

**Puget Sound**

**Region**

December 3, 2013

**Regional Catastrophic Disaster Coordination Plan**

**Situational Status and Medical Surge Support Tool**

# Introduction

The Situational Status and Medical Surge Support Tool seeks to assist Public Health officials, Disaster Medical Control Centers (DMCC’s) and Emergency Managers from the Puget Sound Area regarding the activation, placement and prioritization of medical surge strategies and capabilities. The goal is to develop prioritization and coordination tools to support recommendations regarding the selection of surge strategy and location of medical surge assets across multiple counties. -The below-mentioned tools and templates will assist and inform decision makers at the county, state and federal level within the established procedures, policies and protocols for resource requests and deployment.

## A. Purpose

The Situational Status and Medical Surge Support Tool (“tool”) provides guidance to Local Health Officers, local emergency managers, Disaster Medical Control Centers, the Washington Emergency Management Division and the Washington Department of Health in reaching consensus recommendations regarding activation, prioritization and placement of state, federal and mutual aid medical surge assets across a multi-county area following a catastrophic disaster.

## B. Scope

The tool may be activated for any catastrophic disaster when determined necessary by the Local Health Officer of any of the eight counties identified in the Puget Sound Region Catastrophic Coordination plan. As standard practice the activation of the tool should always occur following a catastrophic incident. Examples of this include earthquakes, major volcanic eruptions or widespread terrorist attack. The tool is not intended to be utilized during routine operations or lower level disasters or incidents where medical surge assets from outside the impact area are not expected to be needed to meet patient care needs; however, individual jurisdictions are welcome to use their county’s tab of the tool if it aids in answering questions during routine disaster response.

Local health officers should expect a very high-level overview of healthcare conditions to be generated after a catastrophic when using this tool. It recognizes that different jurisdictions may be operating from different environments with respect to the type of care offered, types of patients seen, and baseline levels of care. This tool attempts to provide local health officers with a snapshot of the most pressing issues; namely whether people are able to receive life-saving care in their jurisdiction and whether that jurisdiction will need and can accommodate medical surge resources.

**Definitions**

**Alternate Care Facilities (ACF)**: An area where long term (usually longer than 48 hours) medical needs sheltering, urgent (non-acute) care services, and select traditional inpatient services are not usually provided, but which is deliberately repurposed for provision of such services during disasters that overwhelm the existing healthcare system. Locations of potential ACF’s are usually pre-identified, and the ACF is considered part of the healthcare system’s strategy to augment surge capacity.

**Catastrophic Incident**: Any Natural or manmade incident, including terrorism, which results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.

**Disaster Medical Assistance Team (DMAT)**: A group of professional and para-professional medical personnel organized to provide rapid-response medical care or casualty decontamination during a terrorist attack, natural disaster, or other incident in the United States. DMAT’s are part of the National Disaster Medical System and operate under the authority of the Department of Health and Human Services (HHS).

**Disaster Medical Control Center (DMCC)**: The hospital responsible for providing EMS with a planned distribution of patients to area hospitals based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution.

**Federal Medical Station**: A Federal, deployable all-hazards medical asset designed to support and integrate inside of regional, state, tribal and local healthcare agencies responding to catastrophic events.

**Emergency Operations Center (EOC)**: The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place

**Mass Casualty Incident**: Any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident.

**National Disaster Medical System (NDMS)**: A Federally coordinated system that augments the nation’s medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters.

**Puget Sound Region**: The Puget Sound Region is defined as the Seattle Urban Area (UA)/Combined Statistical Area (CSA), which includes the eight Puget Sound Counties: Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Thurston.

**Situational Awareness**: The ability to identify, process, and comprehend the critical elements of information of an incident.

# Planning Assumptions

Catastrophic incidents may produce a significant number of patients requiring medical evaluation and treatment. Such incidents may overwhelm or severely disrupt the existing healthcare system.

Hospitals and other healthcare facilities may be severely damaged or destroyed in a catastrophe.

Critical infrastructure needed to support the delivery of healthcare may be damaged or destroyed in a catastrophe.

In a catastrophic incident there may be insufficient staffing to meet the demands on the healthcare system.

In a catastrophic incident there may be insufficient resources and assets to meet the demands on the healthcare system.

Information gathering following a catastrophic event is a dynamic process. Estimates may be inaccurate, and circumstances might change rapidly at any given time.

