struck Facility of any major changes in patient medical condition in the event that staff has not arrived as of that time.
 - a. The primary call should be to the Disaster Struck Facility with the back-up call to their Stop Over Point if there is no response at the main facility.
 - i. The Health & Medical Area Command will be utilized as a central location for information to be gathered and ultimately reported to DSHS.
 - b. Communicate with the Disaster Struck Facility if you can support them in contacting the patients' responsible parties and physicians as appropriate.
9. Notify Disaster Struck Facility of (their) staff present at your facility.
10. At the end of the disaster all patients, with their medical records and equipment, must be returned to the facility of origin, unless other agreements have been made between sender and receiver or intervention from DSHS.
 - a. All information that arrived with the patient should be returned to the Disaster Struck Facility unless a consumable.
 - b. All records completed while at the Patient Accepting Facility must have copies provided to the Disaster Struck Facility.

IF DISASTER OVERTAKES THE REGIONAL LONG TERM CARE MUTUAL AID PLAN (MAP) AREA

For quick checklist see Section I, Algorithms

When all space is used or otherwise unavailable in Region 6:

1. The adjacent regions will be activated to support evacuation and communication efforts. Priority focuses include:
 - Region 5 (Pierce County/Tacoma): Over [REDACTED] long term care beds
 - Region 1: Over [REDACTED] long term care beds
 - Region 2 (Kitsap County area/Bremerton): Over [REDACTED] long term care beds
 - Region 3 (Thurston County area/Olympia): Over [REDACTED] long term care beds
 - Greater Portland, OR area: Over [REDACTED] long term care beds
 - Region 9 (Spokane): Over [REDACTED] long term care beds
2. DSHS, if available, along with the regional coordinating groups will place facilities in their region on alert.
 - a. There will be a coordination of multiple Disaster Struck Facilities by a centralized coordinating body (Health & Medical Area Command; ESF 8 / Medical Group in Region 5):
 - When assigning patients to Patient Accepting Facilities, follow the **Facility Information and Special Care Categories Reports** for the type and number of patients each facility has agreed to accept.
 - Work with each Disaster Struck Facility's Liaison Officer
 - Work directly with the adjacent regions to have their resources communicating with each potential Patient Accepting Facility.
3. If all communications are unsuccessful with the adjacent regions coordinating agencies, the Disaster Struck Facility and the Health & Medical Area Command should contact facility administrators in another Regional LTC-MAP to accept their patients. If one facility is already full, check others.
4. Ensure the following is sent with the patients: *Resident Evacuation Tracking Form / Tag*, the Active Patient Record/Chart and medications.
 - a. A copy of the *Patient/Medical Record & Equipment Tracking Sheet* should go with the final patient moving to that facility location to complement the other tracking taking place.
5. Federally controlled substances should be sent to the Patient Accepting Facility, if necessary. See Section 6 for guidelines on transporting federally controlled substances.

6. Staff should be sent to the Patient Accepting Facility as soon as possible.
7. Disaster struck facilities will contact responsible parties and physicians.

Use of a Stop Over Point in Other Regional Areas

8. Activate the facility Stop Over Point for another member facility through the Stop Over Point Agreements if the facility is unable to move their patients into the LTC-MAP.
 - a. Appropriately equip and staff the area with the support of area members.
 - b. Move patients into this space until appropriate time to distribute the patients to other Patient Accepting Facilities or return to their initial location.

PROTECTING IN PLACE (BUT IN NEED OF SUPPLIES/EQUIPMENT):

Progressive Plan:

- Obtain supplies from local vendors with whom you have agreements.
- Contact suppliers in the LTC-MAP – Via Health & Medical Area Command or the appropriate EOC/King County ECC.
- Insert a staff member from the Disaster Struck Facility into the local Emergency Operations Center for the town/city to assist in coordinating non-medical resources and supplies.
- Communicate with Health & Medical Area Command and ask them to assist with contacting appropriate local EOC, King County ECC and state EOCs for vendors to support the Disaster Struck Facility.
- Request supplies from other facilities in the region (this should be utilized when the transfer of supplies/equipment would not put the Donor facility in jeopardy.)
- If the disaster exhausts all supply sources in the Region, via the Health & Medical Area Command and appropriate EOC / King County ECC:
 - Contact other regions Coordinating Centers to request help with supplies
 - Go to the vendor lists of another region to request supplies
 - Contact a facility within an adjoining regions MAP to request help with supplies.

NOTE 1: Fax supply requests to those from whom you seek assistance to help the deliveries get through police roadblocks.

NOTE 2: Coordinate supplies through appropriate Incident Commander or Emergency Operations Center (EOC), when requested.

Clinical Transportation Categories for Evacuation Charge Nurse/Physician Decision Making Criteria

a. Patients requiring ALS transport (Paramedic)

- IVs with medication running that are within paramedic protocols (varies by county)
- IV pump(s) operating
- IV with clear fluids (no medications)
- Need limited medications administered via Physician orders by limited means in limited dosage prescribed
- Cardiac monitoring/pacing (only external pacing can be provided by the transport crew)
- Ventilator dependent with own or facility ventilator
- Prone or supine on stretcher required.

b. Patients requiring BLS transport (EMT – *italics for EMT–IV Technician Required*)

- O₂ therapy via nasal cannula or mask (can be provided by the transport crew)
- *Basic maintenance IVF including TPN (total parenteral nutrition)*
- Saline lock and Heparin lock
- Visual monitoring / Vitals (BP/P/Resp)
- Prone or supine on stretcher required or unable to sustain
- If Behavioral Health, provide information regarding danger to self or others.

c. Patients requiring Chair Car/Wheelchair Accessible Bus (No medical training)

- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
- Not prone or supine, no stretcher needed
- No O₂ needed, unless patient has own prescribed portable O₂ unit that can be safely secured en route
- If Behavioral Health, provide information regarding danger to self or others.

NOTE: Some wheelchair van companies provide a standard wheelchair, if needed, for the duration of the trip. Buses do not provide wheelchairs. Some electric wheelchairs cannot be secured in wheelchair vans due to size or design. These are NOT to be transported with the patient.

d. Patients requiring normal means of transport (any vehicle - No medical training)

- No medical care or monitoring needed, unless the patient has their own trained caregiver in attendance capable of rendering the care
- No O₂ needed, unless patient has own prescribed portable O₂ unit that can be safely secured en route
- Not prone, supine, or in need of a wheelchair (can ambulate well enough to climb bus steps)

NOTE: A person with a folding wheelchair, who can ambulate enough to get in and out of a car, could go by car if there was room to bring/pack the wheelchair.

e. Patients requiring bariatric ambulance or transport (>350lbs.)

SECTION 4: PLAN ACTIVATION & COMMUNICATIONS

For quick checklist, see Section 1, Algorithms

Notifications and Continuous Communications

Disaster Struck Facility:

At start of a disaster, the Disaster Struck Facility immediately notifies appropriate first responder agencies via 911 (i.e. Fire, Police, EMS) or non-emergency number based on the initial severity of the incident. Their role will be to activate the appropriate Emergency Manager.

- Activate appropriate internal notifications for your staff and leadership and activate your facility Command Center based on your facility Emergency Operations Plan or Emergency Management Plan. **The internal facility Command Center must be active in order to request resources and support from this Long Term Care Mutual Aid Plan (LTC-MAP.)*
- Develop Incident Action Plan.
- Disaster Struck Facility assesses whether evacuation is necessary or whether they can continue to provide patient care and remain open with additional staff, supplies or equipment. **Evacuation is to be avoided at all costs provided patient and staff safety is not significantly compromised.**
- Unified Command should be established at the Disaster Struck Facility with appropriate emergency agencies to support key decision-making, resource coordination and communications.

1) If a facility requires Supplies, Equipment, Staffing or other Resources (avoid evacuation at all costs) to remain operational:

- Notify the Public Health Duty Officer to activate the Health & Medical Area Command and other local/county resources
 - **NOTE:** After paging the Public Health Duty Officer, leave a phone line available for the return call. That phone call will drive the WATrac activation for all member facilities.
 - Be prepared to communicate the following information:
 - Who – Your contact name
 - Where – Facility Name and Town/City
 - What – Resources you need
 - When – Window of time
 - Why – Reason
 - **Health & Medical Area Command** should:
 - Utilize WATrac to alert King County healthcare facilities and critical partners of the incident
 - Verify the local Emergency Manager and the King County OEM Duty Officer are aware of the incident

- Call out to the LTC-MAP Coordinating Team and inform them if they should report to a centralized location to support the Health & Medical Area Command or a Local EOC / King County ECC to provide communication and coordination support for the member facilities
- Notify the Washington State DSHS for the Disaster Struck Facility if requested
- If necessary, recommend that the Seattle EOC or King County ECC request a State Mission number from the State Emergency Management Division
- Notify DSHS on the CRU Hotline for the reportable incident.
- Assign a Liaison Officer to report to the designated Health & Medical Area Command or appropriate EOC/ECC location to support coordination of medical and non-medical supplies, staff, equipment, etc.

NOTE: If regional resources are not available or are unable to handle the situation due to infrastructure damage, communicate directly with the State EOC and directly with other member facilities and regional suppliers within the LTC-MAP.

2) If Evacuating:

- Notify the Public Health Duty Officer to activate the Health & Medical Area Command and other local/county resources
 - **NOTE:** After paging the Public Health Duty Officer, leave a phone line available for the return call. That phone call will drive the WATrac activation for all member facilities.
 - Be prepared to communicate the following information:
 - Who - Your contact name
 - Where – Facility Name and Town/City
 - What – Evacuating or Potential to Evacuate
 - When – Imminent or window of time
 - Why - Reason
 - **Health & Medical Area Command** should:
 - Utilize WATrac to alert King County healthcare facilities and critical partners of the incident
 - Ensure Hospital Control is provided with a notification of the incident
 - Verify the local Emergency Manager and the King County OEM Duty Officer are aware of the incident
 - Call out to the LTC-MAP Coordinating Team and inform them if they should report to a centralized location to support the Health & Medical Area Command or a Local EOC / King County ECC to provide communication and coordination support for the member facilities
 - Notify the Washington State DSHS for the Disaster Struck Facility if requested
 - If necessary, recommend that the Local EOC or King County ECC request a State Mission number from the State Emergency Management Division
- Notify DSHS on the CRU Hotline for the reportable incident.

- Assign a Liaison Officer to report to the designated Health & Medical Area Command or appropriate EOC/ECC location to support coordination of medical and non-medical supplies, staff, equipment, etc.
- Establish an internal Liaison Officer to communicate with the on-scene Incident Commander and ensure coordination with EMS.

NOTE: If regional resources are not available or are unable to handle the situation due to infrastructure damage, communicate directly with the State EOC and directly with other member facilities and regional suppliers within the LTC-MAP.

3) In the event that the regional plan is being overwhelmed, the following communications take place:

- **Health & Medical Area Command and Seattle EOC / King County ECC:**
 - Communicate with the State EOC / ESF 8 desk to ensure appropriate resources are requested.
 - Advise appropriate agencies if Statewide Mobilization of Fire Resources should be activated across Washington for additional EMS units and emergency staff.
 - ***Prioritize facility evacuation locations with the State EOC / ESF 8 desk and the LTC-MAP Coordinating Team.***
 - ***Work with DSHS, where applicable, to support this prioritization.***
 - Request the activation of Region Medical Evacuation and Patient Tracking Mutual Aid Plan (Hospitals) to support surge capacity needs, if necessary.

Patient Accepting Facility / Loaner Facility:

The Patient Accepting Facility or Loaner Facility (if loaning supplies, staff, equipment, transportation) should be required to report the following at any disaster:

- Number of available beds (open beds – although the facility needs to be prepared to accept 110% of licensed beds at all times).
 - Identify the patient intake area where they should be dropped off if being evacuated to you
- Verification of when a transportation vehicle may be ready to support another member facility, if applicable
- Verification of supplies, equipment and staff that may be available to support another member facility, if applicable

Upon Receipt of Patients:

- Notify Disaster Struck Facility or other designated group (Health & Medical Area Command, etc.) when patients have been received using the Influx of Patients form
- When available, follow-up that communication with the name of the patient to match this up against the *Patient / Medical Record and Equipment Tracking Sheet*

Communication Protocols specifically related to patient movement (evacuation):

Single Facility Evacuation

- The Disaster Struck Facility (via Liaison Officer) communicates with the on-scene Incident Commander regarding patient types and numbers being sent.
- In the early phase, the Disaster Struck Facility may be communicating directly with the other Patient Accepting Facilities (nursing homes). As the incident evolves, Health & Medical Area Command and, if necessary, Hospital Control will support communication with all Patient Accepting Facilities to inform them of expected patient volume to prepare for and type of patients. Primary decision-making will ultimately reside with the Disaster Struck Facility with support from Health & Medical Area Command, Hospital Control and the on-scene Incident Commander.
 - Work with DSHS where applicable to support communication with Patient Accepting Facilities.
- Consider the activation (Police, EMS, Fire, Emergency Manager, Health & Medical Area Command) of an off-site Family Reunification Center for patients qualified for discharge to home and a Regional Call Center (with the Seattle EOC or King County ECC) if the Disaster Struck Facility is overwhelmed by incoming communications.
- Ongoing communications will be distributed via the WATrac system, as necessary.

Multiple Facility Evacuation

- **Health & Medical Area Command with the support of the LTC-MAP Coordinating Team and Hospital Control, as applicable**
 - Coordinate directly with each Disaster Struck Facility
 - A representative of the Disaster Struck Facility provides the appropriate information on the patient volume (type of patients, transportation requested, etc.)
 - Consolidate data on the patient volume, type and transportation requirements and prioritizes timing for patient movement and patient placement locations (see Section 3.)
 - DSHS and Seattle EOC / King County ECC will be intimately involved in decision-making support with Health & Medical Area Command during this incident.
 - Notify Patient Accepting Facilities of the number / type of patients they will be receiving
- Activation of the Stop Over Points will be reviewed early on in the incident and activated by the Local EOC or the Disaster Struck facility as necessary.

- Communicate directly with other Regions and with DSHS to ensure adequate support for an escalating incident.

Communication between Disaster Struck Facility and Patient Accepting Facilities

- Initial contact with Patient Accepting Facilities should be through the Main Number (See Facility Communications Reports from www.mutualaidplan.org).
- Request to speak with the Administrator-on-Call (AOC).
- Once the Patient Accepting Facility's Command Center is fully established, request to speak with the Liaison Officer.
- After initial facility contacts, communications should be through each facility's Liaison Officer.

Modes of Communications:

SEE REGION 6 HOSPITAL EMERGENCY RESPONSE PLAN

NOTE: If all communications have failed, send a representative with a Situation Status Report to the local hospital or local EOC to present the facility status.

