NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX C:

MEDICAL SURGE

OCTOBER 2023

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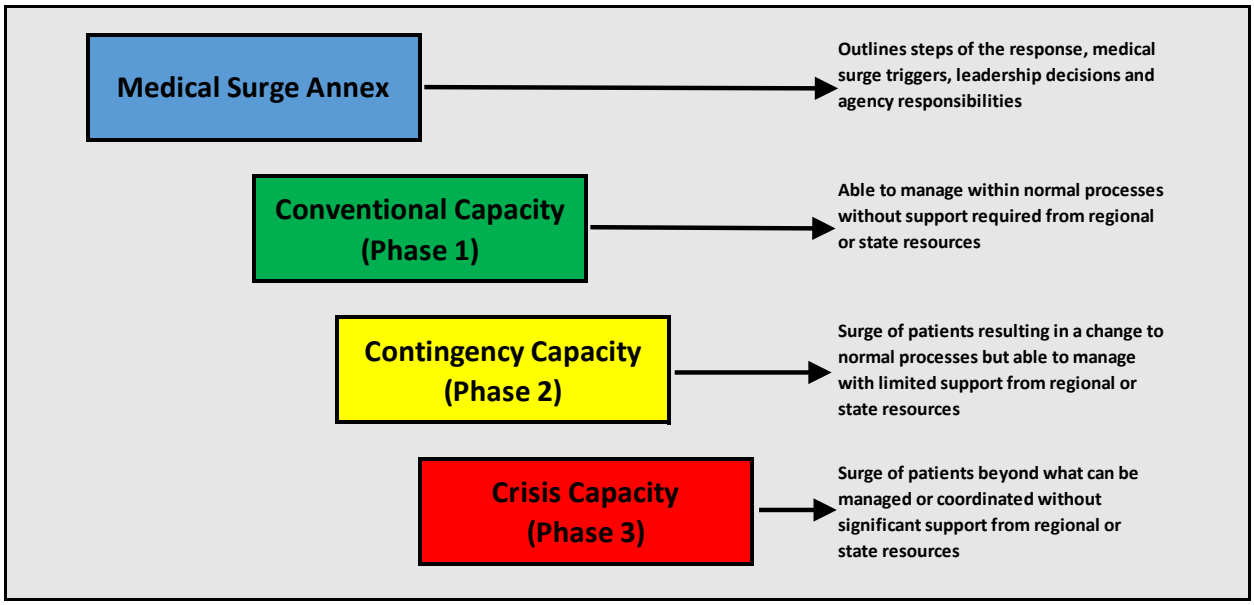
Overview

This plan is considered an annex to the North Carolina Office of Emergency Medical Services Emergency Operations Plan and provides a strategic high-level overview to the roles & responsibilities and the healthcare response coordination that is anticipated during a medical surge incident. The planning process is organized into a phased approach.



Phase 1 is normal day to day operations and is the timeframe in a potential medical surge response when the healthcare system operations are planning for a potential surge of patients but can manage within their normal processes without support required from regional or state resources.

Phase 2 begins when the healthcare system begins to see a surge of patients resulting in a change to their normal operating processes, but the healthcare entities are still able to manage the surge with limited support or coordination from regional or state resources.

Phase 3 occurs when the healthcare system is in a surge situation beyond what they can manage or coordinate and significant support from regional or state resources are required.

This plan considers that many hospitals within North Carolina have a well-developed surge plan and crisis standards process and this is not meant to take the place of those individual plans. This plan is meant to provide a common operating picture that allows the North Carolina Healthcare System to communicate, coordinate and collaborate as one system should the need arise due to overwhelming healthcare surge.

Authorities

The North Carolina Division of Emergency Management (NCEM) is delegated the responsibility and authority to respond to emergencies and disasters by the Governor via The North Carolina Emergency Management Act found in **Chapter 166A** of the North Carolina General Statutes[1].

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

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

Purpose

The purpose of this Annex is to provide local, state, and federal partners, relevant healthcare agencies and organizations, and other stakeholders the strategic high-level overview based on our healthcare system's approach to prepare for, manage, and respond to a medical surge incident in North Carolina safely and effectively.

Situation Overview

- North Carolina has a population of approximately 10.5 million people dispersed over a land area of 54,000 square miles. North Carolina is considered a high-risk jurisdiction based on the percentage of global and national travelers and because of its globalized workforce as well as populations of international origin.

- Ongoing and future medical surge incident pose a risk to the entire population and may adversely affect the ability of the public health organizations, hospitals, and other healthcare infrastructure within North Carolina to resolve them and may threaten to overwhelm the healthcare capacity if not mitigated quickly.

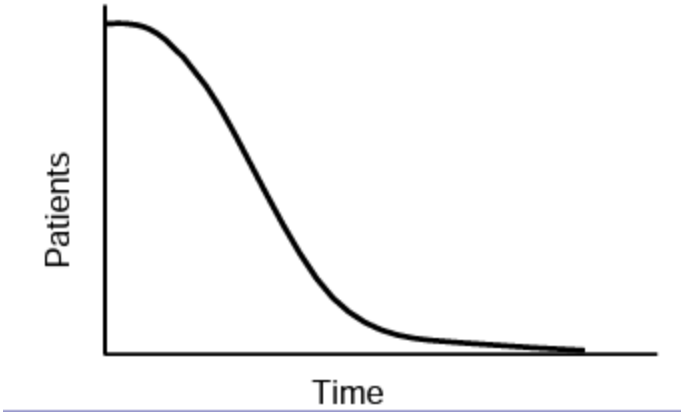
- Early recognition and a coordinated response to a medical surge incident is key to ensuring the healthcare system capacity does not become overwhelmed.

Medical Surge Incidents

When considering medical surge incidents, there are two main types that can occur: Immediate impact and sustained impact.

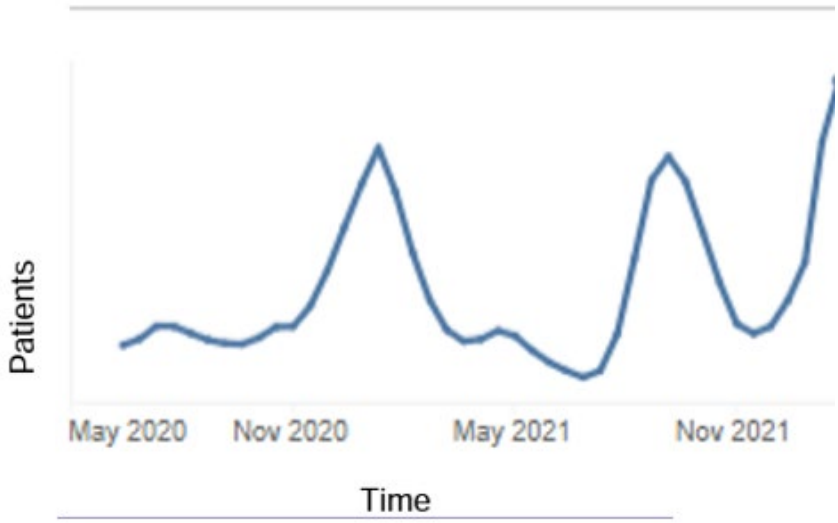
Immediate Impact

A medical surge incident that results in immediate impact (planned event, explosion, airplane crash, earthquake etc.) with an initial surge of patients. The number of patients decreases over time back to a steady state as the incident winds down.