# Activation and Notification

## A. Activation Authority

Any Local Health Officer will notify all local health departments within the Puget Sound Region and the State Department of Health. Notification will occur via e-mail, telephone, text message or 800 MHz radio depending on communications availability. Each local health department will use internal procedures to gather information needed to complete the Patient Care and ACF/FMS tabs.

# Work Flow

## A. Gathering and Entering Data

Once a catastrophic incident occurs, each local jurisdiction should begin gathering information necessary to populate the tool. The information should be entered into the spreadsheet as soon as practical. One jurisdiction will volunteer to collate data, schedule conference calls, ensure data is entered, and answer questions from other jurisdictions, for the entire region once the tool is activated, and will communicate their role to all participating jurisdictions [ideally this would be a jurisdiction that is not significantly impacted by the disaster]. If a cloud based tool is available to all participating jurisdictions at the time of the disaster, then health departments and emergency management agencies will enter data directly into that tool. If no cloud based system is available, each jurisdiction will complete the tool as a spreadsheet, and send it electronically to the coordinating jurisdiction to be compiled for the group.

It is important for information to be filled in for both operational periods to get a sense of the projected trend. It is understood that the data entered represent estimates and that circumstances might change at any point during and after the information-gathering period.

One jurisdiction (coordinating jurisdiction) must volunteer to collate data, schedule conference calls, ensure that data is entered, and answer questions from other jurisdictions for the entire region once the tool is activated. Ideally this would be the jurisdiction that is least impacted by the disaster. It has also been proposed that additional training be provided to jurisdictions in other areas of the state so that they could fulfill the administrative responsibilities associated with the tool.

# Discussion

The conference call agenda (appendix xx5) is intended to assist the group in achieving several objectives. The overall goal relies on the assumption that adequate situational awareness leads to proper identification of surge strategies and asset placement.

The first step in the conference call is roll call. The group should then assess the scope of the impact as well as the functionality of healthcare and infrastructure in the major impact areas. The most impacted counties would provide additional information and updates. The current and future demands for services should be considered. Surge strategies and recommendations for asset deployment should be discussed and, if possible consensus recommendations for request and deployment prepared. Finally, the group should identify next steps including the frequency of conference calls and information updates for the tool.

Once the tool is complete and shared amongst stakeholders it will assist in guiding and informing the discussion. Current as well as future demands for healthcare services can be assessed. The tool is designed with a limited number of medical surge assets in mind, and should be used as a guide for decision makers to better articulate a need, if not identify specific solutions. (appendix xx2)

# Recommendation Model

The purpose of the tool is to provide guidance to Local Health Officers regarding medical surge assets and response strategies that are needed most, and where they should be applied to provide the greatest good to the greatest number of patients. A consensus recommendation model should be utilized by Local Health Officers to identify what regional, state and federal medical surge assets and strategies should be requested and where they should be deployed. Whether consensus is reached or not the tool and conference call notes will be shared with the Washington Emergency Management Division and Washington Department of Health to inform their decision about distribution of medical surge resources. In addition, both the Washington Emergency Management Division and Washington Department of Health will participate in Local Health Officer conference calls.

# Communicating Recommendations to the State

Following the coordination conference call between Local Health Officers, conference call minutes, including any recommendations proposed by the Local Health Officers will be communicated in writing by the coordinating jurisdiction to the Washington Department of Health. Recommendations do not constitute official requests; each county must submit their requests for resource assistance individually to the State Emergency Operations Center through appropriate resource management protocols.

## A. Tool Format

The tool is created in an Excel Spreadsheet format. It is intended to be cloud based for access by multiple users. In the event that the cloud based format is unavailable individual jurisdictions would fill out spreadsheets and send them electronically or verbally to a specified coordinating agency. Public Health Seattle King County is the lead agency for sustainment.

## B. Partners and Stakeholders

The partners and stakeholders are divided into the following groups:

**Public Health Participants**

Island County Local Health Officer

King County Local Health Officer

Kitsap County Local Health Officer

Mason County Local Health Officer

Pierce County Local Health Officer

Skagit County Local Health Officer

Snohomish County Local Health Officer

Thurston County Local Health Officer

Washington Secretary of Health

**Other Participants**

US Department of Health and Human Services

Disaster Medical Control Centers:

* Providence Everett (Region 1)
* Harrison Medical Center (Region 2)
* St. Peter’s (Region 3)
* Good Samaritan (Region 5)
* Harborview Medical Center (Region 6)

Washington State Department of Health

Washington Emergency Management Division

It is expected that many other local subject matter experts (fire, EMS, Tribal Governments, private business) will provide information to the above listed members in the event of a disaster, which will be represented within the completed tool.

