

ESF 8: Public Health, Medical, and Mortuary Services

Appendix 2: Medical Surge Response

ESF Coordinating Agency:

Department of Health (DOH)

Primary Agency:

Support Agencies:

Washington Military Department

Washington State Department of Social and Health Services (DSHS)

Washington State Healthcare Authority (HCA)

Washington State Patrol (WSP)

Washington State Department of Transportation (WSDOT)

US Department of Health and Human Services (HHS)

US Northern Command (USNORTHCOM)

Local Health Jurisdictions

Tribal Governments

Regional Healthcare Coalitions

Regional and State Disaster Medical Coordination Centers (DMCC)

I. Introduction

A. Purpose

The purpose of this appendix is to establish and communicate the respective roles and responsibilities of each major public health, healthcare, and emergency medical services (EMS) partner in Washington State during each phase of response to a medical surge incident. It describes how state entities will provide support and coordination to local jurisdictions and tribal governments throughout the state during a medical surge incident that impacts or might impact healthcare delivery within Washington State. Additionally, this document focuses on coordination and support activities to address public health, healthcare, and EMS needs of jurisdictions responding to a medical surge incident.

The objectives of this appendix are to:

1. Provide common terminology and common framework for public health, healthcare, and EMS system preparedness and response to medical surge.

2. Support coordination between state and federal officials regarding effective response to medical surge.
3. Communicate roles and responsibilities of state and federal agencies with major involvement in response to medical surge.

B. Scope

This appendix is intended to inform but not supersede nor supplant existing local, regional, state, tribal, or federal plans, or plans maintained by healthcare entities, healthcare coalitions (HCCs), and other partner agencies. Rather, this document is intended to provide a unifying framework under which state and federal agencies develop and execute their own plans, protocols, policies, and procedures for response to medical surge incidents in a cohesive manner.

The scope of this plan is not limited by the nature or cause of any particular medical surge incident.

Portions of this appendix remain active during steady state operations, in the absence of a medical surge incident or other emergency condition. Full implementation of this appendix should be considered when one or more of the following occurs:

1. An emergency is declared/proclaimed in any political subdivision of Washington State due to a medical surge threat.
2. Any local or tribal public health partner, state or federal agency, healthcare organization, or HCC requests assistance in response to a medical surge threat that overwhelms or threatens to overwhelm the capability of that organization.
3. When in the judgment of the Secretary of Health, or other individual having statewide authority, there is the need for enhanced coordination of resources to respond to an imminent medical surge incident.
4. The Secretary of Health or Department of Health (DOH) Chief of Emergency Preparedness and Response anticipates an emerging risk to Washington's public health, healthcare, and EMS system that has the potential to overwhelm local capabilities and requires state support to prepare and/or respond effectively.

Coordination responsibilities between DOH and local health jurisdictions (LHJ), HCCs, tribal governments, healthcare entities, and all other non-state or federal agencies and associations are outside the scope of this plan. These relationships are described in the Medical Surge Annex 11 to the DOH Emergency Response Plan-Basic.

C. Policies

RCW 43.70.130 and 43.70.020(3) State Department of Health – Powers and duties of the Secretary of Health

RCW 38.56.020 Intrastate Mutual Aid System – Established

RCW 70.168 Statewide Trauma Care System

II. Situations and Assumptions

A. Situations

A medical surge incident occurs when a greater-than-typical volume of patients enters the healthcare system, threatening overall healthcare system resiliency and resulting in shortages of the capabilities and resources necessary to deliver adequate patient care. In Washington State, medical surge incidents can result from:

- Natural disasters such as earthquakes, volcanic activities, wildfires, flooding
- Extreme weather: severe winter weather, extreme heat
- Communicable diseases: influenza, severe acute respiratory syndrome (SARS)
- Mass casualty incidents: transportation accidents, structure fires
- Terrorist activities: explosive devices, biological attacks

The United States Department of Health and Human Services (HHS) Office of the Assistant Secretary of Preparedness and Response (ASPR) is solely committed to supporting local, regional, state, tribal, and national efforts to prepare for and respond to major medical incidents. The following definitions are excerpted from <http://www.phe.gov/>:

Medical surge describes the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of healthcare organizations to survive a hazard impact and maintain or rapidly recover operations that were compromised (a concept known as medical system resiliency).