Sustained Impact

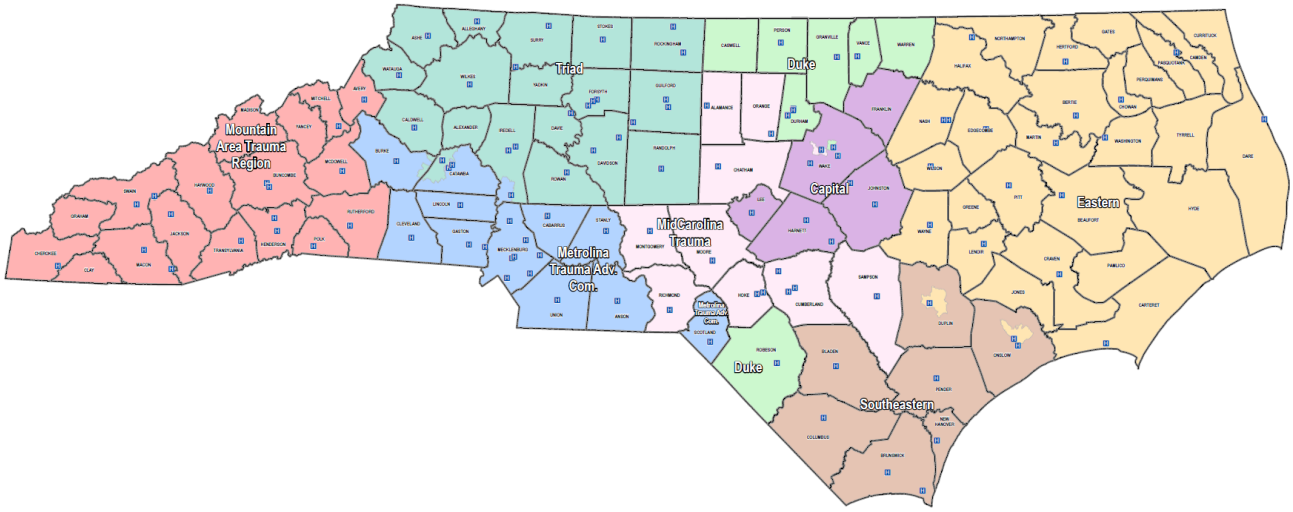
A medical surge incident that results in a sustained impact (highly infectious disease outbreak, high consequence pathogens outbreak etc.) have a gradual increase in number of patients impacting the healthcare system and can rise to a potentially catastrophic number with potentially multiple surges over time.



Hospitals and Healthcare Systems

North Carolina has 124 licensed acute care hospitals, many of which are part of larger healthcare systems which include hospitals, urgent care centers, specialty transport entities, physician offices, home health & hospice, skilled nursing facilities etc. Healthcare systems and hospitals have well-developed surge plans and crisis standards process plans that allow them to manage significant medical surge incidents without any external support. These plans include how hospitals will coordinate their incident command structure, clinical operations, staffing plans, management of supplies and equipment and other important planning elements that are exercised on a regular basis.

Figure 2. Hospitals in North Carolina by Region



Emergency Medical Service Systems

In North Carolina, EMS Systems are the responsibility of county governments to establish and define geographical service area, scope of practice, and written policies and procedures. Each EMS System must have a written Disaster plan, Mass-casualty plan, and Infectious Disease Control Policy which describes how the EMS system will protect and prevent against exposure and illness from infectious diseases to include all patients and EMS Providers[2]. Prehospital Emergency Medical Service Systems and all associated providers should be prepared to evaluate patients for many different known and emerging highly infectious diseases such as Influenza (Flu), Coronaviruses, Measles, Ebola Virus Disease etc. The best approach for prehospital management of all these infections is strong infection prevention habits, an effective respiratory protection program and effective communication between prehospital providers and receiving healthcare facilities. EMS plays a key role in medical surge incidents whether they are immediate or sustained.

North Carolina Office of Emergency Medical Services

North Carolina Office of Emergency Medical Services is the lead agency for Medical Surge response in the state. Part of this responsibility includes deployment of the State Medical Response System to support medical surge incidents. This includes EMS Resources, Personnel Management, Alternate Care Sites, and other surge related missions. Additional details beyond this plan can be found in the **North Carolina Emergency Operations Plan (NCOEMS EOP) ANNEX C: APPENDIX C1 – APPENDIX C4.**

North Carolina Emergency Management

North Carolina Emergency Management (NCEM) has the delegated responsibility and authority to respond to emergencies and disasters in North Carolina. Chapter 166A of the North Carolina General Statutes (NCGS) establishes the authority and responsibilities of the Governor, state agencies, and local government for emergency management. To accomplish this responsibility, NCEM utilizes an organizational structure referred to as the State Emergency Response Team (SERT) to provide,

[2] http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2013%20-%20nc%20medical%20care%20commission/subchapter%20p/subchapter%20p%20rules.pdf

coordinate and arrange for emergency assistance to the counties. The Emergency Services Group is the functional lead for Disaster Medical Response within the SERT and serves as the primary point of contact for situational awareness, support requests and response coordination.

Key Definitions

Conventional Capacity: The physical spaces, healthcare staff, and supplies used are consistent with normal practices within the healthcare facility. These practices are adequate for a major mass casualty incident (MCI) within the immediate area of the facility, even one that triggers activation of the facility emergency operations plan. Majority of the healthcare system operates under conventional capacity on a day to day basis.

Contingency Capacity: The physical spaces, healthcare staffing plan, and supplies used are not consistent with normal healthcare practices, but healthcare facilities are able to still provide care at the same standard of usual patient care practices. According to North Carolina General Statue 131E-84, the Division of Health Service Regulation may temporarily waive certain hospital rules approved by the North Carolina Medical Care Commission to the extent necessary to allow the hospital to provide temporary shelter and temporary services to adequately care for patients (**see Example 1, under Protocols for Allocating Scarce Resources below**). Hospitals and healthcare facilities should refer to CMS for federal waiver requirements. Contingency capacity may be used temporarily during a major crisis or for a more sustained timeframe during a large disaster that is putting strain on the regional or statewide healthcare system. This includes the use of temporary structures or alternate care sites operated by individual healthcare facilities. It is expected that Hospitals and Healthcare systems that are operating under contingency capacity are utilizing all surge capacity efforts to return to conventional capacity as soon as possible including increasing or reallocating staff, decreasing or ceasing non-urgent surgeries, and transferring patients to healthcare facilities throughout the state.

Crisis Capacity: Adaptive physical spaces, healthcare staff, and supplies used are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e. provide the best possible care to patients given the circumstances and resources available). These practices may be used temporarily during a major crisis or during a more sustained timeframe during a large disaster that is putting significant strain on the entire healthcare system regionally or statewide. According to North Carolina General Statue 131E-84, the Division of Health Service Regulation may temporarily waive, during declared disasters or emergencies, certain hospital rules approved by the North Carolina Medical Care Commission to the extent necessary to allow the hospital to provide temporary shelter and temporary services to adequately care for patients. Hospitals and healthcare facilities should also refer to CMS for federal waiver requirements if applicable. It is expected that all hospitals and associated healthcare systems that are operating under crisis capacity have reached out to their partner healthcare systems and their regional healthcare preparedness coalitions for support. It is expected that all measures to manage the surge capacity and return to conventional capacity as soon as possible are being utilized to include ceasing all non-urgent surgeries, implementing regional allocation or diversion, internal decompression and transferring patients to healthcare facilities throughout the state.