## C. Situational Status and Medical Surge Support Tool

The Situational Status and Medical Surge Support Tool exists in an Excel spreadsheet with twenty three sheets that will be referred to as “tabs” hereafter. Each county has two tabs specific to their status in the following categories: Patient Care Tab and ACF/FMS Support Tab.

The remaining tabs for the tool are included with relevant background, definition and completion information. They are titled as follows: Overview; Protocol; Completion Guide; Admin Guide; Sample Call Agenda; Possible Resources; and Summary Sheet.

Appendix A – Completion Guide

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| The Situational Status and Medical Surge Support Tool (“tool”) exists in an Excel workbook with several worksheets (referred to throughout this document as “tabs”). The following guide explains in detail the content of each tab, how they relate to each other, what each question seeks to address and the assumed meaning of each response option. |
|  |
| **Overview** |
| The tool contains eight tabs relevant to each jurisdiction: one for protocol of use, one for directions, one summary document, one to be updated by local health jurisdictions, and one to be updated by local emergency management.  |
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| **Overview tab:** High-level overview of the tool. |
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| **Protocol tab**: Directions for activating the tool as well as the key for Local Health Officers. |
|  |
| **Completion Guide tab**: Detailed instructions for completing the Patient Care and ACF and FMS tabs of the tool. |
|  |
| **Admin Guide tab:** Tasks to complete to ensure successful tool use. |
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| **Possible Resources tab:** Federal, state and local medical resources. |
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| **Summary tab**: Aggregated information from each reporting county regarding patient care (color-coded and with numeric values attached) and the availability of ACF or FMS sites.  |
|  |
| **Patient Care tab**: Two sets of four identical question categories depicting overall ability to provide patient care in the county during current and projected future (72 hours) operations. Responses should be an aggregation; they are not meant to track specific healthcare facility situations.  |
|  |
| **ACF and FMS Support tab**: A set of questions related to pre-identified sites in a county that could be used as an Alternate Care Facility (ACF)\* or Federal Medical Station (FMS) location. It is important to note that the boxes in the Patient Care tab might all be yellow but the boxes in the ACF and FMS support tab may all be green, as the ACF and FMS Support tab is related to a specific location, while the Patient Care tab is an aggregation of data across facilities across the county. |
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| \*Note: for the purposes of this tool, the term ACF refers to a place that can provide in-patient care above what would be found in a medical needs shelter but with lower acuity than a full-service hospital. |
| **Summary Sheet: Patient Care Status** |
| For individual questions, the numbers correlate as follows: |
| Incomplete = 0 |
| Green = 1 |
| Yellow = 2 |
| Red = 3 |
|  |
| The only exception to this is regarding patient evacuation questions B, C and D. Due to the conditional nature of the questions, as well as the fact that ‘black’ is not an appropriate color for the highest designation of patients needing to be moved, green = 1, yellow = 2 and red = 3 or 4 |
|  |
| Using those numbers to inform the category outcome leads to the following number/color relationships: |
| Patient Capacity: |
| 0 = Incomplete |
| 4 = Green (no facilities offline and no capacity issues) |
| 5-7 = Yellow (facility offline but minimal capacity issues) |
| 8-12 = Red (one or more facilities offline and capacity issues) |
|  |
| Capability: |
| 0 = Incomplete |
| 2 = Green (all facilities are working in conventional or contingent standards of care and able to treat most patients) |
| 3 = Yellow (all facilities are working in conventional or contingent standards of care and able to treat critical patients only) |
| 4-6 = Red (facilities may be working in crisis standards of care and / or not able to address the needs of critical patients) |
|  |
| Deficits: |
| 0 = Incomplete |
| 3 = Green (all resources available in sufficient quantities or to meet needs) |
| 4 = Yellow (either resources, infrastructure or staffing are facing challenges but working around them) |
| 5-9 = Red (one area with a serious deficit or multiple areas facing work-arounds) |
|  |
| Evacuation: |
| 0 = Incomplete |
| 1-4 = Green (no evacuation) |
| 5-6 = Yellow (Over capacity without evacuation OR evacuation, but patients can be absorbed within the county and/or there are sufficient transportation resources available. Also factors in the number of patients to be moved.) |