FACILITY INFORMATION (Main Address and Phone Numbers)

SEE ATTACHMENT A

EMERGENCY PHONE NUMBERS FOR PLAN ACTIVATION AND STATE RESOURCES / COMMUNICATIONS LIST (Individual Key Contacts for the Facility) / LOCAL AND COUNTY PHONE NUMBERS

SEE ATTACHMENT B

Tracking and Transfer Forms: Refer to Section 6 of the plan and Attachment E for the forms to support patient movement and tracking. If the facility, due to the emergent nature of the event, has no ability to use the plan's tracking forms and/or transport medical records, the standard MCI management system by EMS is relied on until the *Resident Evacuation Tracking Form / Tag* is recovered and available for use. At minimum, the *Resident Evacuation Tracking Form / Tag* and *Patient / Medical Record & Equipment Tracking Sheet* MUST be utilized.

Special Transportation Concerns

- *Seattle Keiro and/or Seattle Medical:* Ventilator patients
- Dementia Secured Units (Danger to Self of Others)
- Behavioral Issues
- Large Continuing Care Retirement Communities

Other Forms of Transportation to supplement and expand upon EMS capabilities:

- *Long Term Care Facility Vehicles:* Many have vehicles that could help transfer Patients, supplies or equipment from the Disaster Struck Facility to the Patient Accepting Facility or Stop Over Point. Ensure that the deployment of these vehicles to a Disaster Struck Facility is coordinated with EMS and the On-Scene Incident Commander to provide the appropriate Staging Location
- *Private/Public Wheelchair Accessible Buses and Wheelchair Cars/Vans:* Move moderate to low acuity Patients to other Patient Accepting Facilities or Stop Over Points
- *Private/Public Non-wheelchair Accessible Buses:* Move ambulatory Patients with minimal needs for care to other Patient Accepting Facilities, Stop Over Points, or medical shelters
 - *Movement of Family:* Local Public Transit, Private Bus Transports and Personally Owned Vehicles could be utilized and family members would have to be provided a Family Reunification area to go to due to potential high level security at the Patient Accepting Facility and/or Disaster Struck Facility
 - *Movement of Staff:* Local Public Transit, Private Bus Transports, Long Term Care Facility Shuttles and Personally Owned Vehicles could be used to move staff
 - *Movement of Equipment/Supplies:* Work with the Emergency Operations Center for transport vehicles plus facility owned vehicles and supplier trucks

The ***Resident Evacuation Tracking Form*** MUST be utilized for each patient, even if the medical records and other information are accompanying the patient.

NOTES:

1. Patient pickup points should be part of each facility's internal plan.
2. Advise EMS of any vehicles your facility may have or private contracts for other transportation vehicles within the LTC-MAP to help move Patients, staff and equipment. A Staging Officer (from EMS, Fire, or other agency) provides support for the staging of these vehicles upon their arrival.
3. For planning movement of Patients, support EMS by preparing batches of Patients (5-15) to support the Ambulance Strike Teams, which are comprised of 5 ambulances and a focus on batch movement of Patients.

Facility Information Report and Transportation Survey:

Information included on the Mutual Aid Plan website

[REDACTED], for planning purposes, provides EMS, Fire, Emergency Management and the Health & Medical Area Command with additional planning information for the facility-specific acuity levels and special care requirements. Each Member facility is providing the total number of Patients that could be cared for at the facility at full occupancy and the special categories of the Patients (see **Attachment A.**) This dictates for EMS and other Member facility the impact that each facility has on the Patient bed capacity of Region 6.

Each Member facility has also completed a **Transportation Survey** to inform EMS and other resources on the total number of patients, their required means of transportation and any unique information to support this (see **Attachment C.**)

Member Facilities Internal Patient Prioritization: For internal full building evacuation plans, Member Facilities should review how many Patients can be moved per hour down the stairs in the event the elevators are non-operational. This assists EMS in knowing the Patient volume they need to move over specific periods of time. Estimates should also be taken for standard Patient movement using elevators and stairs for evacuation purposes.

- NOTE: This is a recommended approach and not mandated by the MOU.

SEE THE FOLLOWING FOR ADDITIONAL INFORMATION:

- **ATTACHMENT A FOR SUMMARY OF SPECIAL CARE LEVELS / SURGE CAPACITY / STOP OVER POINTS, PREPLANNED EVACUATION LOCATIONS AND TRANSPORTATION VEHICLES**

SECTION 6:

MEDICAL RECORDS & MEDICATIONS (going with patient)

PATIENT IDENTIFICATION AND TRACKING

MEDICAL RECORDS/DOCUMENTATION:

As patients leave the Disaster Struck Facility, the following items must accompany them:

- The *Patient Evacuation Tracking Form*, containing pertinent medical information for a quick review of the patient. This should be pinned to the patients' clothing (on their back or other area where this cannot come free).
 - **Review internally if there are better ways to attach this to the patient (i.e. clear lanyards and the lanyard is attached to the patient)**
- Patient Medical Record/Chart including the Medication Administration Record (MAR.)
 - All records are returned to the original facility (noting plan exceptions in the MOU).
 - Attempt to ensure the following information accompanies the Patient from key areas of the chart:
 - Entire Active Chart, Medical Administration Record (MAR), Care Plans and Photo of Patient
 - Fast Evacuation – Face sheet and MAR (book of all MARs)
 - *All records are returned to the original facility (noting plan exceptions in the MOU) including a copy of all elements from the Patient Accepting Facility chart.*
- *Patient / Medical Record & Equipment Tracking Sheet* (may follow a group of Patients.)
- Stickers should be placed on the Medical Record and equipment with the facility name, address and phone number (to support return of the equipment post-incident.)
 - Keep in a “go-kit” trash bags or other waterproof containers that patients meds, records and basic personal belongings could be transported in

NOTE 1: As nurses and physicians from the Disaster Struck Facility go to various Patient Accepting Facilities to resume care of their Patients, it is recommended they bring the charts, if not already done, and controlled substances (if requested by the Patient Accepting Facility) needed to care for these Patients.

NOTE 2: There are two options with regards to the charts for Patients. When the Patient Record Chart arrives with the Patient, a review is conducted of the records along with an assessment of the Patient and the facility begins documents in the following manner:

- **RECOMMENDED APPROACH:** Start a new chart for each newly accepted Patient, clearly noting the time in the existing chart to delineate where the documentation ended.
 - If using the existing chart due to immediate need to care for the Patient, clearly delineate when and where the Patient Accepting Facility began documenting in the chart.*

* *The Patient Accepting Facility begins a new chart for the Patient as soon as possible.*

NOTE 3: Many facilities are moving towards or have achieved **Electronic Health Records**. If Electronic Health Records are currently in place, it is critical that a strong effort be made to provide a clear and concise *Resident Evacuation Tracking Form* in the event that access to the computers is limited. Issues to consider focusing on include:

- Can the Electronic Health Record be accessed and printed from an outside location? If yes, the facility's internal full building evacuation plan should address the steps necessary to secure access. Usually, this is accessed via a physician portal or other IT means, with the Disaster Struck Facility granting access to the receiving facility.
 - It is recommended that the IT teams from each of the receiving hospitals be briefed by the Disaster Struck Facility as to what options there are to access records.
 - Consideration should be given to controlling the firewall at the Patient Accepting Facility and IT should be consulted if the firewall becomes an issue in accessing information on the patient.
 - A representative from the Disaster Struck Facility may be sent to the Patient Accepting Facility to assist with accessing information.
- Is there independent emergency generator back-up to run the server(s), computer(s) and printer(s) that provide the facility the ability to print out the records?
- Can batch printing be completed by the facility, either at one central location or to the floor, in the event the floor does not have printing capability at the time or the floor is overwhelmed with the patient care needs to secure enough time to print out each record?

IMPORTANT: DOWNTIME PROCEDURES

If a clinical team from the Disaster Struck Facility will be taking over a unit at the Patient Accepting Facility, the Patient Accepting Facility should review moving to downtime procedures to ensure that patient care is the primary focus, and not the short-term re-education of the clinical team on a computer system.

MEDICATIONS:

When sending patient-specific medications, package them along with their other personal affects, label with their name and Medical Administrative Number before sending with the patients (as they are transferred).

Necessary **medications and controlled substances** are sent with the evacuated patient, if possible.

1. It is the discretion of the Patient Accepting Facilities to continue to use these meds or order their own. It is recommended that medications be placed in water resistant, tamper evident containers/bags.
2. Patients arriving with Physician Orders (MAR should accompany the patient) are filled by the Patient Accepting Facility, if necessary, until a physician with privileges at the Patient Accepting Facility is present and can write a new order.

In some situations, a licensed Health Care Professional (HCP) may go with the patient and be responsible for the Controlled Substances. If meds are administered during transport, appropriate documentation on name of medication, quantity and dose administered must be documented.

1. The Patient Accepting Facility may also request that the patients same LTC pharmacy can dispense new supply of medication to new location. The LTC pharmacy computer system will have the current medications of the patient.
 - a. DSHS or other insurance provider may comply with request to fill before usual due date.
 - b. The name of patients' pharmacy will be supplied to new site.
2. If primary LTC pharmacy is not able to dispense medication due to loss of function:
 - a. Medication request sent to other LTC pharmacy from MAR and/or medical record.
 - b. If it is necessary to move outside of pre-designated pharmacies, a new pharmacy will be allowed to dispense (72 hours up to 10 days) medication until new signed medication orders can be obtained. This new pharmacy will include other members of the LTC-MAP.
3. A licensed HCP may bring the medications to the Patient Accepting Facility during or immediately post disaster. If large volumes of medications are necessary, the Disaster Struck Facility may provide larger quantity shipment to the Patient Accepting Facility.
 - a. If civil unrest is taking place or there is potential, consideration should be given for a security or law enforcement personnel presence for transfer of controlled substances

In any situation where the controlled substances are transferred from one healthcare facility to another, there should be clear and concise documentation of the transfer by a licensed nurse or a pharmacist. A DEA Form 222 should be used where applicable and the *Controlled Substance Receiving Log* and copies of the *Narcotics Count Record* (follows after the patients arrive) should be utilized to support this process of transferring medications from facility to facility within Region 6. The process of receiving includes the following:

- form completed by licensed health care practitioner (this verifies a count done by the receiving facilities)
- name of patient, if applicable (*unless a facility to facility transfer*)
- name of medication and amount (solid dose units)
- The Disaster Struck Facility sends a copy of a *Narcotics Count Record* over after the disaster is concluded for verification of the counts.

NOTES:

1. Only unopened vials or solid-dose medications can be transferred. Partially used vials of controlled substances are not to be transferred.
2. The evacuation process already includes the MAR and transfer of the patient record/chart, thus completing the second phase of required documentation. If the patient is returned to the Disaster Struck Facility following the event, this information should be returned with the patient.

PATIENT IDENTIFICATION AND TRACKING (see the next page)

All patients must have wristbands (or some other form of identification). It is recommended that the following information should be contained on the wristband:

- Name and DoB (and MR# if possible)
- If unable to apply a wristband: Utilize a permanent marker on the forehead / arm / belly or other immediately identifiable location writing:
 - Name and DoB

Review having a **digital photo** of each patient to link up to their *Resident Evacuation Tracking Form* number or a **photo that can be printed** and go with the patient. At times, a digital photo is taken of each patient as they leave the building with a close-up picture of their *Resident Evacuation Tracking Form* number.

Patient Accepting Facilities **continue tracking** of incoming patients using the Comment Field on the Face Sheet (*inserting the Resident Evacuation Tracking Form # or previous MR# into that field*) and the location of their original charts. They keep the Disaster Struck Facility advised by contacting them to confirm the patients' arrival.

TRACKING SHEETS (see Attachment E Forms)

- A. The *Patient / Medical Record & Equipment Tracking Sheet* is intended to track patients, their medical records and equipment as the patients leave the Disaster Struck Facility. These fields should be used to capture aggregate patient data for anticipated transportation locations and sent to the Patient Accepting Facility for verification of receipt of the patients.

A sheet should be filled out for each facility that is receiving one or more of your patients. If a number of patients are all being sent to the same facility, these patients can all be listed on one Tracking Sheet. Additionally, if multiple patients are being discharged, several sheets could be used for “discharge to home” and note the vehicle they left in if possible to minimize the risk to the Member facility. The top sheet or a copy of the tracking sheet is kept by the Disaster Struck Facility as a record of where the patients have been sent.

It is important that the Patient Accepting Facilities continue this tracking process. As evacuated patients arrive at the Patient Accepting Facility, the facility should make enough copies of this tracking sheet so that one copy can be placed with each patient’s chart. This information should remain with the patient and their medical records. The Patient Accepting Facility should confirm the arrival of the patients with the Disaster Struck Facility or, if unable to communicate with the Disaster Struck Facility, the Regional Call Center (if active) should be communicated with. If the Regional Call Center is not active, communication should take place with Health & Medical Area Command or appropriate EOC / King County ECC.

When a new medical record number is assigned (due to a new patient medical record/chart being started) to the patient, this should be noted on the Tracking Sheet.

- Patient Accepting Facility should “flag” these charts either physically or electronically to aid in tracking/documenting patients cared for during an evacuation.
- The chart must be “safely kept” for return to the Disaster Struck Facility at the appropriate time.

- B. The *Resident Evacuation Tracking Form* supplies critical information on the patient to enable care to start for the evacuated patient until the “chart” can be reviewed. It should be pinned to the patients’ clothing, on their back or other location where it cannot be lost. These forms should also be used on a day to day basis for the transfer of patients between healthcare facilities. Copies of this form are:

- Copy 3: Retained by the Disaster Struck Facility
- Copy 2: Retained by the Transportation Unit Leader (EMS)
- Copy 1: Retained by the Patient Accepting Facility with a copy made for any local, regional or state groups involved with tracking support

Patient Accepting Facilities **continue tracking** of incoming patients using the Comment Field on the Face Sheet (*inserting the Resident Evacuation Tracking Form # or previous MR# into that field*) and the location of their original charts. They keep the Disaster Struck Facility advised by contacting them to confirm the patients’ arrival.