Surge Plan

A phased medical surge plan will be utilized to define trigger points based on hospital capacity to ensure North Carolina is able to maximize space available should the healthcare system be

overwhelmed during a medical surge response. The phased plan looks at capacity and capability on a statewide and regional level, although a single hospital may result in the need to trigger an action from one phase to another depending on the situation. Each phase should be discussed with the healthcare system throughout the response to ensure flexibility to move between phases as appropriate during a response. The regional triggers are based on the North Carolina Healthcare Preparedness Coalition regions to align geographically with the Healthcare Preparedness Program. The regional trigger indicates when the healthcare systems, within that geographical boundary, have met the stated criteria. The statewide trigger is based on three or more regions activating their regional triggers and/or a statewide capacity metric. Within each given phase are different actions that outline expected response activities to ensure coordination, communication and collaboration can be aligned between NCOEMS, Healthcare Preparedness Coalitions, hospitals, and healthcare systems. Any of the actions can occur across the different phases as necessary.

Surge Phases

Table 1: Medical Surge Phases

Phase	Phase Name	Regional Trigger	Statewide Trigger	Key Actions
Phase 1	Healthcare System operating at Conventional Capacity	Known local spread of highly infectious disease or newly emerged disease / report of immediate surge incident potential	Known regional spread of highly infectious disease or newly emerged disease / report of immediate surge incident potential	• Assess availability of assets & resources • Procurement of additional resources • Monitor metrics
Phase 2	Healthcare System operating at Contingency Capacity	≤7.5% Total Staffed Adult and/or Child ICU Capacity Available	Three or more regional triggers	• Increased monitoring of daily metrics • Regular cadence regional coordination call • Healthcare situation reports
		≤10% Total Staffed Inpatient Bed Capacity Available	≤30% Total Staffed Inpatient Bed Capacity Available	
Phase 2.5	Healthcare System operating at Contingency Capacity	≤5% Total Staffed Adult and/or Child ICU Capacity Available	≤15% Total Staffed Adult and/or Child ICU Capacity Available	• Regular cadence statewide patient coordination calls • Mobilize State Coordinated Alternate Care Sites
		≤0% Total Staffed Inpatient Bed Capacity Available	≤10% Total Staffed Inpatient Bed Capacity Available	
Phase 3	Healthcare System operating at	Use of inpatient temporary space (using tents, mobile	Use of inpatient temporary space (using tents, mobile	• Activate State Coordinated Alternate Care

	Crisis Capacity	facility, or other alternate care space outside facility)	facility, or other alternate care space outside facility) in two or more regions	Sites • Activation of statewide patient coordination team • Recommend suspension of non-urgent surgeries

Phase 1: Healthcare System Operating at Conventional Capacity

The healthcare system across North Carolina manages a large number of patients on a day-to-day basis and is very skilled at managing patient surges without any outside support. This can be seen annually during flu season when for several weeks or months the patient volume to the emergency department and inpatient admissions is increased. Healthcare systems have a variety of surge management methods that they are able to utilize to manage the patient flow and surge that occurs during these higher volume times. During this phase it is important that the Healthcare Preparedness Program (HPP) is providing situational awareness, partner communication, healthcare system guidance and support, and is beginning to prepare for the potential that can result from a medical surge incident by assessing the statewide status of assets, equipment, personnel and determining potential gaps in resource availability. NC HPP has put together considerations for managing medical surge for healthcare facilities to consider (**see Example 2, under Protocols for Allocating Scarce Resources below**). Phase 1 is triggered when there is known local or regional spread of a highly infectious disease, a newly emerged disease, or a potential threat for medical surge due to a planned event or specific threat. This is a time to ensure proper preparedness efforts have occurred for a potential medical surge.

The following actions are expected during this phase:

- Assess availability of existing assets & resources:
  - Alternate Care Site Locations (see notes below) & contract considerations
  - Medical Equipment Status and Availability for Alternate Care Site locations
  - Personnel Availability

- Procurement of additional resources:
  - Establish contracts based on the assessment of existing assets and resources for noted gaps such as medical equipment and consumables, staffing support, transportation support etc.

- Monitor metrics
  - Begin collecting and monitoring daily metrics for hospital capacity and operational triggers.

- Collect Pre-Impact Essential Elements of Information
  - Begin collecting from all hospitals in the potential impact area at least 24 hours before anticipated impact.

Phase 2: Healthcare System Operating at Contingency Capacity

Phase 2 is based on the initial healthcare surge that is expected during any large disaster that puts strain on the healthcare system. This phase is triggered when the available hospital capacity is noted to be sustained at or below 7.5% Adult or Pediatric ICU Capacity (this can be triggered for either adult or pediatric available capacity within the region as the medical surge incident may be impacting one population group more so than the other) and/or below 10% Total Staffed Inpatient Bed Capacity available over a 7-day timeframe. This is determined by the daily reported staffed capacity from the hospital and is not based on licensed capacity. It is anticipated that hospital bed capacity waivers will be available to support the medical surge response within the healthcare system. Hospitals have the best visibility of their own capacity and ability to surge based on staffing, physical space and equipment and supplies. The day to day capacity is noted to change quickly due to small surges within the healthcare system and as such capacity is monitored over a 7-day period to determine if potential triggers are being met.

It is expected that during this phase the healthcare system will be able to manage the surge of patients internally with minimal support needed from regional or state entities through the activation of their internal medical surge plans. During this phase the actions implemented are to ensure that the situation is monitored closely, support provided quickly when needed, and that actions are being taken to prepare to move into the next phase when necessary. Phase 2.5 indicates triggers that have been identified to denote when NCOEMS should request support from the State Emergency Response Team to begin mobilizing State Coordinated Alternate Care Sites, EMS Resources, Emergency Contracts, Statewide Patient Movement Coordination, and Personnel Management.
The following actions are expected during this phase:

- Increased monitoring of daily metrics
  - Daily review of operational triggers should begin to ensure that the set hospital capacity metrics are monitored closely.

- Regular cadence regional coordination call
  - A regular cadence should be set for the regional coordination call between NC HPP & the NC Healthcare Coalitions (HCCs) to ensure good situational awareness of the response, potential gaps, requests for support and information sharing (cadence is expected to change based on response activities). Each Healthcare Coalition should also set a regular cadence for their regional coordination call with partners to ensure good situational awareness of the response, potential gaps, requests for support and information sharing (cadence is expected to change based on response activities).

- Healthcare situation reports
  - Regional healthcare situation reports (sit-rep) or Post-Impact Essential Elements of Information (EEI) should be collected on a regular basis from the healthcare system (daily, weekly etc.) to ensure good visibility of the healthcare system status. The initial elements have been set by the Administration for Strategic Preparedness and Response (ASPR) Healthcare Preparedness cooperative agreement. However, the elements collected may change frequently based on

the evolving situation as required by federal regulatory and response agencies. Elements are expected to include general operating status, indication of impact to normal services, capacity, anticipated needs and current unmet needs.

- EMS Resources
  - Many different medical surge incidents require EMS resources to be able to properly manage patient movement and EMS System surge of emergency responses. Identification of these resources should occur during this phase and throughout the medical surge response. Refer to **North Carolina Emergency Operations Plan (NCOEMS EOP) ANNEX C: APPENDIX C1 EMS Resources** for more information.

- Regular cadence statewide patient coordination calls
  - A regular cadence should be set for the statewide patient coordination calls with the large healthcare systems (cadence is expected to change based on response activities) to support situational awareness of hospital capacity and provide open lines of communications to support the movement of patients across regions and the state to help manage the medical surge. Refer to **North Carolina Emergency Operations Plan (NCOEMS EOP) ANNEX D Patient Movement** for more details on the statewide patient coordination calls.