| 7-12 = Red (Evacuation, but cannot be absorbed within the county and/or there are insufficient transportation resources available. Also factors in the number of patients to be moved.) |
| **Patient Care Tab Questions** |
| This tab is provides local health officers with an overview of the current status of patient care in the county currently (defined as within 12 hours of the incident) as well as projections of the status in 72 hours. When referring to patients or capacity, this should include patients you expect to see / are already seeing arrive from neighboring counties. For all questions, if there is any supporting information, provide it in the notes column. For example, if you have said that one or more facilities are off line, write the facility name and number of beds in the notes column. Any information entered into the notes should be high level and as minimal as possible. |
|  |
| **Patient Capacity** |
| This category of questions seeks to address the general wellbeing of the community in terms of available critical healthcare. It is meant to be an aggregation across major facilities in the county, not an inventory of all facilities. |
|  |
| A. Is demand for inpatient healthcare service above capacity? |
| Capacity refers to regular bed capacity (inpatient and long-term care) as well as surge capacity. The tool is not designed to determine whether operations have shifted into crisis mode, as use of the tool assumes this; rather, the tool identifies the extent and duration to which the jurisdiction’s inpatient healthcare capacity is exceeded.  |
| - Incomplete (White, 0) |
| - No (Green, 1) |
| - Yes (Red, 2) |
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| B. Are any healthcare facilities effectively offline (e.g. primary and back-up utilities out, structure destroyed)? |
| This question focuses on a narrow set of healthcare facilities which provide critical and life-saving and life-sustaining care that, if not regularly provided, will quickly have life-threatening consequences: hospitals, long-term-care facilities and nursing homes, blood centers, dialysis centers and other key public and private healthcare facilities in the county.  |
| - Incomplete (White, 0) |
| - No (Green, 1) |
| - Yes (Red, 2) |
|  |
| C. What percentage of hospital capacity do the offline facilities represent? |
| Capacity refers to regular bed capacity as well as surge capacity. Percentages relative to color (severity) designation may vary between urban and rural counties. The percentages below reflect severity levels for urban counties; it may vary for less urban counties. If that is the case, those counties should use their best judgment as to what green, yellow and red mean for them for that incident. |
| - Incomplete (White, 0) |
| - N/A (Green, 1) |
| - 10% or less (Green, 1) |
| - 10%-20% (Yellow, 2) |
| - Greater than 20% (Red, 3) |
|  |
| D. What percentage of inpatient long-term care capacity do the offline facilities represent? |
| Capacity refers to regular bed capacity as well as surge capacity. Percentages relative to color (severity) designation may vary between urban and rural counties. The percentages below reflect severity levels for urban counties; it may vary for less urban counties. If that is the case, those counties should use their best judgment as to what green, yellow and red mean for them. |
| - Incomplete (White, 0) |
| - N/A (Green, 1) |
| - 10% or less (Green, 1) |
| - 10%-20% (Yellow, 2) |
| - Greater than 20% (Red, 3) |
|  |
| **Capability** |
| This category of questions seeks to address the level of care that is being provided.  |
|  |
| A. Are all functional inpatient healthcare facilities able to maintain conventional or contingent standards of care during this incident? |
| - Incomplete (White, 0) |
| - Yes (Green, 1) |
| - No (Red, 2) |
|  |
| B. Is county/regional patient treatment capability sufficient? |
| - Incomplete (White, 0) |
| - Able to treat most patients. (Green, 1) |
| - Able to treat critical patients only. (Yellow, 2) |
| - Not able to address the needs of critical patients. (Red, 3) |
|  |
| **Deficits** |
| This category of questions is looking at whether resources, infrastructure and staffing are available in sufficient quantities. |
|  |
| A. What is your expected resource status going forward? |
| “Expected channels” refers to normal purchasing systems – same vendors, same or similar ordering process. “Work-arounds” refers to using different vendors, or different means for ordering, which may not be ideal but still allow the necessary supplies to be ordered. |
| - Incomplete (White, 0) |
| - Able to access sufficient supplies via expected channels. (Green, 1) |
| - Able to access sufficient supplies via work-arounds. (Yellow, 2) |
| - Access to sufficient supplies is limited and affecting treatment capacity. (Red, 3) |
|  |
| B. What is the status of infrastructure in your county? |
| The term infrastructure refers to transportation (public transit assets and roads) and utilities.  |