- C. The *Controlled Substance Receiving Log* must be completed by a licensed HCP at the Patient Accepting Facility for each patient and also be utilized for larger volume movement of pharmaceuticals – facility to facility.
- D. The *Influx of Patients Log* should be completed at the intake point for the patients at the Patient Accepting Facility. This will be matched up against the *Patient / Medical Record & Equipment Tracking Sheet*. The Patient Accepting Facility will then have a clear understanding if they have accountability for all patients they are supposed to have received.
- E. The *Health & Medical Area Command or Disaster Struck Facility Patient Tracking Chart (Aggregate)* should be completed at the Health & Medical Area Command location and/or by the Disaster Struck Facility to have complete tracking for all patients. This sheet is populated by the *Patient / Medical Record and Equipment Tracking Sheet* information and by direct calls into the local healthcare facilities. Final confirmation of the exact location of the patients is verified between groups via the information on the *Influx of Patients Log* that is matched against the *Patient / Medical Record & Equipment Tracking Sheet*. This aggregate tool is used to ensure that no patient is misplaced and to support coordination between the Disaster Struck Facility, the Patient Accepting Facility and the Health & Medical Area Command.

SECTION 7: STAFF, PHARMACEUTICAL, SUPPLIES & EQUIPMENT (“In Need of” and “Transportation of”)

To enable a Patient Accepting Facilities to care for Patients, extra **staff, pharmaceuticals, supplies and equipment** may be necessary.

Staff, pharmaceuticals, supplies and equipment may be needed by:

- a Disaster Struck Facility that is not evacuating but is overtaxed by the disaster and in need of emergency support
- a Patient Accepting Facility that needs additional resources
- a Stop Over Point to which a Disaster Struck Facility has evacuated.

A Patient Accepting Facility should be cautious about requesting staff, pharmaceuticals, supplies and equipment from a Disaster Struck Facility. While it is their responsibility to provide these resources and it is the intent of the Disaster Struck Facility to attempt to move staff to the Patient Accepting Facility to support their own Patient population, the severity of their situation may prohibit this from taking place in the early phases of a disaster.

- It is important for facilities to provide realistic orders to suppliers. In certain disasters, facilities order a complete duplicate of their previous order and there are many supplies or pharmaceuticals that they do not need at that time. The ripple effect is that a vendor may fill an order for a facility when another medical institution had greater needs at that time but they were unable to fill additional regional orders due to the overwhelming requests. Working together is a key to success and integration through the LTC-MAP will assist with the prioritization of resources as well.

Facility Actions: The Patient Accepting Facility opens existing staffed beds or areas first. However, overflow areas may need to be utilized and staff, supplies and equipment to care for Patients are necessary to support Patient care. Providing staff, pharmaceuticals, supplies and equipment is the responsibility of the Disaster Struck Facility, if possible. It is assumed that Patient Accepting Facilities and other non-affected facilities help as necessary through staff call-back lists, lending of supplies and working together to ensure vendors are informed of the situation to provided support to the Patient Accepting Facilities.

Region 6 LTC-MAP Website [REDACTED] It is the intent for the facilities to utilize the web-site for a general listing/inventory of available supplies and equipment to support other Region 6 facilities. It is the responsibility of the facilities to update their inventory listings based on request or on an as needed basis and print a hard copy of information on an annual basis to ensure that the paper copy of information from website is available in the event of a systems failure during a disaster.

NOTES:

1. When requesting staff, pharmaceuticals, supplies or equipment, it is recommended that you fax your written request to the Lender. This can be used at police road blocks as these resources are being sent to your facility. Appropriate communication with the Emergency Operations Center (EOC) should be completed to ensure they can inform the appropriate authorities of the resource/assets that should be allowed to access the facility (*NOTE: Access may still be denied by authorities*).
2. All medical needs should be coordinated through the Health & Medical Area Command and all non-medical needs should be coordinated through the Local Emergency Operations Center (EOC) or King County Emergency Coordination Center (ECC).
3. It is in the best interests of the Disaster Struck Facility to have a representative in the Local EOC for coordination purposes.

Special Transportation and Supply Considerations for Vendors and Town / City / Region / State Agencies: There are three primary concerns in dealing with disaster transportation of supplies to Member Facilities:

1. Elevated requests that overwhelm the inventory of the suppliers
2. Inability to communicate with the Member Facility and distribution of pharmaceuticals, supplies or equipment without verification of the safe accessibility to the Member Facility
3. Limited access to the Member Facility due to the scope of the disaster.

Vendor Transportation Prioritization: In most situations, the vendor is able to meet the requests of the Member Facilities and distribute supplies to their site (Elevated Requests – Minimal Impact.) When the requests are Elevated and the impact is High, the Local EOC is the conduit for the vendor to support prioritization for pharmaceuticals, supplies and equipment. This by no means takes the control away from the Member Facility, this approach helps to ensure that the Member Facility is internally prioritizing their needs and working with the Local EOC, with the exception being when the facility is faced with immediate threat to life and this is automatically escalated to the highest level of priority for the Local EOC.

While Traffic Control is to be handled by the Department of Transportation, State Patrol and the local police departments for the areas impacted, appropriate coordination with Emergency Management within the appropriate EOC is of the utmost importance during a disaster that impacts the transportation capacity of the region.

The vendors and the appropriate EOC along with Health & Medical Area Command must coordinate in order to ensure safe access to the Member Facilities and verify if the risk to enter an area is too great based on where the facility is prioritized at that time.

STAFF ASSISTANCE

1. Communication of request: The request for staff help initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the recipient facility.

It is recommended that healthcare facilities prepare to create and deploy integrated clinical and non-clinical teams. These would either be on-call staff responding to the facility for deployment or on-duty teams where staff call-backs are initiated and once the responding staff arrives, the facility is able to deploy the on-duty teams. Requesting healthcare facility should be specific with the resources they request to properly utilize responding staff.

Staff should not be requested from a facility that is involved in an active disaster. If the Lenders staff is at your facility when their facility goes into disaster activation, they must be allowed to return at once, if requested.

2. Documentation/Credentials: The arriving personnel are required to present their facility identification badge at the Borrowers facility upon arrival. The Borrower is responsible for the following:
 - a. Meeting the arriving personnel from a Lender facility and signing them into the facility (sign out will also be required)
 - b. Confirming the personnel's ID badge and Picture ID with the list of personnel provided by the Lender facility
 - c. Providing additional identification, such as "visiting personnel" badge, per facility policy, to the arriving personnel
 - d. If possible, conduct a Watch Background check and check their license with DSDS.

The Borrower accepts the professional credentialing determination of the Lender facility, but only for those services for which the personnel are credentialed for and have privileges to provide at the Lender facility and only if those privileges do not contradict with privileges provided for similar positions in the Borrower facility.

3. Supervision: The Borrower's senior administrator or designee (Medical Care Branch Director, Casualty Care Unit Leader, Labor Pool & Credentialing Unit Leader) identifies where and to whom the donated personnel are to report, and professional staff of the Borrower's facility who supervise them.
 - Provide a baseline orientation for the arriving personnel to the facility (similar to how Traveler staff are handled)
4. Demobilization Procedures: The Borrower provides and coordinates any necessary demobilization procedures and post-event stress debriefing. The Borrower is responsible for providing the personnel transportation necessary for their return to the Lender facility and all documentation of hours worked while on-site along with sign-out.

DISASTER CREDENTIALING AND PRIVILEGING

As a facility evacuates, it is likely that staff and clinicians from one facility will be working at other healthcare facilities, throughout the duration of the disaster, as they help to care for their patients at the Patient Accepting Facilities.

This situation may also occur if physicians, nurses, Nursing Assistants – Certified (NAC) and other care providers from around the community and surrounding communities volunteer their time during a disaster.

Each member facility should have an internal procedure for credentialing of emergency providers/volunteers and granting of temporary privileges in a disaster. These internal procedures should follow the base requirements from The Joint Commission and the DSHS. In order to activate these internal procedures, the facility's Emergency Operations Plan has been activated the facility (Incident Commander / Administrator-on-call, in consultation with Medical Director or designee) determines that it is unable to handle the immediate patient needs with their existing staff.

The Joint Commission standards for Emergency Credentialing are outlined on the following pages and should be followed as the baseline plan for all institutions (accredited by The Joint Commission or directly by CMS).

As soon as the immediate situation is under control, not to exceed 72 hours unless communication is disrupted - this must be documented, the verification process of credentials and privileges of individuals who have received disaster privileges must be completed. This privileging process is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient need.

Within 72 hours, the organization will determine the need to continue this disaster privileging policy.

EM.02.02.13	Granting disaster privileges to volunteer licensed independent practitioners (LIPs).
EM 1	The facility grants disaster privileges to volunteer LIPs only when the Emergency Operations Plan has been activated and additional staff is needed – General.
EP 2	The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer LIPs.
EP 3	The facility determines how it will distinguish volunteer LIPs from other licensed independent practitioners.
EP 4	The medical staff describes, in writing, how it will oversee the performance of volunteer LIPs
EP 5	<p>facility obtains his or her valid government-issued photo identification and at least one of the following:</p> <ul style="list-style-type: none"> - A current picture identification card from a health care organization that clearly identifies professional designation. - A current license to practice. - Primary source verification of licensure. - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response facility or group. - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances. - Confirmation by a LIP currently privileged by the facility or a staff member with personal knowledge of the volunteer practitioner’s ability to act as a LIP during a disaster.
EP 6	The medical staff oversees the performance of each volunteer LIP
EP 7	The facility determines within 72 hours of the practitioner’s arrival if granted disaster privileges should continue.
EP 8a	Primary source verification of licensure occurs as soon as the immediate emergency situation is under control or within 72 hours.
EP 8b	<p>If verification can not be completed in 72 hours, document (all):</p> <ul style="list-style-type: none"> - Reason(s) why it could not be performed within 72 hours of the practitioner’s arrival. - Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services. - Evidence of the facility’s attempt to perform primary source verification as soon as possible.
EP 9	If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner’s arrival, it is performed as soon as possible - General.
EM.02.02.15	During disasters, the facility may assign disaster responsibilities to volunteer practitioners who are NOT LIPs.
EP 1	The facility assigns disaster responsibilities to volunteer practitioners who are not LIPs.

EP 2	The facility identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners.
EP 3	The facility identifies how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff.
EP 4	The facility describes, in writing, how it will oversee the performance of volunteer practitioners.
EP 5	<p>Prior to fulfilling their role, the facility obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and one of the following:</p> <ul style="list-style-type: none"> - A current picture identification card from a facility that clearly identifies professional designation. - A current license, certification, or registration. - Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice). - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response facility or group. - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances. - Confirmation by facility staff with personal knowledge of the volunteer practitioner's ability to act as a qualified practitioner during a disaster.
EP 6	The facility oversees the performance of each volunteer practitioner
EP 7	The facility determines within 72 hours after the practitioner's arrival whether assigned disaster responsibilities should continue.
EP 8	Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the immediate emergency situation is under control or within 72 hours
	<p>If primary source verification of licensure, certification, or registration for a volunteer practitioner cannot be completed within 72 hours due to extraordinary circumstances, the facility documents all of the following:</p> <ul style="list-style-type: none"> - Reason(s) why it could not be performed within 72 hours of the practitioner's arrival. - Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services. - Evidence of the facility's attempt to perform primary source verification as soon as possible.
EP 9	If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

PHARMACEUTICALS, SUPPLIES & EQUIPMENT

I. SUPPLIES AND EQUIPMENT

1. Communication of request: The request for supplies and equipment from a vendor or for the transfer of supplies or equipment from another member facility initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the receipt of any material resources at the Borrower's facility. The Borrower identifies to the vendor or Lender the following:
 - a. The quantity and exact type of requested items
 - b. Time estimate of when supplies/equipment is needed on-site
 - c. Time period for which the supplies/equipment are needed
 - d. Location to which the supplies/equipment should be delivered

The vendor or Lender identify how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. Documentation: The Borrower honors the vendor or Lender facility's standard order requisition form as documentation of the request and receipt of the materials. The Borrower's designee confirms the receipt of the material resources. The documentation details the following:
 - a. The items involved
 - b. The condition of the equipment prior to the loan (if applicable)
 - c. The responsible parties for the borrowed material.

The Vendor or Lender is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, the original invoice is co-signed by the senior administrator or designee of the Borrower, recording the condition of the borrowed equipment.

3. Transporting of supplies or equipment: The Borrower is responsible for coordinating the transportation of materials both to and from the Vendor or Lender through the Local EOC or King County ECC. This coordination may involve government and/or private organizations and the vendor or Lender may also offer transport. The Borrower must return and pay the transportation fees for returning or replacing all borrowed materials.
4. Safety (equipment): The Lender is responsible to verify the operational status and preventative maintenance for all equipment being transported to the Borrower. All reporting requirements, policies, procedures and documentation following receipt of the equipment (i.e. Safe Medical Devices Act) is the responsibility of the Borrower.

5. Supervision: The Borrower is responsible to ensure appropriate staff competency for use and maintenance of all borrowed supplies and equipment.
6. Demobilization procedures: The Borrower is responsible for the rehabilitation and prompt return of the borrowed equipment to the vendor or Lender. To facilitate this, all facility equipment should be properly marked with identification.

II. PHARMACEUTICALS

Pharmaceuticals: Pharmaceuticals follow the same process as supplies and equipment with the exceptions seen in **Section 6**.

- For a Disaster Struck Facility that is not evacuating but is overtaxed by the disaster and in need of emergency support:
 - The Disaster Struck Facility requests emergency support from patients primary pharmacy followed by other area pharmacies
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from other area facilities. Depending on the severity of the incident, police and security measures should be taken into account to safeguard medications.
- For a Patient Accepting Facility that is in need of emergency support:
 - The Disaster Struck Facility requests emergency support from patients primary pharmacy followed by other area pharmacies
 - If response is inadequate to meet the facilities needs, the Disaster Struck Facility requests emergency support from pharmaceutical suppliers within the region and their regional or national supply chain
 - If response is inadequate to meet the facilities needs, the Patient Accepting Facility requests emergency support from other area facilities. Depending on the severity of the incident, police and security measures should be taken into account to safeguard medications.
 - Note that it is expected Patient medications will arrive with the evacuated Patient and this is primarily referencing controlled substances.

ANNEX I:

Long Term Care Mutual Aid Plan (LTC-MAP)

LTC-MAP Memorandum of Understanding

March 4, 2010

I. Introduction and Background

The goal of healthcare providers is to ensure safe and effective care for their patients. Each facility has the potential to encounter situations that may overwhelm or exceed the resources of that individual healthcare facility. When a facility activates their disaster plan, some disasters require a need for a higher level of support from the surrounding healthcare facilities. King County and the surrounding areas are susceptible to disasters, both natural and man-made, that can result in the need for a full scale, coordinated disaster response.

These situations may exceed the resources of more than one healthcare facility. Disasters may involve incidents that generate an overwhelming number of patients that exceed the resources of the impacted facilities or from incidents such as building or plant problems resulting in the need for partial or complete healthcare facility evacuation. It may also be a response to incidents involving biological outbreaks that overwhelm the facility.