- Mobilize State Coordinated Alternate Care Sites
  - It is anticipated to take a minimum of 7 days lead time to activate a state coordinated alternate care site during a medical surge response due to the already increased strain on the healthcare system. Once the decision has been made to mobilize state coordinated ACS, plans should be activated to physically move the equipment and supplies into the Alternate Care Sites and begin assessing staffing resources and contractual needs (oxygen, environmental services, transportation, staff, supplies, feeding etc.). Whenever possible, Alternate Care Sites should be physical structures that are already in existence (e.g. unused healthcare facility space, retail buildings, recreational facilities etc.), when these structures are not available, hard sided mobile structures should be utilized for the highest level of safety, and lastly tent systems should be used only as a last resort unless the use is expected to be short in duration.

Phase 3: Healthcare System Operating at Crisis Capacity

This phase indicates that the healthcare system is being significantly impacted regionally or statewide to the point that crisis capacity standards are being utilized to manage the patient volume, indicating significant support from regional and state partners may be required. This phase is triggered by any hospital within a region needing to manage their surge in a temporary space (using tents, mobile facility, or other alternate care space outside facility) for inpatient capacity. Use of temporary space for outpatient diagnostic or patient flow management does not trigger this phase although should be considered an early warning sign for potential capacity concerns. Any two regions experiencing crisis capacity will trigger a statewide response. Expected actions during this phase are focused on supporting the movement of patients, activating alternate care sites and determining statewide policy decisions to ensure the healthcare system can continue to provide the level of care expected.

- Activate State Coordinated Alternate Care Sites
    - See section below on Alternate Care Sites

- Activation of statewide patient movement team
    - See section below on statewide patient movement coordination

- Recommend suspension non-urgent surgeries
    - The recommendation from state health officials to suspend non-urgent surgeries should be considered a last resort. Healthcare systems should utilize their own judgement on when is best to increase or decrease their surgical load to manage their surge of patients. Consideration of use of alternate care sites and state or federal personnel should take into account the level of surgical cases a healthcare facility is completing prior to approval. Should a recommendation from state health offices be needed to suspend non-urgent (elective) procedures and surgeries regionally or statewide, it is expected to be considered during this phase. The recommendation would outline the expectations for healthcare systems (hospitals and ambulatory surgery centers) regarding the suspension of elective and non-urgent procedures and surgeries. Elective and non-urgent are defined as any procedure or surgery that if delayed would not cause harm to the patient.

Alternate Care Sites

North Carolina will use a tiered approach within each phase for the use of Alternate Care Sites for healthcare related surge management during a medical surge incident to manage scarce resources. Tier 1 is based on local coordination (hospital emergency manager or local county emergency manager requests and manages) and Tier 2 is based on State Emergency Response Team (SERT) coordinated sites which may be requested by a hospital and/or county emergency manager to help support local or regional medical surge. SERT coordinated sites do not require local request to be established and can be based on the phased metrics set forth in this plan.

Table 2: Alternate Care Site Tiers

Phase	Tier 1 (Locally Coordinated)	Tier 2 (SERT Coordinated)
Phase 1	Surge within the Acute Care Hospital walls – exceeding licensed bed capacity (managed by hospital EOC) as requested through state/federal waivers	N/A – during this phase there is no anticipated SERT coordination of surge sites
Phase 2	Surge within existing Healthcare Structures (Ambulatory Surgical Center, Closed Hospitals etc.) - Managed by Healthcare System EOC with support from County EOC	Surge within existing Healthcare Structures (Closed Hospitals, etc.) – Coordinated or Supported by SERT / State Medical Response System (SMRS) –
Phase 3	Alternate Care Sites (existing structures should be considered first) - Managed by County EOC with	Alternate Care Sites (existing structures should be considered first) – Coordinated or Supported by SERT

	support from County Leadership	/ SMRS with support anticipated from Contractual Agreements, EMAC and/or Federal resources

During Phase 1, it is anticipated that the healthcare system will surge within their own facilities first and foremost. Requests for additional support, such as staffing, medical equipment and supplies can be requested through the local emergency manager to increase the surge capacity if anticipated gaps are noted. It is preferred that the medical surge be managed locally within the healthcare system to the extent possible as the use of county or state support alternate care sites introduces additional challenges for managing and maintaining the healthcare system surge and could decrease the availability of already scarce resources.

During Phase 2 and Phase 3, it is anticipated that the normal healthcare system capacity has been exceeded and plans for alternate care sites should be considered.

All tier 1 (locally coordinated) alternate care site assets or resource support requests should flow through the local emergency managers with coordination from the Regional Healthcare Coalitions when necessary. If unable to fill locally, then the request will be considered by the State Medical Response System, but it is required that the following conditions are met before resource requests will be considered for approval:

1. All appropriate state/federal waivers have been requested & approved
2. Alternate Care Site Consideration Checklist with associated plan has been submitted to NCOEMS (see Example 2)
3. Approval received from Emergency Support Function (ESF) 8 Lead or designee and NCEM Emergency Services Group
4. Approval received from Division of Health Service Regulation Construction Section to ensure all life safety requirements have been met

The local entity requesting the alternate care site assets should be prepared to provide a comprehensive plan outlining their staffing plan and how the ACS will be equipped and supplied during the expected time of use. The plan should also address all the life safety requirements including a security plan and traffic flow plan for the ACS location. Failure to provide this information may result in a delay in receiving approval for the ACS assets or resource support requests.

Tier 2 (SERT coordinated) alternate care sites should be initially activated based on the regional capacity triggers as outlined in the medical surge phases. Ideally an ACS should be placed no more than a two hours' drive from the larger population centers (e.g. Wilmington, Greenville, Raleigh/Durham, Greensboro/Winston-Salem, Charlotte, Asheville) to support medical surge and hospital decompression from the largest hospital capacity areas.

Statewide Patient Placement Coordination

Everyday patients across North Carolina are moved to different hospitals due to patient acuity, hospital capacity and capability. These normal patient movement processes should remain intact as long as possible and are not met to be interrupted except when absolutely necessary due to a medical surge incident. **North Carolina OEMS Emergency Operations Plan (NCOEMS EOP) ANNEX D: APPENDIX D1 -**

Hospital Patient Movement Guideline will be utilized to coordinate statewide patient movement and placement during a medical surge incident when indicated by the Statewide Patient Coordination Team. According to this plan the Statewide Patient Coordination Team should begin to meet biweekly during Phase 2 of the response.

State Healthcare Staffing Support

North Carolina utilizes the North Carolina Training Exercise Response Management System (NC TERMS) to recruit and manage volunteers. Previous experiences with volunteer management included the requirement to onboard all volunteers through Temp Solutions to ensure worker's compensation coverage. This is a not a quick process and volunteer management/staffing needs should be considered early due to potential delays in getting this set up. Refer to **North Carolina Emergency Operations Plan (NCOEMS EOP) ANNEX H: State Medical Response System (under construction)** for more information.

Additionally, emergency staffing contracts by NCEM or DHHS should be considered early on so there is time to execute and staff a site based on the potential needs.