| - Incomplete (White, 0) |
| - Infrastructure impacts isolated and small. (Green, 1) |
| - Infrastructure impacts scattered. (Yellow, 2) |
| - Infrastructure impacts are widespread. (Red, 3) |
|  |
| C. What is your clinical staffing status? |
| The term staff includes regular clinical staff and other sources of staff, such as credentialed volunteers. |
| - Incomplete (White, 0) |
| - Sufficient clinical staff is available. (Green, 1) |
| - Clinical staff levels are reduced but able to support critical services. (Yellow, 2) |
| - Serious clinical staffing deficit. (Red, 3) |
|  |
| **Evacuation** |
| These questions address the evacuation of patients via ambulance, helicopter, fixed wing aircraft or any other viable transportation means. The term “patients” includes those who need inpatient hospital care and long-term care, as well as those who regularly receive life-sustaining outpatient treatment (e.g. dialysis). |
|  |
| A. Are inpatient facilities in your county evacuating? |
| This question focuses on a narrow set of healthcare facilities which provide critical and life-saving and life-sustaining care that, if not available, will quickly have life-threatening consequences. Facilities covered include: hospitals, long-term-care facilities and nursing homes, blood centers, dialysis centers and other key public and private healthcare facilities in the county. |
| Counties answering yes should be ready to share the number/type of patients to be evacuated. |
| - Incomplete (White, 0) |
| - No (Green, 1) |
| - Yes (Red, 2) |
|  |
| B. If yes, can the patient load be absorbed by other facilities within the county or healthcare system? |
| - Incomplete (White, 0) |
| - N/A (Green, 1) |
| - Yes (Yellow, 2) |
| - No (Red, 3) |
|  |
| C. If out of county evacuation is necessary, are sufficient local and mutual aid transport resources available? |
| - Incomplete (White, 0) |
| - N/A (Green, 1) |
| - Yes (Yellow, 2) |
| - No (Red, 3) |
|  |
| D. How many patients? |
| This refers to the number of patients that may need transportation assistance outside of the resources available in-county. |
| - Incomplete (White, 0) |
| - N/A (Green, 1) |
| - Fewer than 100 (Yellow, 2) |
| - 100-500 (Red, 3) |
| - More than 500 (Red, 4) |
|  |
| **ACF and FMS Support Tab Questions** |
| These questions refer to (up to five) places that could house an ACF/FMS. It is possible that infrastructure challenges will impact healthcare facilities but not identified ACF or FMS sites, so questions under Patient Care may have different answers. The notes section next to each question are to be used for any necessary elaboration. |
|  |
| 1. Structural Status |
| - Incomplete (White, 0) |
| - Site assessed structurally sound and functional. (Green, 1) |
| - Site has yet to be assessed but is believed to be sound and functional. (Yellow, 2) |
| - Site is not structurally sound or functional. (Black, 4) |
|  |
| 2. Water Status |
| - Incomplete (White, 0) |
| - Potable water is available/wastewater lines are functional. (Green, 1) |
| - Potable water can be delivered/wastewater lines are functional OR potable water is available/portable sanitation. (Yellow, 2) |
| - Neither potable water nor sanitation is available. (Black, 4) |
|  |
| 3. Power Status |
| - Incomplete (White, 0) |
| - Grid power is available. (Green, 1) |
| - Grid power is unavailable but generator power is available with sufficient access to fuel. (Yellow, 2) |
| - Neither grid nor generator power is available. (Black, 4) |
|  |
| 4. Staff Support Availability |
| - Incomplete (White, 0) |
| - Sufficient medical staff is available now. (Green, 1) |
| - Sufficient medical staff will be available within 48 hours. (Yellow, 2) |
| - Sufficient medical staff is not available. (Red, 3) |
|  |
| Accessibility |
| - Incomplete (White, 0) |
| - Staff can access available sites on their own. (Green, 1) |
| - Staff can access available sites with assistance (group transportation or escorts). (Yellow, 2) |
| - Staff cannot access available sites. (Black, 4) |
|  |
| 5. Logistics Support |
| Suppliers |
| - Incomplete (White, 0) |
| - Medical suppliers are able to move supplies to sites quickly. (Green, 1) |
| - Medical suppliers able to move supplies to sites within 48 hours. (Yellow, 2) |
| - Medical suppliers are either not operational or are unable to move supplies to sites. (Black, 4) |
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| EOCs |
| - Incomplete (White, 0) |
| - Local EOCs can coordinate ACF/FMS non-medical logistical needs. (Green, 1) |
| - Local EOCs can coordinate some ACF/FMS non-medical logistical support. (Yellow, 2) |
| - Local EOCs cannot coordinate any ACF/FMS non-medical logistical needs. (Red, 3) |
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| 7. Number of Patients Able to Support |
| - Incomplete |
| - Fewer than 100 |
| - Between 101-250 |
| - Greater than 250 |
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Appendix B – Administrative Guide