II. Purpose of Long Term Care Mutual Aid Plan (LTC-MAP) Memorandum of Understanding (MOU)

The LTC-MAP support concept is well established and is considered "standard of care" in most emergency response disciplines. The continuum of mutual aid is coordinated and based on the scale of the incident. Regardless of the coordinating agency, healthcare facilities and other agencies participating in this agreement are agreeing to support one another in providing patient care.

This MOU also addresses the loan of staff, pharmaceuticals, supplies, and equipment, or assistance with emergent healthcare facility evacuation, including the acceptance of transferred patients.

This LTC-MAP Memorandum of Understanding (MOU) is a **voluntary** agreement among Participating Agencies/Healthcare Facilities that have agreed to lend support in a disaster. The degree and level of support for the number of patients each facility will accept is clearly outlined in the LTC-MAP as each facility must be able to expand bed capacity to 110% of licensed bed capacity (while the goal is to use open beds, each facility needs to be prepared to accomplish this level of surge) whereas other resources will be determined at the time of the incident based on available equipment, supplies, staff and transportation capabilities.

For purposes of this MOU, an all-hazards incident is defined as an overwhelming incident that exceeds the effective capability of the impacted health care facility or facilities. An all-hazards incident requires the Disaster-Struck Facility to establish a Command Center and

may involve the local community or King County Office of Emergency Management to establish a local Emergency Operations Center (EOC) or King County Emergency Coordination Center (ECC) as well as an activation of the Health & Medical Area Command. An incident of this magnitude will always involve the local emergency responders (via 911), local Emergency Management and Public Health – Seattle & King County. The disaster may be an “external” or “internal” incident for the healthcare facility and **assumes that each affected healthcare facility’s Emergency Operations Plans have been implemented through the activation of the facility Command Center.**

This document addresses the relationships between and among healthcare facilities in routine situations and disaster situations and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for healthcare facilities to coordinate under Health & Medical Area Command in concert with local EOCs, King County Office of Emergency Management and the Public Health - Seattle & King County during planning and response. This document does not replace, but rather supplements, the rules and procedures governing interaction with other organizations during an all hazards incident (e.g., law enforcement agencies, the local emergency medical services, local public health department, fire departments, American Red Cross, etc).

By signing this MOU each participating organization is evidencing its intent to support the terms of the MOU:

- A. Provide urgent support to a facility that has activated their Emergency Operations Plan
- B. Provide support in the event of a **regional disaster** that exceeds the effective response capabilities of the impacted healthcare facility or facilities. The terms of this MOU are to be incorporated into the healthcare facility’s Emergency Operations Plan.

III. Definition of Terms

Assistance Costs	Assistance Costs means any direct material costs, equipment rental fees, fuel, and the fully loaded labor costs that are incurred by the Donor or Patient Accepting Facility in providing any requested assets or services.
Census Reduction Plan	Census Reduction Plan is an internal strategy utilized by a healthcare facility to open up existing staffed beds in order to receive additional patients. This plan would include approaches to expedite the safe discharge of patients.
Command Center	Command Center is a location from which the facility’s specific Incident Command oversees all incident operations. It is established in a facility during an emergency and is the facility’s primary point of administrative authority and decision-making. This term references what individual facilities may call their internal Emergency Operations Center, Incident Command Center or other name for internal Command.

Disaster	An incident that exceeds a facility's effective response capability or cannot appropriately resolve solely by using its own resources. A full-scale disaster will impact more than one facility. Such disasters will very likely involve the local EOC, King County Office of Emergency Management and Public Health - Seattle & King County and may involve loan of medical and support staff, pharmaceuticals, supplies, and equipment from another facility, or, the emergent evacuation of patients. Coordination of resources will occur at the appropriate EOC, King County ECC or Health & Medical Area Command location for a full-scale disaster.
Disaster-Struck Facility	The Disaster-Struck Facility is a healthcare facility where the disaster occurred. Transportation, staff, equipment or supplies may be requested, or the evacuation and transportation of patients may be required.
Donor Facility	The healthcare facility that provides staff, pharmaceuticals, supplies, transportation or equipment to a facility.
Emergency Contacts	Emergency Contacts are the persons, in a line of succession, listed in the Long Term Care Mutual Aid Plan (LTC-MAP) for Emergency Contact Information and submitted to the Public Health - Seattle & King County, King County Office of Emergency Management and each local EOC by the LTC-MAP. The list includes names, addresses, and 24-hour phone numbers of the Emergency contact points of each healthcare organization. The people listed as Emergency Contacts have (or can quickly get) the authority of the healthcare facility to commit available equipment, services, and staff for the organization. Note: The phone number of a dispatch office staffed 24 hours a day that is capable of contacting the Emergency contact point(s) is acceptable.
EOC (Local) or ECC (County)	Emergency Operation Center or Emergency Coordination Center is established for the purposes of coordinating the incident response on a local or regional level. The EOC / ECC provides planning, communications, coordination, and oversight of the disaster response including coordination with the Health & Medical Area Command function.
First Responder Agencies	First Responder Agencies' refers to local fire, EMS and police; typically accessed through 911 or a non-emergency direct line.

Health & Medical Area Command	Health & Medical Area Command is an incident management group used to coordinate emergency response efforts across all jurisdictions in King County, and among multiple healthcare agencies vying for the same resources. Health, medical and mortuary response agencies across King County will utilize the Incident Command System, and specifically Area Command, to manage information, resources and decisions during disasters. The health, medical and mortuary response are led by the ESF 8 Area Commander, who reports to the Local Health Officer.
Hospital Control	Hospital Control is a facility designated by King County to coordinate King County pre-hospital patient care and patient distribution between EMS and hospitals. The responsibilities of Hospital Control include communication with the EMS personnel and Emergency Departments and patient distribution. The primary Hospital Control for King County is Harborview. In the event that Harborview is unable to fulfill the duties, then Overlake is the designated alternate.
Long Term Care Mutual Aid Plan (LTC-MAP) Medical Reserve Corp (MRC)	LTC-MAP means this Agreement. The mission of the Medical Reserve Corps (MRC) is to improve the health and safety of communities across the country by organizing and utilizing public health, medical and other volunteers.
Participating Agencies/ Healthcare Facilities	Agencies/ Healthcare Facilities that have fully committed to the LTC-MAP MOU.
Patient Accepting Facility	The facility that receives patients from another Participating Healthcare Facilities in an evacuation or due to another type of all hazards incident.
Stop Over Point / Alternate Care Facility	Nearby building where patients can be held pending return to original healthcare facility or distribution into Mutual Aid Plan. This building should be reviewed for its ability to handle the entire patient population or multiple facilities should be chosen to accomplish this. Additionally, the facility should be reviewed from a vulnerability standpoint to ensure that movement to the facility will not endanger evacuated patients or staff (i.e. flood area).

Surge Capacity Plan (or Influx of Patients Plan) Surge Capacity Plan means an internal strategy utilized by a healthcare facility to open up existing beds and open non-traditional areas of the healthcare facility for patient care and potentially open up an alternate site to support a mass influx of patients over a short duration or extended period of time. This plan might include a Census Reduction Plan, cohorting of patients and other strategies employed that are specific to each individual healthcare facility.

IV. General Principles of Understanding

1. **Participating Healthcare Facility:** Each Participating Healthcare Facility:
 - a. Designates Emergency Contacts to participate with community disaster planning and to coordinate the Long Term Care Mutual Aid Plan (LTC-MAP) initiatives with the individual healthcare facility's Emergency Operations Plan.
 - i. Ensure the most current Emergency Contacts are included in the LTC-MAP and WATrac.
 - ii. Report any changes occurring during the plan year that preclude the Participating Healthcare Facility from participating or modifies the level of actual participating.
 - iii. Maintain a current hard-copy of the LTC-MAP in the healthcare facility Command Center or other designated location.
 - b. Commit to participating in community exercises and drills to test the plans' effectiveness.
2. **Implementation of LTC-MAP Memorandum of Understanding (MOU):** A health care facility becomes a Subscribing Organization when an authorized administrator signs the MOU.

During a disaster, only the authorized administrator (or designee) or Command Center at each facility has the authority to **request or offer assistance** through the LTC- MAP. Representatives from the Local or State Emergency/Licensing Agencies (Public Health - Seattle & King County, Office of Emergency Management, Washington Emergency Management Division, Emergency Medical Services, State DSHS, Local EOC, etc.) may also make this request.

3. **Command Center:** The Command Center is activated when a facility activates its disaster plan. The Disaster Struck Facility must activate a Command Center in order to request resources through this LTC-MAP. The impacted facility's Command Center is responsible for informing the local emergency responders (911) and the Public Health Duty Officer of its situation and defining needs that cannot be accommodated by the healthcare facility itself. The senior administrator or designee is responsible for requesting staff, pharmaceuticals, supplies, equipment, transportation or authorizing the evacuation of patients. The senior administrator or designee will coordinate both internally, and with the Donor / Patient Accepting Facility, all of the logistics involved in implementing assistance under this LTC-MAP MOU. Logistics include identifying the number and specific location where staff, pharmaceuticals, supplies, equipment, or patients should be sent, how to enter the security perimeter, estimated time interval to arrival and estimated return date of borrowed supplies, etc.

4. **Local EOC:** The Local EOC is activated by the local first responders or a request from the Disaster-Struck Facility. The Local EOC will have authority to provide resources to the Scene Incident Commander or Unified Command and will make the necessary request to the King County ECC and the Health & Medical Area Command, as necessary.
5. **King County ECC and Health & Medical Area Command:** The King County ECC is activated by the King County Office of Emergency Management Duty with requests for activation coming from Public Health - Seattle & King County, local EOCs, by law enforcement, by fire service, or by other approved sources. The ECC, when fully activated, includes a liaison from Health & Medical Area Command. Health & Medical Area Command will consist of representatives from the Public Health - Seattle & King County, participating hospitals, EMS and other agencies/healthcare facilities as necessary.

Health & Medical Area Command has the authority and responsibility to coordinate and direct all disaster related medical response for the healthcare facilities. The healthcare facilities remain responsible for internal operational issues.

6. **Documentation for Loans of Supplies, Transportation, Staff and Equipment:** During an all-hazards incident, the Donor Facility will accept and honor the requesting facility's standard requisition forms or verbal communication in the event of a technological failure (this will be followed by a written requisition form at the earliest possible time and prior to demobilization.) Documentation provided by the Donor Facility should detail the items or individuals involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material (if applicable.)
7. **Payment for Supplies, Transportation, Staff and Equipment:** The recipient facility will assume responsibility for the supplies, transportation, staff and equipment from the Donor Facility upon receipt and during the time the supplies, transportation, staff and equipment are at the recipient facility. If the Donor Facility requests reimbursement for salaries or expenses, the recipient facility shall reimburse the Donor Facility, to the extent permitted by federal law, for all of the Donor Facility's costs determined by the Donor Facility and the recipient facility working together to determine the appropriate costs. Costs includes all use, breakage, damage, replacement, and return costs of borrowed materials. Staff wages, benefits, taxes, insurance, or other compensation is always paid by their home facility (employer). Reimbursement will be made within a mutually agreed upon timeframe between the Donor Facility and the recipient facility following receipt of the invoice.

All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

8. **Patient Care Responsibility:** Once admitted, the patient is under the care of the Patient Accepting Facility's admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g. equipment) if possible. At the end of the disaster, patients may be returned and must be accepted at the Disaster Struck Facility as capable. The following conditions immediately eliminate the potential for a transfer:

- a. The patient is discharged to home or alternate level of care (rehabilitation hospital, skilled nursing facility)
- b. The patient/family/responsible party refuses transfer
- c. The attending physician deems the patient unstable for transport.

NOTE 1: The parties hereto recognize that certain parties hereto are religious or church-sponsored entities and that with respect to said parties any services provided hereunder must be provided in a manner that is consistent with said parties' Mission and Core Values and the moral tradition as articulated in such documents as The Ethical and Religious Directives for Catholic Health Care Services (other documents as applicable)

NOTE 2: From an ethical standpoint, it is expected that no marketing efforts will be made by the Patient Accepting Facility.

9. **Communications**: The impacted healthcare facilities are responsible for informing emergency agencies and the appropriate Washington State licensure agency (DSHS) of its situation and defining needs that cannot be accommodated by the facility itself. The senior administrator (or designee) in the Disaster Struck Facility Command Center is responsible for requesting supplies or authorizing the evacuation of patients in conjunction with Emergency Agencies.

Communications between facilities for formally requesting and volunteering assistance should therefore occur among the senior administrators (or designees).

10. **Public Relations**: Each Participating Healthcare Facility is responsible for developing and coordinating with other healthcare agencies, relevant organizations, and the appropriate EOC for the media response to the disaster. Coordination of public information during an all hazards incident will occur through the Joint Information Center activated by the appropriate EOC / King County ECC.
11. **Hold Harmless Condition**: The recipient facility should hold harmless the Donor Facility for acts of negligence or omissions on the part of the Donor Facility in their good faith response for assistance during an all hazards incident. The Donor Facility, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the recipient facility.

V. General Principles Governing Medical Operations, the Transfer of Pharmaceuticals, Supplies or Equipment, or the Evacuation of Patients

1. **Mutual Aid**: When an isolated facility has activated their disaster plan, the impacted facility may request assistance from another healthcare facility for staff, supplies, transportation or equipment and then the Donor Facility will inform the requesting facility of the degree and time frame in which it can meet the request.
2. **Operational Status**: Participating Disaster Struck Facility and/or, when activated, the Health & Medical Area Command of their operational status.
3. **EOC / ECC / Health & Medical Area Command**: All facilities are responsible for notifying the appropriate EOC (Local) for any non-medical resource needs including staff, supplies, transportation or equipment. Any evacuation of patients

and medical needs requests will be via Health & Medical Area Command who will request an updated resource assessment to determine the availability of additional staff or material resources, including the availability of beds, as required by the situation. The Health & Medical Area Command will prioritize requests and direct the distribution of the resources in coordination with the appropriate EOC. Once resources have been assigned, the recipient facility will be informed to contact the Donor Facility directly and complete the arrangements. The Incident Commander (or designee) of the recipient or Disaster Struck Facility, will coordinate directly with the Incident Commander (or designee) of the Donor or Patient Accepting Facility for this assistance.

** NOTE: For evacuation of patients, the Disaster Struck Facility may initially be communicating directly with Patient Accepting Facilities and their Stop Over Points with Health & Medical Area Command standing up while the incident is unfolding to provide supplemental coordination support.*

VI. Specific Principles of Understanding

A. Loaning of Staff

1. **Communication of request:** The Incident Commander (or designee) of the recipient facility authorizes the request. The request for the transfer of staff initially can be made verbally to the Incident Commander or designee of the Donor Facility. The request must be followed up with written documentation before staff will be released and in the event of a technological failure this will be followed by a written requisition form at the earliest possible time and prior to demobilization. The documentation may be sent by any available means including fax, radio, phone, e-mail, or courier.