The NC Board of Nursing should be requested to share with Nursing Executives that the Board of Nursing has position statements related to delegation to Unlicensed Assistive Personnel (UAP). The position statements include Delegation and Assignment of Nursing Activities, Delegation of Non-Nursing Activities, Delegation of Immunization Administration to UAP, and Delegation of Medication Administration to UAP. The Board of Nursing also provides a Decision Tree for Delegation to UAP. These resources can be found on the NC Board of Nursing website (https://www.ncbon.com/practice-position-statements-decisions-trees). This includes recruitment for individuals willing to volunteer as a UAP and go into hospitals to help support clinical staff (**see recruitment letter Example 3, under Protocols for Allocating Scarce Resources below)**.

Protocols for Allocating Scarce Resources

In March of 2020 and again in January of 2021 a group of North Carolina experts came together to develop a statewide protocol: North Carolina Protocol for Allocating Scarce Inpatient Critical Care Resources in a Pandemic. This protocol was developed by the North Carolina Institute of Medicine (NCIOM), North Carolina Medical Society (NCMS) and the North Carolina Healthcare Association (NCHA) with support from the North Carolina Department of Health and Human Services (NC DHHS). One of the goals of the protocol was to present a recommended protocol to the Secretary of NC DHHS. This group should be reconvened to review this protocol should North Carolina be in a similar situation in the future.

NC DHHS also has Guidelines for Allocation of PPE. These guidelines were created to help manage scarce PPE resources during a pandemic. The guidelines were written due to a lack of PPE supplies and a high demand for those resources. The main goal of the guidelines was to prevent transmission of COVID-19 to those at highest risk of severe clinical disease and assure personal protective equipment to workers delivering emergent life-saving services (**see Example 4 below)**.

Example 1: North Carolina Healthcare Regulatory Waivers

MEMORANDUM

TO: North Carolina Hospital CEOs

On Tuesday, March 10th, the Governor issued an Executive Order declaring a State of Emergency to coordinate response to the spread of COVID-19. Pursuant to his Executive Order and General Statute 131E-84, the North Carolina Emergency Management Director, and Department of Health and Human Services (DHHS) Secretary have directed the Division of Health Service Regulation (DHSR) to temporarily waive certain hospital rules approved by the North Carolina Medical Care Commission to the extent necessary to allow the hospital to provide temporary shelter and temporary services to adequately care for patients that may be stricken by COVID-19.

At this time, DHSR will waive the limitations found in 10A NCAC 13B.3111 (for example, the limitation on increasing beds to 10% above licensed bed capacity when census exceeds 90%, the limitation on utilization of observation beds only, and the limitation for a period not greater than 60 consecutive days) to the extent necessary to allow a hospital to provide temporary services to adequately care for patients that may be stricken by COVID-19 based on the following parameters:

1. A hospital may temporarily increase its acute care bed capacity over its licensed bed capacity and temporarily relocate existing licensed acute care beds into physical space that meets federal life safety requirements, unless any of those requirements are waived by the Centers for Medicare and Medicaid Services (CMS) for inpatients, for the purposes of accommodating patients:
    a. receiving treatment for COVID-19;
    b. awaiting results of testing for COVID-19; or
    c. relocated to accommodate other patients treated for COVID-19 elsewhere in the facility or community;

for the period of consecutive days specified in the approval of the DHSR. Such physical space may include clinical or non-clinical space within the hospital facility, including space used for other categories of licensed beds, or in other facilities or space operated as a campus of the hospital.

2. DHSR may approve a temporary increase in licensed bed capacity or temporary relocation of inpatient beds if:
    a. the hospital has submitted such request in writing, including, but not limited to, the number of additional beds, description of the physical space to be utilized and how it will be utilized, and the anticipated duration;
    b. DHSR has determined that the request has met the requirements of paragraph 1 above; and
    c. the hospital administrator provides an explanation and certifies that:

i. the increase in bed capacity is necessary for public health and safety in the geographic area served;

ii. physical facilities to be used are adequate to safeguard the health and safety of patients and will be operated in accordance with CMS hospital conditions of participation and any applicable temporary CMS requirements for inpatient care; and

iii. all hospital patients will receive appropriate care and their health and safety safeguarded.

This approval will be revoked if DHSR determines that these conditions are not met, or safeguards are not adequate to safeguard the health and safety of patients.

A hospital may address its request to temporarily increase its acute care bed capacity to adequately care for patients to DHSR's Acute and Home Care Licensure and Certification Section Chief,

Example 2: Considerations for Managing Medical Surge

All healthcare facilities should have preplanned strategies for managing the medical surge capacity that may result during the COVID-19 response. Medical Surge is defined as the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community.

As part of preplanning for Medical Surge, healthcare facilities should look to define their Medical Surge Capacity and their Medical Surge Capability:

Medical Surge Capacity: The ability to evaluate and care for a markedly increased volume of patients – one that challenges or exceeds normal operating capacity. Considerations for addressing medical surge capacity should focus on systems and processes:

1. Identify the medical need
2. Identify the resources to address the need in a timely manner
3. Move the resources expeditiously to locations of patient need (as applicable)
4. Manage and support the resources to their absolute maximum capacity

Medical Surge Capability: The ability to manage patients requiring unusual or specialized medical evaluation and care to included specialized care situations where additional expertise, information, procedures, equipment or personnel will be needed.[3]

Medical Surge Preparedness Steps[4]:

- ❑ Review your hospital emergency operations plan for information on immediate bed availability and patient surge strategies
- ❑ Review thresholds and triggers for activating your emergency operation plan and your surge management strategies
- ❑ Begin preplanning for use of alternate care strategies (telemedicine services, capacity of nurse triage lines, increased hours for outpatient clinics, alternate care sites etc.)
- ❑ Review inpatient surge activities (early discharge planning, opening already certified beds or units, and the use of remote locations)
- ❑ Review outpatient surge activities (use of tents or mobile facilities located on/within the hospitals' campus)
- ❑ Coordinate your plans with partner agencies (local emergency management, local emergency medical service agencies, local public health agencies, public safety answering points, other nearby hospital systems, outpatient clinics not part of the healthcare system, regional healthcare coalitions)
- ❑ Communicate with partners agencies and regulatory authorities when thresholds and triggers within your emergency operations plan have been met and alternate care strategies are being considered

Alternate Care Site Considerations:

[3] "What is Medical Surge?" 14 February 2012. Public Health Emergency. <https://www.phe.gov/Preparedness/planning/mscc/handbook/chapter1/Pages/whatismedicalsurge.aspx>.

[4] "Considerations for the Use of Temporary Surge Sites for Managing Seasonal Patient Surge" February 2018. ASPR TRACIE < https://asprtracie.hhs.gov/technical-resources/resource/5312/considerations-for-the-use-of-temporary-care-surge-sites-for-managing-seasonal-patient-surge>

Hospitals that are considering the use of alternate care sites as part of their medical surge strategies should be begin preplanning now and be prepared to provide specific details on their planning efforts when requesting use of alternate care sites. The following considerations should be part of the preplanning phase:

- ❑ Determine appropriate location for alternate care site based on regulatory requirements (availability of 1135 waiver, availability of NC GS 131E 84 waiver)
- ❑ Determine how to handle traffic control issues related to the alternate care site to ensure Emergency vehicular access to the ED for patient drop off and emergency response vehicle access (e.g. police, fire, EMS) can be maintained
- ❑ Determine what types of patients will be served in the alternate care site
- ❑ Determine how to staff and support the patients in the alternate care site
- ❑ Determine how to provide adequate equipment and supplies for the alternate care site (beds, patient monitors, oxygen, crash cart, restrooms, handwashing stations with hot water at 105-120 degrees etc.)
- ❑ Determine how to manage clean supplies and soiled supplies within the alternate care site
- ❑ Determine how to support necessary services for the alternate care site (generators, electrical access, lighting equipment etc.)
- ❑ Determine heating/cooling and ventilation system can be continuous (ventilation system should consider how to ensure the air is ventilated outside and minimum number of air exchanges (12 air changes per hour) can be met
- ❑ Determine a security site plan that specifically addresses staff and patient safety and physical protection for the alternate care site
- ❑ Determine a safety site plan (to include evacuation plan in case of emergency and how to maintain constant communications with the staff working in the alternate care site)
- ❑ Determine what hours of the day you will utilize the alternate care site
- ❑ Determine local code authority for fire and building codes are consulted during planning efforts

Example 3: NC Recruitment Letter for Unlicensed Assistive Personnel

North Carolina's Healthcare Systems Need Workers Like You – Support the Fight Against COVID-19!