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| In order for the Surge Support Tool to successfully assist decision-makers during a disaster, there are a few tasks that need to be managed. The county that agrees to be responsible for managing this process should take the following actions. |
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| **Confirming Tool Use** |
| 1. Refer to the contact list and make positive contact with the designated contact person within each of the eight counties. Positive contact may be a phone conversation, a returned voice mail, a radio discussion, or an email sent to you from the contact. DO NOT assume that an email or phone call has been received unless you get confirmation. |
| 2. In this contact, communicate that the Medical Surge Decision-Making Support Tool has been activated and that their county is requested to complete the tool on line by the specified time. Confirm who will be the contact for this (if it is not them) so that you can follow up as needed. |
| 3. If they are not available and you end up contacting someone who is not familiar with the tool, share with him or her the one-page overview and the guide, and make yourself available to answer questions he or she may have. |
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| **Using the tool (instructions for participating counties)** |
| Local Health Jurisdiction, Healthcare Partners, and Local Emergency Management are responsible for determining the most appropriate way to compile all information for the Patient Care tab and the ACF/FMS tab. All parties should work as part of a coordinated information management system within the jurisdiction.. |
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| **Compiling the Information** |
| 1. Open a fresh version of the Tool and save it with the name of the disaster and the date. All cells that can be completed should already be set to “incomplete.” |
| 2. Load the tool to the cloud environment and alert the counties that it is up and ready for use. |
| 3. Each county will be responsible for completing the Patient Care and ACF/FMS tabs and preparing to speak to their results on the upcoming coordination call. They should update THEIR TABS ONLY on the tools, and notify you when they have done so. |
| 4. If any counties have not responded by 15 minutes before the responses are due, call to confirm that they will be sent soon. |
| 5. Confirm that the summary sheet colors and numbers match the corresponding colors on the respective spreadsheets. If there was a technology error, adjust the summary sheet to match the corresponding cells from the county spreadsheets. |
| 6. If they have not completed all three ACF/FMS location sections, please delete the incomplete ones from both their spreadsheet AND from the summary tab. This may result in empty cells next to some counties on the summary sheet. |
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| **Preparing the Summary Sheet** |
| 1. The summary sheet is already set up to remain within a landscape-oriented 8.5 by 11 inch sheet of paper, three pages in total. To turn it into a .pdf, first ensure that you have Adobe Reader installed on your computer. |
| 2. To create the .pdf, make sure that you have clicked on the summary sheet. Click on print; select “Adobe PDF” as the printer and click print. It should create a PDF that opens; save it with the same name as the spreadsheet. |
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| **Scheduling the Conference Call** |
| 1. A one hour conference call should be scheduled after all the information is due from each participating county. Refer to the contact sheet for a list of all people to be on that call. All Local Health Officers or their designees must be on the call. Local EM, DMCCs, DOH, HHS, and EMD may also participate on the call. |
| 2. To ensure that they all receive information about the call, follow the positive contacts procedure above. |
| 3. Identify someone to take detailed notes during the conference call. |
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| **Preparation for Conference Call** |
| 1. Adjust the conference call agenda template based on the current incident. |
| 2. Share the PDF, along with the agenda, prior to the conference call. |
| 3. Post the PDF in the WATrac Command Center |
| 4. Prepare list of the expected call attendees for roll-call. |
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| **Follow-Up** |
| 1. Once the call is complete, email participants any follow-up actions agreed to. |