The recipient facility will identify to the Donor Facility the following:

- a. The type and number of requested staff.
- b. An estimate of how quickly the requested staff are needed.
- c. Information regarding parking, entry, where to report, and who to report to.
- d. An estimate of how long the staff will be needed.
- e. The method of transportation.

The Donor Facility will provide:

- a. A list of names and credentials of the volunteers.

2. **Documentation:** The arriving donated staff will be required to present their facility identification badge along with another accepted form of identification (see Credentialing in the LTC-MAP: Section 7) at the time of arrival and continue to wear the badge while on duty at the recipient facility.

The recipient facility will be responsible for the following:

- a. Meeting the arriving donated staff at the entry point and escorting them to the Labor Pool or check in location for sign-in.
- b. The check in process will include:

- Confirming the donated staff's ID badge with the list of personnel provided by the Donor Facility and a second form of identification per the LTC-MAP.
 - Providing additional identification, e.g., "visiting staff" badge, to the arriving donated staff. This is to be worn in addition to the volunteer's normal badge.
 - Providing a briefing regarding the situation.
 - Designating an assignment and supervisor for each individual based on experience and credentials.
 - Escorting or directing staff to assigned area.
- c. Completing timesheets and documentation of assignments and providing copies to the Donor Facility.

The recipient facility will accept the current professional credentialing status of the Donor Facility. Additional privileges may be granted at the discretion of the recipient facility with agreement from the appropriate senior physician and/or Medical Director, as determined by the facility, and the individual.

3. **Supervision:** Each volunteer will be assigned to a direct supervisor as well as an all-hazards incident position leader. The supervisor or designee will meet the donated staff in the labor pool and brief them on the situation and their assignment. The direct supervisor is responsible for ensuring that the volunteer is oriented to the work area, understands and is capable of the assignment, and has the ability to ask questions and report concerns. In addition the supervisor will assess the donated worker periodically and relieve the individual if unfit to continue to work.

If appropriate, the "emergency staffing" rules of the recipient facility will govern assigned shifts. The donated staff's shift will not exceed the shifts outlined in the emergency-staffing plan. The length of the shift may be negotiated in advance with the Donor Facility.

4. **Demobilization procedures:** Donated staff are expected to remain on duty until relieved, unable or unsafe to continue, or dismissed. The supervisor is responsible for communicating with the individual any change in assignment. All donated staff will be expected to sign out through the labor pool, return the identification badge, and document their time on the assignment log.

The recipient facility will provide and coordinate:

- a. Any necessary demobilization procedures and post-incident stress debriefing.
- b. Transportation necessary for their return to the Donor Facility.
- c. Copy of the assignment log and time sheets for tracking and payment purposes.

NOTE: If the Donor Facility is experiencing a disaster, a process for rapid demobilization will be implemented to support returning staff to their primary place of employment.

5. **Payment for Services:** Normal payroll procedures will be followed by the Participating Healthcare Facility. If the Donor Facility requests reimbursement for salaries or expenses, the Donor Facility shall submit the payroll expenses to

the recipient facility. The Donor Facility will also accept the timesheets from the recipient facility as evidence of hours worked. All financial matters will be worked out between the participating facilities.

If the Donor Facility requests reimbursement for salaries or expenses, the recipient facility shall reimburse the Donor Facility for the salary expenses incurred by donated personnel while working at the recipient facility. An invoice will be submitted to the recipient facility for reimbursement. Recipient facility shall pay to the Donor Facility all valid and invoiced Assistance Costs in a mutually agreed upon amount of time following the receipt of the Donor's invoice, for all of the Emergency Assistance services provided by the Donor.

All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

6. **Exceptions:** In the event that the Donor Facility is actually the Disaster Struck Facility that has evacuated and sent staff along with patients, it is the requirement of the Disaster Struck Facility to provide transportation to the staff during demobilization.

B. Transfer of Pharmaceuticals, Supplies or Equipment

1. **Communication of Request:** The Incident Commander or designee of the recipient facility authorizes the request. The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made verbally to the Incident Commander or designee of the Donor Facility. The request must be followed up with written documentation before pharmaceuticals, supplies or equipment will be released or verbal communication in the event of a technological failure and this will be followed by a written requisition form at the earliest possible time and prior to demobilization. The documentation may be sent by any available means including fax, radio, phone, e-mail, or courier.

The recipient facility will identify to the Donor Facility the following:

- a. The quantity and exact type of requested items.
- b. An estimate of how quickly the requested items are needed.
- c. Time period for which reusable supplies or equipment will be needed.
- d. Location to which, and to whom, the items should be delivered.
- e. Transportation method

The Donor Facility will identify how long it will take them to fulfill the request. A timely response to the requests is critical for effective disaster response.

2. **Documentation:** The Donor Facility will honor the recipient facility's standard order requisition form as documentation of the request and receipt of the materials. The receipt of supplies, equipment, and pharmaceuticals will be the responsibility of a designated individual within the recipient facility. The recipient facility's designee will confirm the receipt of the material resources. The documentation will detail the following:

- a. The items delivered.
- b. The condition of the equipment received (if applicable).
- c. Recipient facility's contact person for durable medical equipment or reusable supplies.

The recipient facility is responsible for tracking the borrowed inventory via their standard requisition system.

3. **Transporting of pharmaceuticals, supplies, or equipment:** The recipient facility is responsible for coordinating the transportation of materials both to and from the Donor Facility. The appropriate EOC will facilitate transportation when requested, and if available. This coordination may involve government and/or private organizations, and the Donor Facility may also offer transport. Upon request, the recipient facility must return and agree to pay or reimburse the transportation fees for returning or replacing all borrowed material.
4. **Supervision:** The recipient facility is responsible for appropriate use and maintenance of all borrowed pharmaceuticals, supplies, or equipment.
5. **Demobilization Procedures:** The recipient facility is responsible for the cleaning, maintenance, and prompt return of the borrowed equipment to the Donor Facility. It is expected that the equipment will be returned in good working order. Once the equipment is no longer in use, or upon resumption of normal operations, every reasonable effort will be made to replace the borrowed equipment or return it to the Donor Facility in a timeframe that is acceptable to both institutions. Upon the return of the equipment the original invoice will be co-signed by the Incident Commander or designee of the Donor Facility recording the condition of the returned equipment. A copy of the signed invoice will be provided to the Donor Facility as part of the tracking process.
6. **Payment for pharmaceuticals, supplies, or equipment:** If the Donor Facility requests reimbursement for materials and expenses, the recipient facility shall reimburse the Donor Facility for its costs in replacing any used, damaged, or lost pharmaceuticals, supplies, or equipment. The Donor Facility is expected to submit an invoice detailing the cost of the pharmaceuticals, supplies, equipment, maintenance, and transportation for reimbursement to the recipient facility. Recipient facility shall pay to the Donor Facility all valid and invoiced costs under this Section in a mutually agreed upon amount of time following the receipt of the Donor's invoice. In the event the Donor provides supplies or parts, the Donor shall have the option to accept payment of cash or in kind for the supplies or parts provided.

All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

C. Transfer/Evacuation of Patients

Please note that a facility is not required to provide beds with a Confirmed Admission as a bed for evacuated patient.

1. **Communication of request:** The Incident Commander or designee of the Disaster Struck Facility will authorize the decision to transfer or evacuate patients. Patients may be transferred or evacuated if facility conditions are not safe to continue to provide patient care. The request for the transfer or evacuation of patients initially can be made verbally to the senior administrator or designee of the Patient Accepting Facility. Requests for transfers or evacuation should be coordinated with Health & Medical Area Command with the exception being when there is an immediate threat to life and the local Authority Having Jurisdiction (AHJ) orders an evacuation of the facility or a situation whereby the Health & Medical Area Command is acting in a support role only in a situation where the Disaster Struck Facility, EMS and Patient Accepting Facilities have coordinated all patient transfers. The request must be followed up with written documentation prior to the actual transferring/evacuating of any patients or verbal communication in the event of a technological failure or immediate threat to life and this will be followed by a written requisition form at the earliest possible time and prior to demobilization. The documentation may be sent by any available means including fax, radio, phone, e-mail, or courier.

2. **Medical Staff:** The Patient Accepting Facility is also responsible for coordinating with the Medical Staff to assign a care provider. Whenever possible, the transferring physician will contact the receiving physician and provide information regarding the care. In the event that the physician is credentialed in both facilities, the physician may continue to care for the patient unless the disaster prevents this from occurring. If time and condition permits, patient permission for transfer should also be obtained.

3. **Documentation:** The Disaster Struck Facility will provide for the Patient Accepting Facility (certain disaster conditions may impact the ability to provide this information in a timely manner and all efforts should be made to accomplish this):
 - a. The number of patients needing to be transferred.
 - b. The general nature of their illness or condition.
 - c. Any type of specialized services required (i.e. cycler)
 - d. Patient condition reports given to the receiving facility's medical and nursing staff.
 - e. Mode of transportation
 - f. Expected time of arrival
 - g. *Resident Evacuation Tracking Form/Tag* for each patient
 - h. *Patient/Medical Record and Equipment Tracking Sheet* for the total number of patients to be provided as the last patient(s) arrive at the Patient Accepting Facility
 - i. If time and situation permits, the Disaster Struck Facility is responsible for providing the patient's complete medical records, insurance information and other patient information necessary for care. The Disaster Struck Facility is responsible for tracking the destination of all patients transferred out and providing such tracking information to the Health & Medical Area Command who will work in coordination with the Disaster Struck Facility and the Patient Accepting Facilities to ensure all patients are accounted for.
 - j. All HIPAA requirements should be maintained by the Participating Healthcare Facilities unless removed by Federal Waiver.

NOTE: Many facilities are moving towards or have achieved electronic medical records. If electronic medical records are currently in place, it is critical that a strong effort be made to provide a clear and concise Resident Evacuation Tracking Form in the event that access to the computers are limited. The facility should attempt to batch print the records, if possible, on each evacuating unit. Additionally, if the facility was unable to print the appropriate sections of the records prior to evacuation, it should be reviewed if the electronic medical record can be accessed from an off-site location and be printed out from that location to support patient care.

4. **Transporting of patients:** The Disaster Struck Facility is responsible for coordinating and financing the transportation of patients to the Patient Accepting Facility(ies). The transferring/evacuating facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) as time and condition permits along with the patient.
 - The Patient Accepting Facility will:
 - Designate a point of entry
 - Assign medical staff and other care providers
 - Identify the location for care
 - Communicate back to the transferring/evacuating facility to inform them of the receipt of the patients
 - Or Health & Medical Area Command will facilitate this communication if the transferring/evacuating facility is not accessible and all coordination has been channeled through Health & Medical Area Command.
5. **Supervision:** Once admitted, that patient becomes the Patient Accepting Facility's patient and under care of the Patient Accepting Facility's admitting physician until discharged, transferred or reassigned.
6. **Notification:** The Disaster Struck Facility is responsible for notifying both the patient's family or authorized surrogate decision maker and the patient's attending or personal physician of the situation. The Patient Accepting Facility may assist in notifying the patient's family and personal physician or a centralized Regional Call Center may assist in these efforts.
7. **Exceeding Licensed Bed Capacity:** It is the intent of this Mutual Aid Plan to support patients with placement into licensed beds. In situations where the bed capacity is going to exceed licensed beds, this will be addressed in conjunction with DSHS or with decisions being made by local Authorities Having Jurisdiction to protect the lives of patients.
 - A. Fast-out Evacuation: If you are receiving immediate transfers of evacuated patients from a Disaster Struck Facility, you are allowed to exceed the number of licensed beds by the amount stated in the plan (10%) and provide appropriate care for them in "open space" (i.e. activity rooms, OT/PT rooms, etc.) or in existing patient rooms.
 - Additionally, this disaster may include the movement of patients to a Stop Over Point (YMCA, Gymnasium, etc.) to provide protection of the patients until they can return to the Disaster Struck Facility or a

distributed to other area Patient Accepting Facilities. In coordination between Public Health - Seattle & King County, DSHS and the Patient Accepting Facility, a waiver will be requested (post-incident due to the fast-out evacuation.) If the disaster exceeds a certain period of time or the acuity of the patient dictates it, the patient may be moved to another facility with more capacity or beds available.

- B. Fast-out Evacuation or slow out but returning within a few days to the Disaster Struck Facility (usually this is a loss of HVAC during high heat or extreme cold, a fire that does not effect the safety of the patients but does require relocation, a generator failure during a power loss, etc). While the Mutual Aid Plan is activated and patients are being moved, additional requests and communication will take place through Health & Medical Area Command and DSHS to find open beds. The goal is to keep the patients in close proximity to the Disaster Struck Facility to ensure that staff from the evacuating facility can go with them, if necessary, and that families can visit them. Additionally, this disaster may include the movement of patients to a Stop Over Point to provide protection of the patients until they can return to the Disaster Struck Facility or a distributed to other area Patient Accepting Facilities. A waiver would be requested, as necessary, for a Patient Accepting Facility.
- C. Slow-out evacuation where the Disaster Struck Facility will clearly not be opening anytime soon (flooding inside the building, substantial fire, etc.)
 - a. This will involve movement of patients to open beds and may spread a larger geographic area. Patients may initially move into a local Patient Accepting Facility, but then patients without beds would be moved further out as the beds become available. A waiver may need to be requested for the short term care provided at a Patient Accepting Facility.

In each of these situations, the Patient Accepting Facility will work on preplanning how they can either open beds for the patients they receive (discharge of patients ready to go home and their bed is not accounted for yet) or ensure that every effort is being made to provide an appropriate level of care. It is assumed that patients may not have beds initially, but the planning should include requesting beds/equipment/supplies from other Mutual Aid Plan members not affected by the disaster, requesting beds/equipment/supplies from the town or city Emergency Operations Center, and requesting beds/equipment/supplies from vendors.

- 8. **Payment for Patient Care:** The member healthcare facilities will work with the appropriate payer (Medicare, Medicaid or Private Payer) to work through the payment of services for the care of patients.

If it is required that there be a division of payment, each party will attempt to work out the division of payment amicably and incorporate into the discussions, as necessary, the Washington State DSHS and the appropriate payer (private, state or federal.)

NOTE: Reimbursement covers facility costs but not necessarily ambulance/ transportation costs. Please review your facility specific business interruption insurance and agreements with private Emergency Medical Services transportation firms or private bus contracts.