Medical Surge Capacity

Medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations.

Because of its relation to patient volume, most current initiatives to address surge capacity focus on identifying adequate numbers of hospital beds, personnel, pharmaceuticals, supplies, and equipment.

Medical Surge Capability

Medical surge capability refers to the ability to manage patients requiring unusual or very specialized medical evaluation and care. Surge requirements span the range of specialized medical services (expertise, information, procedures, equipment, or personnel) that are not normally available at the location where they are needed (e.g.: pediatric care provided at non-pediatric facilities). Surge capability also includes patient problems that require special intervention to protect medical providers, other patients, and the integrity of the healthcare organization.

B. Limitations & Assumptions

The following assumptions are made in the development and implementation of this framework:

1. Preservation of life safety including the prevention of morbidity and mortality is the primary mission objective for all involved agencies during any emergency.
2. Supporting health equity and making provisions for people with access or functional needs are critical.
3. The Secretary of Health may direct the statewide public health, healthcare, and EMS response as necessary and is authorized by state law to protect the health of the public (RCW 43.70.130 and 43.70.020(3)).
4. DOH is the lead agency for responding to multijurisdictional public health emergencies in Washington.
5. Public health, healthcare, and EMS services, resources, facilities, and personnel may be limited in availability or capacity during and following a medical surge incident.
6. LHJs, HCCs, tribal governments, and healthcare facilities will implement their emergency response plans, including mutual aid agreements, and will request additional resources when their own resources are, or it is anticipated their resources will soon be, exhausted as outlined in the Washington State Comprehensive Emergency Management Plan (CEMP) and the ESF 8 Annex.
7. Responding to a medical surge incident may require resources from intrastate, interstate, and international mutual aid, as well as from Washington State and U.S. government agencies, none of which may be immediately available. Other than intrastate mutual aid agreements, resource requests from any of the aforementioned resource providers must be made through the State Emergency Operations Center (SEOC) using the Emergency Management Assistance Compact (EMAC) or the Pacific Northwest Emergency Management Arrangement (PNEMA).
8. Medical surge incidents might require exercising legal authorities in a shift from conventional to contingency to crisis standards of care in terms of how care is provided and/or how medical resources are allocated. In certain circumstances, medical resources and care may be rationed in alignment with operational objectives.
9. All healthcare entities may need to provide care to a greater number of patients, different patient populations, and provide different types of care than the entity normally provides to meet the needs of the population during a medical surge incident.
10. An alternate medical care site or system of sites may be needed in order to meet the medical needs of the public during a widespread medical surge incident.

11. Public perception of the severity of the incident may not be consistent with reality. For this reason, effective coordination of information sharing between response partners and timely public information during a medical surge incident is essential.

III. Concept of Operations

A. General

Most minor medical surge incidents are managed through normal operations of EMS and healthcare providers. This section describes the ongoing roles and responsibilities for managing low-impact medical surge incidents.

1. Inpatient healthcare facilities

Inpatient healthcare facilities, particularly hospitals, commonly experience a chronic stress on the capacity of their facilities. As noted in the Planning Assumptions section of this appendix, internal strategies are frequently implemented to alleviate the impacts of a patient surge and to hasten the delivery of necessary medical care to patients who need it. Some of these strategies may include:

- Assessing situational awareness and availability of non-standard healthcare capacity
- Activating the facility's Medical Surge Plan and following the mitigation strategies outlined therein, including notifying DOH Health Systems Quality Assurance (HSQA) division
- Using the WATrac bed tracking system to indicate that an emergency department is temporarily not accepting non-trauma patients (subject to regional protocols)
- Utilizing in-facility capacity to admit or hold patients
- Referring patients to other supportive services that may better suit their needs
- Calling in additional staff members and/or shifting to alternate staffing ratios

All of the above actions, and others, can be used at any hospital or long-term care facility at any time to manage their internal patient surge. This does not typically require coordination with any external partners, though facilities may elect to reach out to partner agencies to share information.