As North Carolina prepares for another large surge of cases and hospitalizations during this pandemic, NC DHHS is undertaking an effort to bolster staff to join our health care systems and facilities to ensure we can prevent illness and care for those impacted by the virus. A crucial part of that effort is recruiting workers (**clinically licensed and non-licensed**) to supplement the health care workforce in hospitals, EMS agencies, and long-term care facilities. **If you're interested in working for NC healthcare systems, please complete this form: https://nc.readyop.com/fs/4dti/a6fc to provide contact information that can be shared with healthcare systems so they can hire, onboard and train personnel to support their daily operations.**
We are recruiting for workers that can assist in the following duties:

1. Data Entry
2. Vital Sign Checks
3. EKG Procedure
4. Pulse Oximetry
5. X-Ray Procedures
6. Laboratory Functions
7. Answering Phones
8. Supporting Activities of Daily Living
9. Driving Ambulances
10. Various Other Tasks

Should you have any questions please contact OEMSStaffingSupport@dhhs.nc.gov
Thank you for your commitment to protecting the health and wellbeing of all North Carolinians. North Carolina needs you!

Example 4: Guidelines for Allocating PPE to Healthcare Settings

Guidelines for Allocation of Personal Protective Equipment (PPE) to Healthcare Settings

Dear partners,

As you know, the global shortage of personal protective equipment (PPE) has posed a tremendous challenge to the COVID-19 pandemic response here in North Carolina, across the country, and internationally. We continue to request supplies from the federal government and have engaged hundreds of public and private vendors and manufacturers as we search the globe to bring as many supplies as we can to North Carolina. We know that you have also worked tirelessly in your own communities to identify and purchase supplies and we are committed to partnering with you to track down all possible leads and look for innovative solutions to get more supplies into our state.

Since the launch of our COVID-19 response, requests to the State Emergency Response Team for PPE have far outpaced our ability to source and fulfill them given the lack of product availability. Therefore, until supply chains improve, we have developed a process for fulfillment of resource requests for PPE across the state. In developing this process our overarching goal is to **prevent transmission of COVID-19 to those at highest risk of severe clinical disease & assure personal protective equipment to workers delivering emergent life-saving services.**

While we continue to work to identify additional supplies, we are also working on conservation methods and strategies such as increasing the use of telehealth, decontaminating supplies for reuse, and extending use of PPE beyond its indicated shelf life in appropriate settings.

Ideally, we would be able to meet the requests of everyone on this list. Unfortunately, the lack of global supply for PPE makes that impossible and scarcity forces difficult decisions.

Please note that the list below was developed to extend inventory amounts up to 7 days based on current burn rates. This document does not guarantee fulfillment of every order that meets the criteria, nor does it ensure complete fulfillment of orders. Also, orders may be partially filled due to limited stock, until supply chains stabilize.

<u>Group 1:</u>

Acute Care:

a. Hospitals with highest number of COVID-19 cases
b. Hospitals with COVID-19 cases
c. Hospitals with ICU/ECMO/Ventilator Capacity
d. Hospitals
e. Emergency Departments (including free-standing)
f. 911-Emergency Medical Services
g. Emergency Medical Services (Providing Critical Care)

Long Term Care:

a. Skilled Nursing Facilities with highest number of COVID-19 cases
b. Skilled Nursing Facilities with COVID-19 cases

c. Skilled Nursing Facilities
d. Palliative & Hospice Providers caring for COVID-19 cases
e. Home Health caring for COVID-19 cases
f. ICFs (Intermediate Care Facilities) for Individuals with IDD with highest number of COVID-19 cases
g. ICFs (Intermediate Care Facilities) for Individuals with IDD with COVID-19 cases
h. ICFs (Intermediate Care Facilities) for Individuals with IDD
i. Adult Care Homes with highest number of COVID-19 cases
j. Adult Care Homes with confirmed COVID-19 cases
k. Adult Care Homes
l. Behavioral Health & Intellectual and Developmental Disabilities and Traumatic Brain Injury group homes with highest number of COVID-19 cases
m. Behavioral Health, Intellectual and Developmental Disabilities, and Traumatic Brain Injury group homes with COVID-19 cases
n. Behavioral Health & Intellectual and Developmental Disabilities and Traumatic Brain Injury group homes
o. Shelters, Correctional Facilities, Dormitories, Unlicensed Residential Treatment Facilities, etc. with COVID-19 cases

Group 2:

Public Health & Testing/Contact Tracing Initiatives:

a. Public Health Departments
b. Primary Care Providers
c. Federally Qualified Health Centers
d. Specialty Care Providers
e. Urgent Care Centers
f. Pharmacists
g. Community Sample Collection Sites

Healthcare/First Responder Agencies:

h. Adult Protective Services & Child Protective Services
i. Law Enforcement
j. Fire Departments
k. Palliative & Hospice Providers (not covered under Group 1)
l. Home Health (not covered under Group 1)
m. Dialysis Centers
n. Healthcare workers in school settings
o. Non-Emergency EMS Transport Agencies (not covered under Group 1)
p. All medical transportation agencies
q. All other healthcare providers

Other considerations: All requests for PPE will be verified and vetted to ensure assignment based on maintaining up to 7 days of inventory. Requests for greater than 7 days of inventory or requests without proper justification cannot be accommodated due to the high demand for these resources.

PPE is provided based on this grouping schedule regardless of urban/rural/tribal, non-profit/for-profit agency. The North Carolina State Emergency Response Team Unified Command may modify these criteria based on emerging response needs.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX C1: EMS Resources

June 2024

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Purpose

The purpose of the EMS Resources Plan is to provide a framework for NCOEMS personnel to activate, deploy, manage, and demobilize EMS resources when necessary. This appendix focuses on the management processes for all EMS resources that may be available for deployment during emergencies or disasters.

Scope

This appendix covers the roles and responsibilities for EMS resources that may be utilized during an event or incident, to include Ambulances, Ambulance Buses, Air Ambulances, Single Response Units, EMS Personnel, and operational/logistical support vehicles. Through coordination with the Healthcare Coalitions (HCCs), and in partnership with local agencies, NCOEMS maintains plans, equipment, and training focused on the efficient and effective delivery of EMS resources in response to requests for resources.

Planning Assumptions

- EMS resources deployed under this plan are considered state-level resources and must meet all requirements outlined in this plan and as directed by NCOEMS.