NURSING FACILITIES (NF):

Emergency Involving NF to NF Transfer – Licensed Beds:

In the event that the patient **WILL** be able to return in 30 days, DSHS would continue to reimburse the disaster-struck facility during this 30 day period. It will be the responsibility of the two Nursing Facilities (disaster-struck and patient accepting) to divide the payment amicably and the allocation of DSHS member patient paid amounts.

In the event the patients will **NOT** be able to return in 30 days, the disaster-struck facility should proceed with discharge documentation on day 16 (DSHS does not pay for day of Discharge) and the Patient Accepting Facility should commence with admission procedures on day 16 for these DSHS members (DSHS does pay for day of Admission.)

In effect, on day 16 these patients would be treated like any new admission. The Patient Accepting Facility would follow all standard admission procedures and practices.

NOTE 1: DSHS may make a determination with the Disaster Struck Facility and the Patient Accepting Facility that the facilities should move forward with the discharge and admit process in advance of the day 15 decision-making process.

***NOTE 2:** Consistent with the Center for Medicare and Medicaid Services (CMS) guidelines, the discharge and admission process should be completed within the 30 day timeframe. It is understood that it would be impractical to completely discharge all patients from one Disaster Struck Facility and admit all of the patients in other facilities in one day. The key from a billing and payment standpoint regarding discharges and admissions is to ensure the discharge forms and the Admissions forms are filled out on the same day by the Disaster Struck Facility and the patient receiving facility. The day of discharge is not paid for, but the day of admissions is and would therefore limit the financial impact on both organizations.

** This model should be reviewed by other payers for acceptance. This approach would be accepted by CMS and the federal payer program as the language above was modified from the CMS guidelines released on 9/30/2007 in the Provider Survey and Certification FAQ on Declared Public Health Emergencies – All Hazards.*

Emergency Involving NF to NF Transfer: Un-licensed Beds – overflow/surge:

The same provisions as above would apply provided DSHS issues the necessary approvals (licensure and certification) to the Patient Accepting Facility to commence with and continue in an overflow situation.

The approvals would need to be effective from the first day of the emergency.

NOTE: It is assumed private paying patients will follow the same guideline above.

Patient Choice – Clarification Regarding Discharge from Facility with Emergency Situation:

In the event that a patient chooses, during the first 30 days of the emergency period to:

- a) become a full time patient of the Patient Accepting Facility OR
- b) wishes to transfer to a new Nursing Facility.

The Disaster Struck Facility should initiate standard discharge and transfer procedures while the Patient Accepting Facility should initiate standard admission practices. This situation may not be applicable whereby the facility does not have a contract with the insurance company or does not take Medicaid. Therefore a patient would not be allowed formal admission to the facility and a transfer request would be put into effect.

NOTE: While DSHS will continue to pay for a DSHS member during this 30 day period, the process does not prohibit or preclude a DSHS member from seeking a different nursing facility to care for their needs. In that event, standard operating procedures governing admissions and discharges would apply.

** This model should be reviewed by other payers for acceptance.*

VII. Payment for Services and Assistance

- A. All parties agree upon working to secure payments for emergency services and support amongst themselves (as detailed in Sections IV and VI). If there are any disputes, see XIII for Mediation and Arbitration approaches.
- B. All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

VIII. Term and Termination

- A. This LTC-MAP is effective upon execution by two or more Participating Healthcare Facilities.
- B. A Participating Healthcare Facility opting to terminate its participation in this LTC-MAP, shall provide written termination notification to the Preparedness Director at Public Health - Seattle & King County, [REDACTED], Phone at [REDACTED] or by Fax at [REDACTED]. Notice of termination becomes effective 60-days following receipt by Public Health -

Seattle & King County who shall, in turn, notify all Participating Agencies / Healthcare Facilities. Any terminating Participating Healthcare Facility shall remain liable for all obligations incurred during its period of participation, until the obligation is satisfied.

IX. Independent Contractor

Each party is an independent contractor with respect to the other parties of this MOU. Neither party is authorized or permitted to act or to claim to be acting as an agent or employee of the other party. Nothing in this Agreement alters in any way control of the management, assets or affairs of either party. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of any kind incurred by the other party to this Agreement. Nothing in this Agreement shall be construed as limiting the rights of either party to contract with any other facility on a limited or general basis.

X. Loans of Equipment

Use of equipment, such as construction equipment, road barricades, vehicles, and tools, shall be at the Donor Facility's current equipment rate, or if no written rates have been established, as mutually agreed between recipient facility and Donor Facility. Equipment and tool loans are subject to the following conditions:

- A. At the option of the Donor Facility, loaned equipment may be loaned with an operator. See XII for terms and conditions applicable to use of borrowed staff.
- B. Loaned equipment shall be returned to the Donor Facility upon release by the recipient facility, or immediately upon the recipient facility's receipt of an oral or written notice from the Donor Facility for the return of the equipment. When notified to return equipment to a Donor Facility, the recipient facility shall make every effort to return the equipment to the Donor Facility's possession within 24 hours following notification.
- C. Recipient facility shall, at its own expense, supply all fuel, lubrication and maintenance for loaned equipment. The recipient facility takes proper precaution in its operation, storage and maintenance of Donor's equipment. Equipment shall be used only by properly trained and supervised operators. Recipient facility takes responsibility to assure users are properly trained in the use of any equipment or supplies. Donor Facility shall endeavor to provide equipment in good working order. All equipment is provided "as is", with no representations or warranties as to its fitness for particular purpose.
- D. Donor Facility's cost related to the transportation, handling, and loading/unloading of equipment shall be chargeable to the recipient facility (if the Donor Facility request reimbursement for materials and expenses.) Donor Facility shall provide copies of invoices for such charges where provided by outside sources and shall provide hourly accounting of charges for Donor Facility's employees who perform such services.
- E. In the event loaned equipment is lost or damaged while being dispatched to recipient facility, or while in the custody and use of the recipient facility, or while being returned to the Donor Facility, recipient facility shall reimburse

the Donor Facility for the reasonable cost of repairing said damaged equipment. If the equipment cannot be repaired within a time period indicated by the Donor Facility, then recipient facility shall reimburse Donor for the cost of replacing such equipment with equipment, which is of equal condition and capability. Any determinations of what constitutes “equal condition and capability” shall be at the discretion of the Donor Facility. If Donor Facility must lease or rent a piece of equipment while the Donor Facility’s equipment is being repaired or replaced, recipient facility shall reimburse Donor for such costs. Recipient facility shall have the right of subrogation for all claims against persons other than parties to this LTC-MAP who may be responsible in whole or in part for damage to the equipment. Recipient facility shall not be liable for damage caused by the sole negligence of Donor Facility’s operator(s).

XI. Exchange of Materials and Supplies

If the Donor Facility requests reimbursement for materials and expenses, the recipient facility shall reimburse Donor Facility in kind or at Donor Facility’s actual replacement cost, plus handling charges, for use of partially consumed or non-returnable materials and supplies, as mutually agreed between recipient facility and Donor Facility. Other reusable materials and supplies which are returned to Donor in clean, damage-free condition shall not be charged to the recipient facility and no rental fee is charged. Donor Facility shall determine whether items returned are “clean and damage-free” and items shall be treated as partially consumed or non-returnable materials and supplies if item is found to be damaged.

XII. Loans of Staff

If the Donor Facility requests reimbursement for salaries and expenses, the recipient facility shall reimburse the Donor Facility appropriately. Donor Facility may, at its option, make such employees, as are willing to participate, available to recipient facility at recipient facility’s expense equal to Donor Facility’s full cost, including employee’s salary or hourly wages, call back or overtime costs, benefits and overhead, and consistent with Donor Facility’s personnel union contracts, if any, or other conditions of employment. Costs to feed and house loaned staff, if necessary, shall be chargeable to and paid by the recipient facility. The recipient facility is responsible for assuring such arrangements as may be necessary to provide for the safety, housing, meals, and transportation to and from job sites/housing sites (if necessary) for loaned staff. The Participating Healthcare Facility’s Emergency Contacts or their designees shall develop planning details associated with being a recipient facility or Donor Facility under the terms of this LTC-MAP Agreement. Donor Facility staff providing Emergency Assistance shall be under the operational control of the command structure of the recipient facility. Donor Facility shall not be liable for cessation or slowdown of work if Donor Facility’s employees decline or are reluctant to perform any assigned tasks if said employees judge such task to be unsafe.

XIII. Limitation of Liability and Disputes

- A. DELAY/FAILURE TO RESPOND. No Participating Healthcare Facility shall be liable to another Participating Healthcare Facility for, or be considered to be in breach of or default under this LTC-MAP Agreement on account of any delay in or failure to perform any obligation under this LTC-MAP

Agreement, except to make payment as specified in this LTC-MAP Agreement.

- B. **MEDIATION AND ARBITRATION.** If a dispute arises out of delay or failure to make payment, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation. Thereafter, any unresolved controversy or claim arising out of or relating to this Agreement, or breach thereof, may be settled by arbitration, if they agree to do so, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The parties to this Contract may seek to resolve disputes pursuant to mediation or arbitration, but are not required to do so.

XIV. Worker's Compensation and Employee Claims

Each party's employees, officers or agents, made available to a recipient facility, shall remain the general employee, officer or agents of such party while engaged in carrying out duties, functions or activities pursuant to this LTC-MAP Agreement, and such party shall remain fully responsible as employer for all taxes, assessments, fees, premiums, wages, withholdings, workers' compensation and other direct and indirect compensation, benefits, and related obligations with respect to its own employees. Likewise, each party shall provide worker's compensation in compliance with statutory requirements of the state of residency.

XV. Modifications

No provision of this LTC-MAP Agreement may be modified, altered, or rescinded by any individual Participating Healthcare Facility without two-thirds affirmative concurrence of the Participating Healthcare Facilities. Public Health - Seattle & King County is the coordinating body for facilitating modifications of this LTC-MAP Agreement. Modifications to this LTC-MAP Agreement must be in writing and becomes effective upon approval of the modification by a unanimous affirmative vote of the Participating Healthcare Facilities. Modifications must be signed by an authorized representative of each Participating Healthcare Facility.

XVI. Non-Exclusiveness and Prior Agreements

This Agreement shall not supersede any existing mutual aid agreement, transfer agreements or any other agreements between two or more Participating Healthcare Facilities, and as to assistance requested by a party to such mutual agreement within the scope of the mutual aid agreement, such assistance shall be governed by the terms of the mutual aid agreement and not by this LTC-MAP Agreement.

XVII. Governmental Authority and Law

This Agreement is subject to laws, rules, regulations, orders, and other requirements, now or hereafter in effect, of all governmental authorities having jurisdiction over the emergencies covered by this LTC-MAP Agreement, the Participating Healthcare Facility or either of them. This LTC-MAP Agreement shall be interpreted, construed, and enforced in accordance with the laws of Washington State.

XVIII. No Dedication of Facilities

No undertaking by one Participating Healthcare Facility to the other Participating Healthcare Facilities under any provision of this LTC-MAP Agreement shall constitute a dedication of the facilities or assets of such Participating Healthcare Facility, or any portion thereof, to the public or to the other Participating Healthcare Facility. Nothing in this LTC-MAP Agreement shall be construed to give a Participating Healthcare Facility any right of ownership, possession, use or control of the facilities or assets of the other Participating Healthcare Facility.

XIX. No Partnership

This LTC-MAP Agreement shall not be interpreted or construed to create an association, joint venture or partnership among the Participating Healthcare Facilities or to impose any partnership obligation or liability upon any Participating Healthcare Facility. Further, no Participating Healthcare Facility shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other Participating Healthcare Facility.

XX. No Third Party Beneficiary

Nothing in this LTC-MAP Agreement shall be construed to create any rights in or duties to any Third Party, nor any liability to or standard of care with reference to any Third Party. This Agreement shall not confer any right, or remedy upon any person other than the Participating Healthcare Facilities. This LTC-MAP Agreement shall not release or discharge any obligation or liability of any Third Party to any Participating Healthcare Facilities.

XXI. Entire Agreement

This Agreement constitutes the entire agreement amongst the Participating Healthcare Facilities.

XXII. Successors and Assigns

This LTC-MAP Agreement is not transferable or assignable, in whole or in part, and any Participating Healthcare Facility may terminate its participation in this LTC-MAP Agreement subject to XVI.

XXIII. Venue

Any action which may arise out of this LTC-MAP Agreement shall be brought in Washington State and King County.

XXIV. Waiver of Rights

Any waiver at any time by any Participating Healthcare Facilities of its rights with respect to a default under this LTC-MAP Agreement, or with respect to any other matter arising in connection with this Agreement, shall not constitute or be deemed a waiver with respect to any subsequent default or other matter arising in connection with this Agreement. Any delay short of the statutory period of limitations, in asserting or enforcing any right, shall not constitute or be deemed a waiver.

XXV. Invalid Provision

The invalidity or unenforceability of any provisions hereof, and this LTC-MAP Agreement shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

XXVI. Notices

Any notice, demand, information, report, or item otherwise required, authorized, or provided for in this LTC-MAP Agreement shall be conveyed and facilitated by the Public Health - Seattle & King County, [REDACTED] Phone at [REDACTED] or by Fax at [REDACTED]. Such notices, given in writing, and shall be deemed properly given if (i) delivered personally, (ii) transmitted and received by telephone facsimile device and confirmed by telephone, or (iii) sent by United States Mail, postage prepaid.

The document will be reconfirmed annually and be maintained at Public Health - Seattle & King County offices.

King County Memorandum of Understanding
Long Term Care Mutual Aid Plan (LTC-MAP)

This Memorandum of Understanding (MOU) is effective on [REDACTED] by and among signatory healthcare facilities, the designated representatives of which have signed hereto.

It is understood that ***this MOU is not a legally binding document***, but rather signifies the belief and commitment of the signatory healthcare facilities that in the event of a single facility, multiple facility and/or a region-wide disaster, the medical needs of the community will be best met if they cooperate and coordinate their response efforts.

This MOU and any attached exhibits constitute the entire MOU between the signatory healthcare facilities. Amendments to this MOU must be in writing and signed by participating healthcare facilities. A signatory healthcare facility may at anytime terminate its participation in the MOU by providing sixty-day written notice to the lead administrative agency for the LTC-MAP.

[REDACTED]

Signature

Date

Name (Printed)

Title

[REDACTED]

Signature

Date

Name (Printed)

Title

[REDACTED]

Signature

Date

Name (Printed)

Title

[REDACTED]

Signature

Date

Name (Printed)

Title

[Redacted]

Signature

Date

Name (Printed)

Title

[Redacted]

Signature

Date

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Multicounty MOU
MEMORANDUM OF UNDERSTANDING

Your organization provides the ability for a Region 6 / King County long term care facility to safely evacuate this special care population out of the region in a disaster.