As conditions persist, hospitals may employ additional tactics to create available capacity, such as:

- Decompressing their census by discharging patients with lower acuity conditions to a more appropriate level of care
- Postponing elective surgical and other procedures

Disaster response by inpatient facilities to a medical surge incident is discussed in further detail in the Medical Surge Annex to the DOH Emergency Response Plan.

2. Emergency Medical Services (EMS)
EMS agencies may be the first to know that a medical surge incident is developing, based on their presence in the field and their awareness of what is occurring in the region. In this case, EMS dispatch centers can communicate with hospitals and use WATrac to help inform decisions about patient destination, often directing ambulances to transport patients to the most appropriate destination. This prevents overloading any particular emergency department with a disproportionate number of patients.

B. Organization

In the event that a medical surge incident exceeds local or regional healthcare resources, the following strategies may be implemented: regional and state decision making systems, patient distribution, alternate facilities for patient care, and scarce resource allocation. This section describes the state-level organizations with whom DOH would coordinate and develop response strategies in support of healthcare facilities, local, and tribal partners.

1. Washington Military Department
As per the State CEMP, the Washington Military Department, Emergency Management Division (EMD) is the host agency for the Washington State Emergency Operations Center (SEOC). The SEOC remains activated and staffed 24 hours a day, 7 days a week, in a monitoring posture (Level 3 activation). At the onset of an incident, EMD raises the activation levels to either enhanced or full (Levels 2 and 1 respectively) to support the response efforts of political subdivisions (also called local governments) and partner agencies, or to coordinate a statewide response effort. During an increased activation level (i.e., beyond Level 3), all necessary Emergency Support Functions (ESFs) are staffed to meet the needs of the incident. DOH is the coordinating agency for ESF 8 (Public Health, Medical, and Mortuary Services) and provides the majority of personnel to staff ESF 8, when activated. During an incident, the SEOC is the statewide central coordination point for receiving incident-related information and requesting state and federal resources. DOH would route requests for federal medical resources through the SEOC.

The Army and Air National Guard have medical personnel and logistic capabilities that may be requested during a medical surge incident.
2. Department of Social and Health Services
The Department of Social and Health Services (DSHS) licenses, coordinates with, and maintains information regarding all long-term care facilities across the state. During medical surge incidents, DOH would utilize DSHS as a source of information regarding impacts to and functionality of long-term care facilities to support statewide healthcare situational awareness.
3. Health Care Authority
The Health Care Authority (HCA) serves as an additional source of information regarding impacts to and functionality of healthcare systems,

facilities, and providers. During medical surge incidents, the HCA can help facilitate communication with key national partners, healthcare organizations, associations, and stakeholders. The HCA may also take additional steps, such as assisting in the identification of healthcare resources, system capacity and capability; providing data for analytics, coordinating outreach with contracted organizations; and developing protocols for patients who need specialized care or have co-morbidities who may be at higher risk.

4. Washington State Patrol
Support of local law enforcement agencies in coordinating law enforcement and security in medical surge-related medical shelters and alternate care sites will be directed to ESF 13.
5. Department of Transportation
The Department of Transportation can assist in the area of route planning when moving patients during or after an emergency.

During medical surge incidents, DOH coordinates extensively with a wide range of partner organizations including Disaster Medical Coordination Centers (DMCC), LHJs, tribal government, HCCs, statewide health and medical associations, and large healthcare systems. Details regarding coordination with these partners are included in the Medical Surge Annex to the DOH Emergency Response Plan-Basic.

Federal Partners

1. Department of Health and Human Services (HHS)
HHS will provide response and recovery support by acting as a liaison between DOH and other federal agencies (Department of Defense, Veteran's Administration, Indian Health Services, Federal Aviation Administration, etc.) to assist with surging resources in and/or moving patients out of state. HHS will help to vet, prioritize, and fulfill state-level medical surge resource requests. Additionally, it may provide incident management and coordination resources and support.
2. U.S. Northern Command (USNORTHCOM)
Joint Regional Medical Plans and Operations (JRMPO) will serve as a technical specialist to DOH regarding all Department of Defense logistical, public health, medical, and mortuary services resources and capabilities that could be applied to addressing ESF-8 missions.