- EMS resources deployed under this plan may be utilized in various arrangements as appropriate to the situation and resource availability. General EMS resource configurations that may be deployed under this plan include:
    - Ambulance(s) (ALS/BLS/Specialty Care)
    - Ambulance Bus(es)
    - Ambulance Strike Teams (typically 5 ground ambulances)
    - Ambulance Task Forces (combination of ambulances and ambulance buses)
    - Air Ambulances
    - Single Response Vehicles
    - Alternative Transportation (Wheelchair Vans, Paratransit Vans, Public/Private Transportation etc.)

- Initial request for EMS resources should occur at the local level through county-to-county mutual aid. County-to-county mutual aid is not part of the State Medical Response System and while NCOEMS may be involved in the coordination, this plan does not cover the specific details of county-to-county mutual aid.

- Anticipated vs. Unanticipated Incidents
  EMS resources may be requested due to anticipated (24-hours advanced warning) or unanticipated incidents (less than 24-hours advanced warning). The fulfillment of EMS Resource requests is not a quick process and is likely to be limited or unavailable during initial response to unanticipated incidents. County-to-county mutual aid is the best initial option during unanticipated incidents.

- The deployment, logistical support, communication protocols, and demobilization of EMS resources will:
    - Adhere to basic National Incident Management System (NIMS) principles and concepts including those under the Incident Command System (ICS)
    - Utilize processes and practices established by NCOEMS, HCCs, and local EMS partners for operations within the State Medical Response System (SMRS). More details can be found in TAB C1A: Minimum Requirements for NC SMRS EMS Participation.
    - Be accomplished under an authorized ESF8 mission request. Resources will not self-dispatch to the scene of the event or incident

EMS Resource Assets

All vehicles deployed should be appropriately licensed and permitted based on the vehicle type. The vehicles should be in good running order and stocked appropriately. Licensed EMS vehicles should meet the standards outlined in NCOEMS Rule in 10A NCAC 13P.

Logistics Trailers or Support Vehicles: All logistics trailers and support vehicles will be maintained in good condition and supplied per the recommended standards under TAB C1C: Recommended Standard Equipment and Supplies. Equipment and supplies on the trailer/vehicle will be maintained in good, usable condition. EMS agencies which maintain Ambulance Strike Team Logistics Trailers should coordinate with their regional HCCs to evaluate and develop plans to resolve any shortcomings in equipment or supplies which may affect their ability to respond.

For information on the EMS resources for out of state deployments Refer to: **TAB C1B: Emergency Management Assistance Compact (EMAC) Deployment of EMS Resources.**

Concept of Operations

Activation

Activation of this plan may be initiated at any time with the approval of the ESF8 Lead. Initiation may be in response to a local request for EMS resources to fulfill a single, finite need, or in conjunction with a larger activation of the SERT where the NCOEMS Emergency Operations Plan has already been activated to fulfill several, varied needs statewide. NCOEMS will assess the demand for EMS resources through local requests for EMS resources placed in NC SPARTA, patient movement planning forms, and/or based on the expected magnitude of the incident. NCOEMS will work with requesting entities to determine resource configurations and, in situations where there are not enough resources to fulfill all requests, develop methods for the equitable distribution of scarce resources.

EMS Resource Availability:

- NCOEMS will provide the information on the requested need to the regional Healthcare Coalitions (HCCs) to begin polling local agencies for available resources.
    - The HCC region that initiates the EMS Resources Request will reach out to their region to assess availability of resources. Based on the response received from the region and the scale of the incident, the request for support may include multiple regions or be statewide.

    - HCCs may be requested to poll their regions multiple times throughout the duration of the request to determine additional availability.
    - If an incident has statewide impact, a centralized coordinator should be used to receive all EMS Resource availability details and provide activation details direct to agencies available to respond.
- NCOEMS staff may support the HCCs by reaching out to EMS agencies across the state to help garner additional resources.
- If unable to meet the requested need, NCOEMS should discuss activation of the state EMS Resource Contract through NCEM. Considerations for this contract include funding source, time constraints, circumstances around resource request etc. Part of the request to NCEM for activation of this contract should include detailed information on the number of resources needed, timeframe of need, and a scope of work for the contract.
- Additional options that would be available during a State of Emergency declaration for North Carolina includes:
    - Emergency Management Assistance Compact
        - Should consider if temporary credentials/permits are necessary.
    - National Medical Transport and Support Services (NMTS) Contract which is maintained by FEMA. The coordination for the request and associated scope of work must flow through the HHS Administration of Strategic Preparedness & Response Regional Emergency Coordinator (ASPR REC). Documents needed include:
        - Requires signed annual reciprocity agreement
        - Medical Direction/Scope of Practice Waiver
        - Resource Request Form through NCEM to FEMA with outlined Scope of Work
- When requesting EMAC or Federal ambulance support, consider the development of a standardized resources support survey to be able to fully understand the number of EMS resources needed across a region or statewide.

Dedicated Resources vs. Non-Dedicated Resources

All EMS resources that are being considered to fulfill a resource request are considered either dedicated or non-dedicated resources.

- Dedicated Resources: EMS resources (e.g., contractual, local support, EMAC, FEMA etc.) that have been obtained and assigned specifically to support a given event/incident and are typically able to be utilized for multiple mission types (staging, 911 backup, patient movement, healthcare operational sites etc.). Resources that are dedicated to an event/incident are under the operational oversight of ESF8 and can be assigned, reassigned, and demobilized as necessary.
    - The ESF8 desk will enter all dedicated resources individually into the ReadyOp Transportation Resources Form to capture asset details:
        - Resource Information
        - Assignment Details
        - Personnel
    - The ESF8 desk is responsible for assigning EMS resources into operational units based on mission demands.

- Non-Dedicated Resources: EMS resources (e.g., EMS agencies, Specialty Care Agencies etc.) that can complete a single request, often as part of a single shift, to support an event/incident and are typically utilized for only specific mission types (e.g., patient movement, funeral coverage etc.).
    - If non-dedicated resources are being utilized, then assigning those resources involves ensuring they are approved and entered by the SEOC ESF8 desk into WEBEOC. The information for the non-dedicated resources should be sent to the OEMSSEOC@dhhs.nc.gov email address and followed up with a text/phone call if response is not received in 15 minutes. The information should include the following:
        - Deidentified Location From
        - Deidentified Location To
        - Transportation Type Necessary (e.g., wheelchair van, BLS or ALS ambulance etc.)
        - Time and Date of transport
        - Company Providing the Transportation
        - Point of Contact for Transportation Company

Request Process

Processes for handling requests for EMS resources will vary depending on the operational situation. In situations where there are no ongoing ESF8 response operations, requests for EMS resources will most likely be facilitated by the acting Shift Duty Officer (SDO) in coordination with Healthcare Coalitions (HCCs) of the regions both supplying and receiving the resources. Refer to **NCEOP Appendix 1: Shift Duty Officer Standard Operating Guideline (SDO SOG)**.

In situations where NCOEMS is activated and there are ongoing ESF8 response operations, requests for ambulance resources will most likely be facilitated by the ESF8 Lead, or their designee in coordination with the appropriate HCCs. These processes will follow those established under **NCEOP Appendix 4: Medical Resource Management SOG**.

Request Verification & Vetting

Requests for EMS resources should be vetted and verified by the SDO or ESF8 Lead before consideration of fulfillment. This may include collecting information from the requesting entities to help determine the need and best method to fulfill the request. The collection of this information should include all partners involved (e.g., NCEM, HCCs, Local EM, EMS Agencies, Hospitals etc.). More details on the process for vetting requests can be found in **NCEOP Appendix 4: TAB 4A: Guidelines for Managing Resource Requests**

Resource Fulfillment

Once requests are vetted and verified, NCOEMS will begin the resource identification process by assessing EMS Resource availability and anticipated supply.