Appendix C – Sample Conference Call Agenda

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| Decision-Makers |
| Island County Local Health Officer |
| King County Local Health Officer |
| Kitsap County Local Health Officer |
| Mason County Local Health Officer |
| Pierce County Local Health Officer |
| Skagit County Local Health Officer |
| Snohomish County Local Health Officer |
| Thurston County Local Health Officer |
| Washington Secretary of Health |
| Other Participants |
| US Department of Health and Human Services |
| Disaster Medical Control Centers: |
| * Providence Everett (Region 1)
 |
| * Harrison Medical Center (Region 2)
 |
| * St. Peter’s (Region 3)
 |
| * Good Samaritan (Region 5)
 |
| * Harborview Medical Center (Region 6)
 |
| Washington State Department of Health |
| Washington Emergency Management Division |
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| Facilitator |
| Coordinating Jurisdiction staff (ideally the least impacted local jurisdiction) |
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| Objectives: |
| By the end of this call we will have: |
| 1. Assessed the scope of impact, demand for critical healthcare services, and functionality of existing healthcare and supporting infrastructure across the region |
| 2. Identified and evaluated the feasibility of various medical surge options |
| 3. Reached consensus recommendations on prioritizing requests for and deployment of medical surge assets |
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| Agenda: |
| 1.               Roll Call |
| 2.              Situation overview |
| a.       Functionality of healthcare and supporting infrastructure in major impact areas (updates from the most heavily impacted counties) |
| b.      Current and future demand for healthcare services (updates from Disaster Medical Control Centers) |
| 3.              Medical surge options |
| a.       Summarize results of Medical Surge Decision Making Support Tool |
| b.      Discuss feasible medical surge resource deployment options to meet region-wide patient demand and capacity limitations (updates from State DOH/EMD, US HHS) |
| 4.               Finalize and review consensus recommendations on requesting and deploying medical surge assets |
| 5.               Confirm tool update frequency and identify next steps / need for future calls |
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Appendix D – Relevant Medical Surge Assets