The intent of this agreement is for your organization to agree to accept these patients from the Disaster Struck health care facilities as requested when the long term care facilities within King County are unable to provide appropriate levels of care for these patients.

You agree to the language and content of this Long Term Care Mutual Aid Plan (LTC-MAP) and its terms to support the transfer/evacuation of these patients to your member facilities.

It is important that you maintain an updated 24/7 contact number within this LTC-MAP.

Name of County / Agency / Organization [PRINT]: _____

Name of Person Representing this County / Region / Organization: [PRINT]:

Name: _____

Signature: _____

Date: _____

24/7 Contact Name and Phone Number [PRINT]:

ATTACHMENT A

AGGREGATE PATIENT CATEGORIES OF CARE

FACILITY INFORMATION

- ADDRESSES AND PHONE NUMBERS
- PATIENT CATEGORIES OF CARE
- BEDS & SURGE CAPACITY NUMBERS
- STOP OVER POINTS
- TRANSPORTATION RESOURCES
- EVACUATION SITES (HEALTHCARE FACILITIES)

(Currently on Website)



ATTACHMENT B: CONTACTS

CONTACTS

- EMERGENCY ACTIVATION PHONE NUMBERS
- FACILITY EMERGENCY CONTACTS (Currently on Website
[REDACTED])
- LOCAL AND COUNTY PHONE NUMBERS

ATTACHMENT B: CONTACTS

EMERGENCY PHONE NUMBERS FOR PLAN ACTIVATION AND STATE RESOURCES

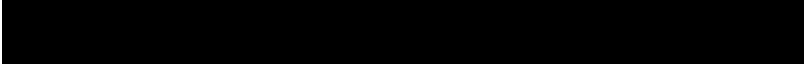
For Any Potentially Life Threatening Emergency, Contact 9-1-1

Main Office/Region	Primary Phone	Alternate Phone
Hospital Control – [REDACTED] (Primary)	[REDACTED]	[REDACTED] (Charge Nurse)
Hospital Control – [REDACTED] (Back-up)	[REDACTED]	
Public Health Duty Officer	[REDACTED] (activation mode for Health & Medical Area Command)	
Washington State Emergency Management Division (EMD) and Emergency Operations Center (EOC)	[REDACTED] or [REDACTED] for 24/7 emergency phone numbers	[REDACTED] for State EOC, if active
Washington State Department of Health	[REDACTED] or [REDACTED] (24/7 DoH Duty Officer)	
Western Washington Medical Services Communications Team (A.R.E.S. Medical Services Teams)	Text or Numeric Page: [REDACTED] (USA Mobility)	

ATTACHMENT B: CONTACTS

➤ **FACILITY EMERGENCY CONTACTS**

(Currently on Website)



ATTACHMENT B: CONTACTS (INCOMPLETE AS OF 1.28.10)

LOCAL AND COUNTY EMERGENCY CONTACTS

CITY OF AUBURN									UPDATED 9/17/08
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#	
PRIMARY	██████████	██████████	██████████			██████████	██████████	██████████	
SECONDARY	██████████	██████████	██████████			██████████	██████████	██████████	
TERTIARY	██████████	██████████	██████████		██████████	██████████	██████████	██████████	
EMERGENCY OPERATIONS		██████████			██████████				
ValleyComm/ 24-7		██████████							
800 MHz PRIMARY TALKGROUP = ██████████					VHF/HAM: ██████████				
800 MHz SCANLIST:	██████████	██████████							
CITY OF BELLEVUE									
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#	
PRIMARY	██████████	██████████	██████████			██████████			
SECONDARY	██████████	██████████	██████████			██████████			
TERTIARY	██████████	██████████	██████████			██████████			
ECC/EOC / 24-7		██████████	██████████						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:				
800 MHz SCANLIST:	██████████	██████████							

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF BOTHELL								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF BURIEN								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████	██████████		██████████	██████████	██████████	
SECONDARY	██████████	██████████	██████████	██████████	██████████	██████████	██████████	
TERTIARY	██████████	██████████	██████████	██████████	██████████	██████████	██████████	
ECC/EOC		██████████						
ValleyComm /24-7		██████████						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF DES MOINES								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

As of:
9/11/08

CITY OF ENUMCLAW								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████	██████████		██████████	██████████		
SECONDARY	██████████	██████████	██████████					
TERTIARY	██████████	██████████	██████████					
ECC/EOC		██████████		██████████	██████████			
800 MHz PRIMARY TALKGROUP =					VHF/HAM: ██████████			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF FEDERAL WAY								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████	██████████		██████████	██████████	██████████	
SECONDARY	██████████	██████████	██████████		██████████	██████████	██████████	
TERTIARY								
ECC/EOC		██████████						
ValleyComm / 24-7		██████████						
800 MHz PRIMARY TALKGROUP =					VHF/HAM: ██████████			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF ISSAQUAH								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████	██████████	██████████		██████████		
SECONDARY	██████████	██████████	██████████			██████████		
TERTIARY	██████████	██████████	██████████			██████████		
ECC/EOC		██████████						
Police Dispatch / 24-7		██████████						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████						

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF KENT								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF KIRKLAND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	Helen ██████████	██████████	██████████	██████████		██████████		
SECONDARY	██████████	██████████	██████████			██████████		
TERTIARY	██████████	██████████	██████████			██████████		
ECC/EOC		██████████						
24/7		██████████						
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████						

As of:
9/11/08

MERCER ISLAND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF NORTH BEND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF REDMOND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████	██████████	██████████		██████████		
SECONDARY	██████████	██████████	██████████			██████████		
TERTIARY	██████████	██████████	██████████			██████████		
ECC/EOC		██████████	██████████		██████████			
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████						

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF RENTON								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
SECONDARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
TERTIARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
TERTIARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]		
ALT- COMM.	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]				
ECC/EOC		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
ALT-ECC COOR.	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
800 MHz PRIMARY TALKGROUP = [REDACTED]					VHF/HAM: [REDACTED]			
800 MHz SCANLIST:	[REDACTED]	[REDACTED]	[REDACTED]		Portable sat Phone [REDACTED]			
CITY OF SEATTLE								
As of: 9/11/08								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
SECONDARY	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		
TERTIARY								
ECC/EOC - 105 5th Avenue South; Seattle 98104		[REDACTED]				[REDACTED]		
Staff Duty Officer / 24-7		[REDACTED]						
					VHF/HAM: [REDACTED]			
800 MHz SCANLIST:	[REDACTED]							

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF SHORELINE								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

CITY OF SNOQUALMIE								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY	██████████	██████████				██████████		
SECONDARY	██████████	██████████				██████████		
TERTIARY								
ECC/EOC / 24-7		██████████			██████████	██████████		
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████						

CITY OF TUKWILA								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:	██████████	██████████	██████████					

ATTACHMENT B: LOCAL & COUNTY EMERGENCY CONTACTS (Cont.)

CITY OF VASHON								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
ECC/EOC								
ValleyComm /24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:								

KING COUNTY EM								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
Duty Officer								
KC ECC								
3511 NE 2nd St.								
800 MHz PRIMARY TALKGROUP =KC EOC COMMON					VHF: Primary Secondary			
800 MHz SCANLIST:								

As of:
9/11/08

HEALTH & MEDICAL AREA COMMAND								
PLANNING CONTACT INFORMATION	NAME	OFFICE	CELL	PAGER	FAX	E-MAIL	NEXTEL DC#	NEXTEL PIN#
PRIMARY								
SECONDARY								
TERTIARY								
EOC / Public Health Duty Officer / 24-7								
800 MHz PRIMARY TALKGROUP =					VHF/HAM:			
800 MHz SCANLIST:								

ATTACHMENT C

AGGREGATE TRANSPORT NUMBERS FROM TRANSPORTATION EVACUATION SURVEY

Organization Name, City	Region (5 or 6)	Total Number of Residents	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Bariatric Residents (included in overall Total)	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Discharge Home Residents (included in overall Total)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Special Notes
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	[REDACTED]

ATTACHMENT C (CONT.)

AGGREGATE TRANSPORT NUMBERS FROM TRANSPORTATION EVACUATION SURVEY

Organization Name, City	Region (5 or 6)	Total Number of Residents	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Bariatric Residents (included in overall Total)	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Discharge Home Residents (included in overall Total)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Special Notes
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

ATTACHMENT C (CONT.)

AGGREGATE TRANSPORT NUMBERS FROM TRANSPORTATION EVACUATION SURVEY

Organization Name, City	Region (5 or 6)	Total Number of Residents	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Bariatric Residents (included in overall Total)	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Discharge Home Residents (included in overall Total)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Special Notes
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

**ATTACHMENT C (CONT.)
AGGREGATE TRANSPORT NUMBERS FROM TRANSPORTATION EVACUATION SURVEY**

Organization Name, City	Region (5 or 6)	Total Number of Residents	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Bariatric Residents (included in overall Total)	ALS Transport (Paramedic)	BLS Transport (EMT)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Total # of Discharge Home Residents (included in overall Total)	Wheelchair Accessible Vehicle	Normal (bus, etc.)	Special Notes
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
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ATTACHMENT C (CONT.)

AGGREGATE TRANSPORT NUMBERS FROM TRANSPORTATION EVACUATION SURVEY

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[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
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[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	
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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
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[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]		[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	

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[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

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[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	
[REDACTED]	1	■		■	■	■	■		■	■	■	■	■	■	
[REDACTED]		■		■	■	■	■		■	■	■	■	■	■	

ATTACHMENT D:

AGGREGATE FACILITY-SPECIFIC EQUIPMENT AND SUPPLIES

(Currently on Website)

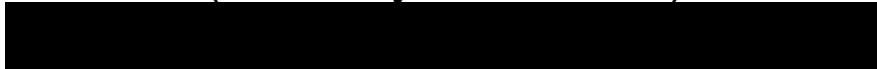


ATTACHMENT D:

INDIVIDUAL FACILITY EQUIPMENT AND SUPPLIES

EQUIPMENT AND SUPPLIES

(Currently on Website)



**ATTACHMENT D:
VENDOR LISTS**

(Currently on Website)



ATTACHMENT E

FORMS

(see attachment)

- **Resident Evacuation Tracking Form / Tag**
- **Patient / Medical Record and Equipment Tracking Sheet**
- **Controlled Substance Receiving Log**
- **Influx of Patients Log (completed as patients enter the facility)**
- **Health & Medical Area Command & Disaster Struck Facility Patient Tracking Spreadsheet (Aggregate)**

ATTACHMENT F

VENDOR MEMORANDUM OF AGREEMENT

The Region 6 (King County) Long Term Care Mutual Aid Plan (hereafter "LTC-MAP") and _____ (hereafter "Supporting Vendor") agree to provide support to one another in a local and regional disaster and in times of normalcy.

WHEREAS, the LTC-MAP Members have expressed a mutual interest in the establishment of an Agreement with Supporting Vendor to facilitate and encourage Emergency Assistance during a local or regional disaster; and

WHEREAS, in the event of a disaster, an LTC-MAP Member may need Emergency Assistance in the form of supplemental staff, equipment, transportation, supplies or other support; and

WHEREAS, the Supporting Vendor agrees to provide _____ (insert products and services) to the LTC-MAP Members to enable them to continue to provide care to their patients in a disaster situation; and

WHEREAS, the LTC-MAP agrees to notify all Members of the willingness of the Supporting Vendor to sign on to the plan and recommit this participation annually with the Supporting Vendor and all Members; and

WHEREAS, each LTC-MAP Member who requests services from the Supporting Vendor will at minimum provide a verbal order followed by a written order in the form of a fax (if technology systems are functioning) and will provide subsequent payment in a timely manner once the effects of the disaster have been mitigated.

NOW THEREFORE, in consideration of the Agreement hereinafter set forth, the undersigned Supporting Vendor agrees as follows:

- Supporting Vendor provides needed items to health care facilities located in Region 6 / King County (see attached listing).
- The intent of this Agreement is for Supporting Vendor to agree to deliver products or services to the Disaster Struck Health Care Facilities when requested when these health care facilities are unable to obtain the needed supplies, equipment and/or transportation.
- The Supporting Vendor also agrees to deliver to any LTC-MAP member facility who calls for assistance, regardless of existing contracts. The requesting facility(ies) will fax (if possible) their request. This written request can be used at police roadblocks to help justify the need to reach the Disaster Struck Facility(ies). Payment will be made by the requesting facility(ies). This payment commitment is confirmed when the LTC-MAP members sign the LTC-MAP Memorandum of Understanding.

- It is understood by the LTC-MAP that if the Supporting Vendor is impacted by the disaster or extensive needs arise by the Supporting Vendors' existing client base due to the disaster, the Supporting Vendor is not obligated to provide goods or services and should make the Local Emergency Operations Center or King County Emergency Operations Center (for non-medical equipment and supplies) or the Health & Medical Area Command (for medical equipment & supplies) aware of the situation.

It is important that the Supporting Vendor maintain an updated 24/7 contact number within this LTC-MAP.

Name of Vendor Company [PRINT]: _____

Name of Person Representing this Vendor: [PRINT]: _____

Signature: _____

24/7 Contact Name and Phone Number [PRINT]:

Decision on Signatory

[SIGNATURE]: _____

Printed Name: _____

Organization: _____

*NOTE: Potential signatories include: Private EMS, Local Municipalities, Fuel Suppliers, Pharmaceutical Suppliers, Medical Equipment Suppliers, etc.

ATTACHMENT F

SAMPLE STOP OVER POINT AGREEMENT / TOOLS

- **Stop Over Point Memorandum of Understanding (Sample)**
- **Stop Over Point Guide (Sample)**
- **Stop Over Point Cover Sheet (Sample)**
- **Stop Over Point Survey Tool (Sample)**

MEMORANDUM OF AGREEMENT (SAMPLE)

STOP OVER POINT

The below listed Participants, by affixing their signatures to this Memorandum of Agreement (MOA), agree in principle to voluntarily coordinate mutual aid service with each other in a good faith effort to maximize the ability of participants to provide patient care when the health care facility is forced into an evacuation.

_____ (“Health Care Facility”)

_____ (“Stop Over Point”)

I. Scope and Applicability

The Participants agree that, in the event of a natural or unnatural disaster which precipitates an evacuation of the Health Care Facility (hereinafter "Event"), the Health Care Facility may request assistance from the Stop Over Point in allowing the Health Care Facility to convert a part of the Stop Over Point into a Temporary Medical Care location in order to provide patient care during the crisis. This MOA shall govern the Stop Over Point for activation and support. A Stop Over Point should not be in operation for greater than 3 days and will typically be in operation for a period of 2 – 8 hours.