Proclaiming or Declaring Emergencies

A governor's emergency proclamation is a last-step approach to addressing medical surge. Additionally, proclaiming an emergency may not provide the level of relief that some partners envision.

First and foremost, it should be noted that local health officers cannot waive any federal requirements, such as the 25-bed limit that the Center for Medicare &

Medicaid Services (CMS) has defined for critical access hospitals. In fact, no agency or policy decision maker within Washington State has this power.

As per Chapter 43.06 RCW, the governor may proclaim a state of emergency. However, the governor's powers pursuant to a proclamation currently do not include authorizing crisis standards of care, nor the ability to bring about CMS waivers (as noted above). The governor's proclamation enables state agencies to use their resources, and doing everything "reasonably possible," to assist affected political subdivisions. This supports the DOH response, and can provide indirect benefits to healthcare facilities, but does not provide any direct benefit to them.

However, a governor's proclamation is a required first step to receiving both a presidential disaster declaration, and a public health emergency declaration from the United State Secretary of HHS. Both of these are essential to receiving the types of waivers from which hospitals may benefit most (such as the CMS 1135 waiver).

As for triggers and indicators for the governor proclaiming an emergency to support healthcare facilities, DOH considers several factors including:

- the extent to which facilities across multiple counties have activated emergency plans;
- the extent to which all facilities are at or above capacity;
- limitations on critical infrastructure that supports healthcare facilities, or access to medical supplies by those facilities
- no signs of the crisis abating; and
- all facilities within a region having thoroughly exhausted all options available to them to enhance capacity.

When there is no federal emergency declaration, Region 10 HHS/ASPR is a resource for discussing potential federal HHS support options (e.g., Using existing CMS rules, assistance to healthcare facilities can sometimes occur without a declared emergency.).

C. Whole Community Involvement & Non-Discrimination

The "Whole Community" includes individuals, families, and households; communities; the private and nonprofit sectors; faith-based organizations; and local, tribal, state, and federal governments. This ESF is committed to communicating with the Whole Community as needed during emergency response and disaster recovery operations. The Whole Community includes populations with Limited English Proficiency (LEP), individuals with disabilities, and Access and Functional Needs (AFN).

IV. ESF Responsibilities Aligned with Core Capabilities

The following table aligns the Core Capabilities that this ESF most directly support, and the agencies and organizations identified provide services and resources in accordance with their individual missions, legal authorities, plans and capabilities in coordination with the State Emergency Operations Center (SEOC). All ESFs support the core capabilities of Planning, Operational Coordination, and Public Information and Warning.

Coordinating State Agency	Responsibilities	Core Capabilities
Department of Health	<ul style="list-style-type: none"> • Coordinate and develop response strategies in support of healthcare facilities, local, and tribal partners • Provide the majority of personnel to staff ESF 8, when activated • Coordinate extensively with a wide range of partner organizations including Disaster Medical Coordination Centers (DMCC), LHJs, tribal government, HCCs, statewide health and medical associations, and large healthcare systems to obtain and share situational awareness • Route requests for federal medical resources through the SEOC 	Planning Public Info & Warning Operational Coordination Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services Situational Assessment

Support Agency	Responsibilities & Actions	Core Capabilities
Washington Military Department	<ul style="list-style-type: none"> • Support the response efforts of political subdivisions (also called local governments) and partner agencies • Coordinate a statewide response effort • statewide central coordination point for receiving incident-related information and requesting state and federal resources • Washington Army and Air National Guard have medical personnel and logistic capabilities that may be requested 	Operational Coordination Logistics and Supply Chain Management Situational Assessment
Department of Social and Health Services (DSHS)	<ul style="list-style-type: none"> • Provide information regarding impacts to and functionality of long-term care facilities to support statewide healthcare situational awareness 	Planning Intelligence and Information Sharing Health and Social Services Public Health, Healthcare, and Emergency Medical Services