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| This document remains a work in progress and should be revised and updated as necessary. |
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| **Federal** |
| **USPHS Commissioned Corps (USPHS):**  |
| Rapid Deployment Force (RDF): |
| The RDF consists of five pre-identified teams, each with 105 multidisciplinary staff. |
| Capable of deploying within 12 hours of notification.  |
| Built-in command structure and can provide mass care at shelters (including FMSs), and staff Points of Distribution and Casualty Collection Points. |
| Can also conduct community outreach and assessments, among other functions.  |
| Applied Public Health Team (APHT):  |
| Public health department in a box  |
| Deploy within 36 hours of notification  |
| Provide assistance in public health assessments, environmental health, infrastructure integrity, food safety, vector control, epidemiology, and surveillance.  |
| Mental Health Team (MHT): |
| Mental and behavioral health experts who assess stress and suicide risks within the affected population |
| Manage responder stress |
| Provide therapy, counseling, and crisis intervention |
| Can deploy within 36 hours of notification.  |
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| [More information: http://www.phe.gov/preparedness/support/pages/default.aspx](http://www.phe.gov/preparedness/support/pages/default.aspx) |
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| [National Disaster Medical System (NDMS)](http://www.phe.gov/Preparedness/support/medicalassistance/Pages/default.aspx#usp)  |
| <http://www.phe.gov/Preparedness/support/medicalassistance/Pages/default.aspx#usp> |
| Disaster Medical Assistance Teams (DMATs) |
| Typically deploy 35 clinicians |
| Are self-sufficient for 72 hours, but will require support beyond that (hotels, places to camp, etc.) and 25% of response cost and would be reaching out to FEMA for logistical support |
| Includes physicians, nurse practitioners, physician assistants, nurses, pharmacists, respiratory therapists, paramedics, EMTs and others. |
| International Medical Surgical Response Teams (IMSuRTs) |
| 50-member teams |
| Come with equipment and supplies (including pharmaceuticals and blood) |
| Have a mobile field hospital |
| Provide acute care, operative care, critical care and evacuation at fixed and mobile hospital facilities |
| [Additional link: http://www.imsurtwest.com/](http://www.imsurtwest.com/) |
| Transportation of patients out of area |
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| **Federal Medical Stations (FMS)**  |
| <http://www.phe.gov/Preparedness/support/medicalassistance/Pages/default.aspx#fms> |
| 100 personnel need to staff it (often provided by USPHS) |
| Three-day supply of medical and pharmaceutical resources for 250 stable patients |
| Can provide mass ambulatory vaccination services / prophylactic medication administration |
| Can provide pre-hospital triage and initial stabilization |
| Requirements: |
| 40,000 square feet of space |
| 10 people to set it up |
| Electricity, heating, air condition, ventilation, and clean water |
| Bathroom and shower facilities |
| Billeting for staff |
| Contracted support for food, potable water, laundry, ice, oxygen and biomedical waste disposal |
| 48-96 hours from request to delivery + 12 hour assembly time |
| Per Rick Buell at HHS – More important that sites be identified ahead of time. Likely won’t send if sites  |
| Go Bag: |
| Rapidly deployable light strike team staffed by USPHS |
| Basic medical and pharmaceutical resources for 50-100 stable ambulatory patients |
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| **FEMA Ambulance Contract** |
| <http://www.njha.com/ep/pdf/772010101922AM.pdf> |
| The purpose of the Federal National Ambulance and Para-transit Support Services contract is to provide a full array of licensed ground and air ambulance services and para-transit services that may be ordered as needed to supplement the Federal and Military response to a disaster, act of terrorism or other public health emergency. |
| The FEMA National Medical Transport and Support Contract is activated to evacuate patients and at-risk populations from an area at significant risk, or to provide pre-hospital care and transport services in a region that has already been affected by a disaster. The FEMA contract is not specifically intended for returning patients back to their point of origin; however, at the discretion of FEMA and under the advice from ESF-8, it may be used for returning patients in the immediate aftermath of a disaster if the healthcare infrastructure is in place and operational. |
| Per Zone: |
| Ground Ambulance |
| 300 ground ambulances (ALS & BLS) |
| Typically a 60%/40% ALS/BLS split |
| Air Ambulance |
| 25 air ambulances, helicopter and/or fixed wing |
| Para-Transit |
| Ability to Transport 3,500 individuals |
| Not 3,500 vehicles |
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| **Durable Medical Equipment Contained within SNS (not medications)** |
| Once requested by the state, assets may be redeployed to assist areas with the greatest need. |
| **State** |
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| **Medical staff and resources acquired via cross border, intra- or interstate mutual aid** |
| Staff arriving from outside the jurisdiction will need to be credentialed. They will also need access to accommodations, such as hotels or base camps, and may require transportation to get to the accommodations. They may require more support than teams that are traditionally deployed together. |
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| **Locally Managed Equipment and Supplies** |
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| **King – Alternate Care Facility** |
| Long term care facility support |
| Patients are not necessarily presenting with an acute or new medical condition but require some medical surveillance and / or special assistance beyond what is available in a standard shelter. |
| Inpatient Nursing Module activated |
| Emergency stabilization capabilities (patients with complex medical care transported elsewhere) |
| 50 inpatient bed minimum, 200 inpatient bed maximum, increases in 50-bed increments |
| Staffing will include personnel from the evacuating facility |
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| Example of reason for activation: |
| A long-term care facility experiences a power outage and the ambient air temperature in the facility is above 75 degrees that leads them to need to evacuate to an ACF. Other long-term care facilities are not able to absorb all of the patients. |
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| **Hospital support** |
| Inpatient nursing care activated in response to a significant loss of regional inpatient capacity, a surge in the number of patients with illnesses or injuries due to a disaster that cannot be accommodated by existing healthcare infrastructure, or a combination of both. 100, 150 or 200 inpatient beds made available depending on the need, plus acute care, ambulatory care, pediatric care, and behavioral health, each with additional beds available, up to 250 beds total. Oxygen bottles or distribution system, pharmacy and limited lab services may be available. If patients with complex medical care are unable to be accommodated in the ACF, emergency stabilization measures will be undertaken to allow them to be transported elsewhere. |
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| Patients able to be treated include: |
| Patients admitted primarily for IV antimicrobials and monitoring to ensure their condition does not worsen and who are expected to be discharged within 48-72 hours (e.g. patient with moderately severe cellulites without sepsis). |
| Post-surgical patients anticipated ready for hospital discharge within 48 hours. |
| Patients ready for discharge and awaiting a vacant bed at a long-term care facility or skilled nursing facility. |
| Other patients without potentially life-threatening symptoms or vital signs |
| Patients who are dying and for whom palliative care is indicated. |
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| **Equipment** |
| **King:** |
| 600 beds, plus pediatric beds and cribs and bariatric beds |
| Enough equipment and supplies to support: |
| Simple wound management, including suturing |
| Short-term fracture/ musculoskeletal injury management |
| Oral or IV fluid resuscitations (e.g. for patients with nausea and vomiting) |
| Non-narcotic prescription refill and authorization |
| IV antimicrobial administration  |
| IV symptom relief (e.g. antiemetic) |
| Short-term oxygen delivery |
| Bronchodilator therapy/ peak flow assessment  |
| Oral medications (select) |
| Pain management |
| Limited laboratory |
| Equipment stored in Zone 5 (Seattle) and Zone 3 (South King County) with additional access to Zone 1 (East and North King County) |
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