Each Participant agrees to take all appropriate actions without regard to race, color, creed, national origin, age, sex, gender orientation, religion, or handicap to assist the Health Care Facility as necessary, and agrees to follow the guidelines set forth herein to the extent possible. There shall be no cause of action or basis of liability for breach of this MOA by either Participant against the other Participant.

This MOA is not intended to replace the Health Care Facility’s Disaster Plan or to adversely affect existing transfer agreements between other health care facilities, but is intended to support those plans and agreements. Each Participant shall incorporate this MOA into its disaster plan consistent with the provisions agreed to herein.

II. Guidelines

A. SUPPLIES AND EQUIPMENT

The Stop Over Point shall provide habitable space and other requested areas, use of existing infrastructure, and equipment as described below. It is recognized that the Long Term Care Mutual Aid Plan for Evacuation and Resources / Assets intends to provide necessary supplies and equipment to support the Stop Over Point, and that the Stop Over Point shall not be required to expend additional resources outside its normal operations to establish the Stop Over Point.

The Stop Over Point will permit the Health Care Facility to use and operate its physical facilities and equipment, including but not necessarily limited to:

Designated areas of the Stop Over Point (list):

- _____

- Office equipment including telephones, copy machines, computers, fax machines
- Tables, chairs, desks, cots, wheelchairs
- Refrigerators
- Other equipment, materials, or resources, including but not limited to:

- Other resources and materials as mutually agreed upon by Participants to be utilized during an Event are incorporated by reference in this agreement.

B. POINTS OF CONTACT

The Stop Over Point will designate two points of contact:

- An administrator who will serve as the primary point of contact and who has authority to open the building.
- A building maintenance and systems point of contact, to include or in addition to a janitorial point of contact who will work with Stop Over Point personnel to move tables, chairs, etc.

The Health Care Facility will provide a point of contact to answer any questions that the Stop Over Point may have.

	Health Care Facility	Stop Over Point
Contact:	_____	_____
Title:	_____	_____
Phone:	_____	_____
Alternate:	_____	_____

C. OTHER AGREEMENTS

The Stop Over Point will allow visits to the Stop Over Point by members of the Health Care Facility, the local health department, local and/or state law enforcement and Washington State Department of Social and Health Services (DSHS) for the development and maintenance of a Stop Over Point plan. The Facility understands that these visits may take place before a disaster (for advance planning purposes), and/or while the Stop Over Point is serving as a Stop Over Point.

The Stop Over Point will encourage personnel to volunteer to work at the site, or to assist in other response activities. The Health Care Facility and the Stop Over Point shall develop and provide an appropriate notice to any volunteers that provide services to the Stop Over Point indicating that their services shall neither be compensated nor covered by any general liability or workers compensations insurance coverage.

The Health Care Facility will coordinate the provision of extra support personnel, and will provide any post-event cleanup that is needed.

It is understood that the Stop Over Point will maintain and does not relinquish its flexibility to make arrangements that will minimize the disruption that serving as a Stop Over Point site could entail.

D. COST OF SERVICES, EQUIPMENT, AND PERSONNEL.

The Health Care Facility may attempt to seek reimbursement for patient care provided during the activation and operation of the Stop Over Point pursuant to the Health Care Facility's applicable credit and collection policies, or through available public or private resources. The Health Care Facility recognizes and agrees that it shall be responsible for covering the costs required in providing the patient care, as well as covering the operational costs of the Facility. Such operational costs shall be mutually agreed upon by the Participants including, but not limited to, utilities and supplies that are used during the Stop Over Point activation and operation. The Health Care Facility shall coordinate with the Stop Over Point to ensure that appropriate property and/or casualty insurance is provided. The Health Care Facility and Stop Over Point shall further not be responsible to pay for any resources or supplies provided by a public or private entity to run the Stop Over Point, pursuant to an understanding that such resources and supplies are freely given.

Both Participants agree to help each other in providing documentation that may be necessary in seeking reimbursement for expenses from any private, state or federal payer programs, Washington State Emergency Management Division, the Federal Emergency Management Agency, or any other public or private entity. Both Participants recognize that this MOA is executed without knowing what those reimbursements may be or whether there will be any reimbursement forthcoming that precipitates the activation of this agreement.

III. Effective Date, Future Amendment, and Construction

This MOA shall become effective on _____. The date at which it becomes active shall be determined by the Health Care Facility and DSHS through appropriate notice to the contacts determined throughout this MOA. Either Participant may terminate its participation in this MOA by giving 120 days written notice to the other Participant of its intentions to terminate.

This MOA shall be reviewed periodically to ensure that it meets the requirements of the Participants.

This MOA shall automatically terminate after three (3) years; i.e. on _____. The Participants agree to review any renewal agreements before that time and renew it if necessary.

_____ [Stop Over Point] has reviewed and approves the provisions of this agreement.

Facility Chief Executive Officer/Administrator Date

_____ [Health Care Facility] has reviewed and approves the provisions of this agreement.

Health Care Facility Chief Executive Officer/Administrator Date

Stop Over Point Selection and Survey Guide

OVERVIEW:

This guide is designed to assist you in completing the Stop Over Point Survey to select suitable locations to be established for a slow or fast-out evacuation for an isolated, local or regional disaster. The intent is to use this site in the event the facility is:

- ① Quickly forced to the sidewalk in adverse conditions and sheltering is necessary for the patients
- ① Evacuated from the facility yet the facility should be able to reopen in a short period of time (hours instead of days)
- ① It is safer to move the patients to a Stop Over Point instead of distributing them at greater distances due to regional conditions.

Most questions will be answered with a simple “yes” or “no.” Supporting information should be filled in based on questions in the Comments section, clarifications listed in this document or with Additional Information based on your observations.

NOTE: If it is 25 degrees outside and there is snow falling – if you are forced to evacuate to the sidewalk, where can you go right away to shelter your patients?

I. SITE LOCATION

- Enter the site name and other information about their location and contact information.
- Type of Facility: This will be either Public or Private.
- Type of Business/Use: This helps us to understand the reality of how long we will be able to keep the Stop Over Point operational and additional resources that can be utilized to prepare the site to accept equipment.
- Duration of Potential Use: In a disaster, how long would you be able to move operations in order to allow the Stop Over Point to function?
- Site Availability: Can the site be made available and prepared to accept people and equipment within 4 hours or greater? This is focusing on how quickly you can A) get someone there to open the facility and/or B) clear the space in order to begin bringing in the supplies.
- Is the site available 24 hours? If not, is there anything that can be done to make it available 24 hours a day – security, etc.
- Are there any other agreements in place for the use of the facility? This may include them being a Red Cross Shelter, special needs shelter or a Point of Distribution. If so, we will need to consider abandoning this site as there could be contradictory needs.

III. FACILITY PHYSICAL CHARACTERISTICS

- Security: What is the type of security in place: Guards, electronic lockdown, cameras, etc.?
- Structural Integrity of Floors, Roofs and Walls: Are they structurally sound based on cracks, integrity issues, decrepit condition, etc.?
- Location Hazards: Town maps and facility experiences will verify flood zone information. Other dangers can be observed by an exterior tour.
- Electrical Power: For getting power to the patient care floor, this should be reviewed as to how they may have done it in the past and what mechanisms are currently in place to support outlets for the patient care floor.
- Electrical Power: In dealing with generator hook-up capability, this has proven to be an issue in many regional disasters. It can be fixed, but the question needs to be asked about if they have hooked up a generator before and/or if they are set-up to accept a generator (what size).
- Electrical Power: Additional questions may be added on such things as lighting to find out if they are not 100%, what is actually covered.
- Refrigeration: Appropriate contracts for use of refrigeration trucks or other sources may be acceptable. Detail this and ask for the written agreements.
- Fire Safety: In the comments, put in if the facility is fully sprinkled and detected. The carbon monoxide detectors are important due to trucks, ambulances and cooking under unique conditions that the facility may not have initially been designed for. May present a risk to staff and patients.
- Food Supply and Prep Area: Detail what they have currently and add additional information for what could be made available based on current capabilities.
- Laundry Service Area: How many commercial washers and dryers?
- Accessibility/Proximity to Public Transportation: We are most concerned with understanding if this facility will be obstructing other services and is the site easily accessible for staff, patients, suppliers, Emergency Medical Services and family.
- Facility Services: This should help to understand what services we could potentially receive from the site and where we will need to augment services.
- NOTES: Please attempt to get clean floor plans so that that logistics and operations can review the patient flow and supply flow for the facility. Additionally, the more pictures that can be provided, along with video footage, would be beneficial.

Stop Over Point
Evaluation Cover Sheet

I. SITE LOCATION

Site Name: _____ Type of Facility: Private / Public / Other: _____

Address: _____ Type of Business/Use: _____

City: _____ Duration of Potential Use: _____

Zip Code: _____

Telephone: _____ Fax: _____

Can the site be made available and prepared to accept people and equipment:

Within 4 hours of request? YES NO

> 4 hours of request? YES NO

Total Estimated Amount of Time: _____

Is the site available 24 hours? YES NO

Can the map be posted on the web, if necessary? YES NO

Is the site familiar to the local population? YES NO

Are there any other agreements in place for use of the facility in an emergency (ie: Shelter, POD)? YES NO

II. CONTACT INFORMATION

Primary Contact:

Secondary Contact:

Name: _____

Position: _____

Phone Number: _____

Cell Phone: _____

E-mail Addresses: _____

Can the contact person be contacted after hours and on holidays?

YES NO YES NO

If yes, what is the best way to contact the each person after hours and on holidays?

Stop Over Point
Survey Tool

BUILDING INFRASTRUCTURE		Comments	Additional Information / Notes
<p>Building & Perimeter Security: -To monitor patient traffic -To control ingress/egress -To secure perimeter</p> <p>Doors: -Minimum 33" for gurney</p> <p>-Entry and internal doors ADA compliant</p> <p>Floors: -Tile or other hard cleanable surface in patient care area -Condition: Structurally Sound</p> <p>Roof: -Condition: Structurally Sound</p> <p>Walls: -Condition: Structurally Sound</p> <p>Location Hazards: -Flood Zone (building or access routes to the building) -Danger from falling trees or projectiles (stone ballast roof) in high wind conditions</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Type of Security: _____</p> <p>One external entry way and one to enter bedding area.</p>	

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<p>Loading/Unloading Area: -Supply delivery area able to accommodate semis or box trucks? -Do you have a loading area? -Is forklift, pallet jack & operator available?</p> <p>Parking: -Is parking available? -Adjacent lots available? -Is the parking area lit? -Alternate parking capabilities</p> <p>TOILETS/SHOWERS: Men's Room: Total number of: -Toilets/urinal (ADA) -Showers (ADA)</p> <p>Women's Room: Total number of: -Toilets (ADA) -Showers (ADA)</p> <p>-Are bathrooms/showers accessible without using stairs? -Are men's & women's bathrooms separate from each other?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Number of spaces: _____</p> <p>Number of spaces: _____</p> <p>Distance? _____ Comments: _____</p> <p># of Toilets/Urinals: _____</p> <p># of Showers: _____</p> <p># of Toilets/Urinals: _____</p> <p># of Showers: _____</p>	<p>For a school, # if school is out: _____</p>

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<p>Lighting: Dimmer switch in sleeping area? Is sufficient lighting available?</p> <p>Fire Safety: -Does facility have sprinklers? -Does facility have fire alarms? -Does facility have smoke detectors? -Does facility have carbon monoxide detectors (exhaust issues)?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Auxiliary lighting can be brought in to supplement internal and external needs with FD approval.</p>	
<p>TOTAL SPACE & LAYOUT:</p> <p>Auxiliary Rooms/Space: Are there rooms that could be considered appropriate for: -Chapel/Family Counseling -Common Area / Family rest area -Waiting area -Incident Command/Communications -Security Office -Medical / Pharmacy / Storage Area -Equipment / Supply Area</p> <p>Open bedding area: -What is the square footage of open space?</p> <p>Secured Areas: -Are there areas that can be locked down and secured?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Please provide square footage for each separate room and of all open space.</p> <p>Total Square Footage: _____ Individual Room Square Footage (list below):</p> <p>Open Area Square Footage: _____</p> <p>Square Footage of those spaces: _____ _____</p>	

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<p>Floor Layout: -Are the open areas at grade level? -If not, are there elevators available for other floors?</p> <p>Staff Break Area: -Quiet and isolated in secured area -Staff bathrooms -Staff sleeping area -Staff showers</p> <p>Food Supply and Prep Area: -Full commercial kitchen -Warming kitchen -Partial kitchen -Walk-in refrigerator/freezer</p> <p>Laundry Services Area: Commercial Washers/Dryers?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Is there a Cafeteria: Yes / No How many people can it hold: _____</p>	
<p>COMMUNICATIONS:</p> <p>Phones: -Analog phone lines? -Digital phone lines? and ports available per room/area. -Fax availability -Cell phone friendly with no interference or signal shielding which could affect connectivity.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>How many: _____ How many: _____ Ports per room: _____ Carriers (if known): _____</p>	

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<p>Two-way Radio/800 mhz/Ham Radio: -No interference or signal shielding which could affect transmissions? Is there a room with an antenna feed?</p> <p>IT and Internet Access: -Is it wired for internet access and IT? -Capacity to add additional ports as needed. -Wireless friendly with no interference or signal shielding which could affect connectivity. -Wired for CAT 5 or above?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Number of Ports Available: _____</p>	
<p>OTHER SERVICES:</p> <p>Accessibility/Proximity to Public Transportation: -Located on/near Public Transportation -Located on/near congested roadway? -Located on/near Interstate Highway -Will the location interfere with Fire, Police or EMS response</p> <p>Proximity to an area hospital:</p> <p>Proximity to an area shelter:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Driving Time: _____ Facility/Facilities Name: _____</p> <p>Driving Time: _____ Facility Name: _____</p>	

FACILITIES SERVICES:

During operations, can the facility provide these services or do so with outside vendors . . .

- | | | |
|----------------------|------------------------------|-----------------------------|
| Bio-waste Removal | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Janitorial Services | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food Service | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Restroom Maintenance | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Security | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Laundry Services | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

NOTE 1: Agreements with vendors must be in place for any service not provided by the facility.

NOTE 2: A building survey should take place to verify the safety & integrity of the structure by an appropriate Building Inspector or Town Engineer.

***Attach Facility Layout and Flow Plan: If Accepted as a Stop Over Point, Create and Attach Facility Map for Pre-established Location of Services. Include Digital Pictures and any Video of the Site**