<p>Healthcare Authority (HCA)</p>	<ul style="list-style-type: none"> Facilitate communication with key national partners, healthcare organizations, associations, and stakeholders Assist in the identification of healthcare resources, system capacity and capability; providing data for analytics, coordinating outreach with contracted organizations; and developing protocols for patients who need specialized care or have co-morbidities who may be at higher risk 	<p>Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services</p>
<p>Washington State Patrol (WSP)</p>	<ul style="list-style-type: none"> Supporting local law enforcement agencies in coordinating security, protection, and law enforcement in medical surge-related medical shelters and alternate care sites 	<p>On-scene Security, Protection, and Law Enforcement</p>
<p>Washington State Department of Transportation (WSDOT)</p>	<ul style="list-style-type: none"> Assist in the area of route planning when moving patients during or after an emergency 	<p>Planning Intelligence and Information Sharing</p>
<p>US Department of Health and Human Services (HHS)</p>	<ul style="list-style-type: none"> Response and recovery support by acting as a liaison between DOH and other federal agencies Help to vet, prioritize, and fulfill state-level medical surge resource requests Provide incident management and coordination resources and support 	<p>Operational Coordination Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services Situational Assessment</p>
<p>US Northern Command (USNORTHCOM)</p>	<ul style="list-style-type: none"> Serve as a technical specialist to DOH regarding all requested Department of Defense logistical, public health, medical, and mortuary services resources and capabilities 	<p>Logistics and Supply Chain Management Public Health, Healthcare, and Emergency Medical Services</p>
<p>Local Health Jurisdictions</p>	<ul style="list-style-type: none"> Provide situational awareness to DOH 	<p>Planning Public Info & Warning Operational Coordination Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services Situational Assessment</p>

Tribal Governments	<ul style="list-style-type: none"> • Provide situational awareness to DOH • Support the health and medical needs of tribal populations 	Intelligence and Information Sharing
Regional Healthcare Coalitions	<ul style="list-style-type: none"> • Provide situational awareness to DOH • Respond to support the information and resource needs of healthcare facilities within coalition regions 	Planning Public Info & Warning Operational Coordination Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services Situational Assessment
Regional and State Disaster Medical Coordination Centers (DMCC)	<ul style="list-style-type: none"> • Provide situational awareness to DOH • Coordinate patient placement across regions 	Operational Coordination Intelligence and Information Sharing Public Health, Healthcare, and Emergency Medical Services

V. Resource Requirements

The Region X Resources Catalog is a FEMA Region X (Alaska, Oregon, Idaho, and Washington) joint catalog that provides responders with an up-to-date list of resources available within the Region. The catalog provides not only the available resources but a complete logistical information about the items, including photos. This catalog is a living document and each state is responsible for maintaining their individual section.

VI. References & Support Plans

- ESF 8 – Public Health, Medical, and Mortuary Services Annex to State CEMP
- Regional Patient Tracking Concept of Operations
- Pierce County Patient Reception Area Operational Plan (PRA OPLAN)

VII. Terms, Acronyms & Definitions

AFN – Access and Functional Needs

ASPR – Assistant Secretary of Preparedness and Response

CEMP – Comprehensive Emergency Management Plan

CMS – Center for Medicare & Medicaid Services

DMCC – Disaster Medical Coordination Centers

DOH – Department of Health

DSHS – Department of Social and Health Services

EMAC – Emergency Management Assistance Compact

EMD – Emergency Management Division

EMS – Emergency Medical Services

HCA – Health Care Authority

HCC – Healthcare Coalitions

HHS – United States Department of Health and Human Services

HSQA – Health Systems Quality Assurance Division

JRMPO – Joint Regional Medical Plans and Operations

LEP – Limited English Proficiency

LHJ – Local Health Jurisdiction

PNEMA – Pacific Northwest Emergency Management Arrangement

SARS – Severe Acute Respiratory Syndrome

SEOC – State Emergency Operations Center

USNORTHCOM – US Northern Command