Resource Configuration

The different EMS resource configurations allow for maximum flexibility for each individual situation; multi-unit responses may require additional support resources to manage span of control:

- Configuration A: 1-4 Ambulances, 1 Team Leader*
- Configuration B: 5-10 Ambulances, 1 Team Leader and 1 Logistics Specialist*
- Configuration C: Each additional 5 Ambulances, + 1 Team Leader per group, total of 1 Logistics Specialist
- If 20+ ambulances are being deployed, then a Division / Group Supervisor should be considered

	Configuration A	Configuration B	Configuration C
Ambulances	Up to 4 Ambulances	5 - 10 Ambulances	Each Additional 5 Ambulances
Team Leader	1*	1	+1
Logistics Specialist	0	1*	1

* These positions may be filled by personnel serving in other roles (e.g., Team Leader could be a paramedic on an ambulance, or Logistics Specialist could also be a Team Leader).

In configuration B & C, it is expected that the Team Leader will have their own transportation with the ability to provide oversight and logistical support (if not assigned separately) to their assigned units.

In configuration C it is expected that the Logistics Specialist will have their own transportation with the ability to provide logistical support to their assigned units. A logistics specialist may be utilized with or without a logistics support trailer depending on the size and need of the response.

Forward Operating Base

Depending on the size of the response, a Forward Operating Base or a Joint Reception, Staging, Onward Movement, and Integration (JRSOI), may be set up by NCEM or by NCOEMS. Depending on the incident there may be more than one location setup in the state, but EMS resources that have been configured together into a team should not be separated. These locations can provide the following:

- Tracking the status of all resources assigned to them and ensure they have visibility of any concerns or issues related to their logistical support.
- All incident check-in activities to include preparing and processing resource status and managing a master list of all deployed resources.
- Billeting & Sustenance for crews that are off shift or between deployments
- Refueling and Restocking location
- Central point of communication for team leaders and ESF8.

Scarce Resource Factors

In situations where there are insufficient EMS resources to fulfill the resource requests of two (2) or more local jurisdictions and the acuity of the hazards faced are similar, equitable processes for determining the distribution of scarce ambulance resources must be developed. During past responses, OEMS has utilized the following process to determine the initial distribution and re-distribution of scarce ambulance resources:

- Identify and rank (if necessary) the specific factors/data points that characterize the need for ambulance resources (e.g., use of waivers to reduce need)
- Develop a standard Ambulance Support form, based on the specific factors/data points identified, and distribute to jurisdictions via ReadyOp for requests to be submitted.
- Develop an Ambulance Support scorecard to evaluate and rank jurisdictions' reports of need.
- Evaluate the needs and deploy ambulance resources based on the needs ranking (initial distribution)
- Monitor the use of ambulance resources through the leaders of deployed units (via weekly activity reports)
- Re-evaluate resource needs and redistribute ambulance resources accordingly (based on usage levels)
- Demobilize or redirect ambulance resources to other areas of need as jurisdiction needs are met and local resources return to service.

The development of the specific factors/data points used to inform the distribution of scarce ambulance resources will vary with each specific response situation and, for that reason, are difficult to standardize. Examples of factors/data points that have been used in the past and should be considered in the future include:

- Ambulances out of service (consider staffing situation, hospital turnaround times etc.)
- Call volume
- Hospital/ED resources in jurisdiction
- Diversion Status
- Available convalescent transport
- Use of waivers to reduce need.
- Use of Mutual Aid
- Number of calls per shift
- Number of shifts covered per ambulance.

Deployment

Assignment Types

All resources will initially be assigned to the SEOC/Staging Area while awaiting an assignment. Depending on the mission type, EMS resources may be assigned at the State, Regional or Local level (see examples below).

- State Assignments
    - Mobile Disaster Hospital
    - State Medical Support Shelter
    - State Coordinated Patient Movement

    - State Coordinated Shelters
    - Federal Coordination Centers
- Regional Assignments
    - Regional Coordination Centers (RCCs)
- Local Assignments
    - County Coordinated Patient Movement
    - 911-Support
    - Funeral Coverage

Assignment Details

Once a resource request has been approved for deployment, an ESF8 representative will notify the EMS resources of the specific mission details, including:

- Report date/time.
- Response location.
- ESF8 emergency contact and local point of contact.
- Communication information (via 205).
- Resupply procedures (if applicable).
- Incident Action Plan (if applicable).
- Reporting of significant or unusual events.
- 214 reporting details, etc.

This information can be provided via conference call with all parties but should also be sent in writing. All personnel deployed through this plan are expected to operate in compliance with the SMRS Professional Behavior Policy, refer to **Annex H: State Medical Response System** (under review).

Initial Assembly & Convoy

All EMS resources should have the following completed before leaving their home base for a mission:

- Conduct a checklist assessment of the readiness and equipment availability.
- Conduct a safety check of vehicle.
- Review and adhere to the SMRS Deployment Code of Conduct
- Completed rosters to include each responding person's name, mobile phone number, email address and their emergency contact information.

Organizations coordinating/providing the EMS resources may choose to assemble at one location before traveling to the designated response location to introduce team members, conduct initial briefing, determine travel routes/plans, assess the readiness and equipment availability, and identify communication pathways.

Ambulance crews will maintain responsibility for their personal equipment, their ambulance, and their medical equipment/supplies. Any problems should be reported to the Team Leader. Throughout the duration of the mission, it is expected that Team Leaders will report any deployment related incidents/accidents and/or other events that may cause an ambulance unit to become undeployable to the local POC and the ESF8 emergency contact.

Deployment Locations

EMS resources may be deployed to different locations depending on the type and need of the mission. Most often a staging location is identified for the initial response. These areas are typically identified in resource requests and maintained and staffed by the jurisdiction requesting support. Depending on the situation, the ESF8 Desk will coordinate through the SERT to identify and maintain adequate staging locations.

Upon arrival at the assigned deployment location, it is expected that all ambulances will report to their local POC and ESF8 contact for check in. If EMS resources have not already assembled prior to arrival, then the Team Leader will be responsible for completing the initial assembly tasks.

Once deployed, ambulance resource activities may be managed by the requesting jurisdiction, the regional coordinating entity or the ESF8 Support Cell. These activities should be managed in cooperation with the assigned Team Leader(s). Each Team Leader is expected to report significant deployment milestones (EMS Resource Assignment & Tracking form) and any unusual events (EMS Unusual Event Report) via Ready Op. These reports provide information back to the ESF8 Desk to ensure proper management and utilization of resources.

The Team leader(s) is expected to attend all operational shift briefings and keep all personnel on the team informed of existing and predicted conditions. If the individual units of the EMS deployment are assigned to single resource functions (e.g., patient transportation, triage, or treatment) it is expected that the Team Leader will communicate with the personnel at least once during each Operational Period. If possible, all units in an EMS deployment will stay together when off-shift unless otherwise directed by the Team Leader.

Medical Protocols

Whenever deployed, each Team Leader, EMT, or Paramedic who provides any medical care during the incident, may utilize the scope of practice for which they are trained and credentialled according to the policies and procedures established by their home EMS Agency. Personnel may not exceed their medical scope of practice regardless of direction or instructions they may receive from any authority while participating in an EMS resource deployment.

Logistical Support

Deployed EMS resources should not expect logistical support services to be in place in the early stages of the response. For this reason, all deployed ambulance resources are expected to be self-sufficient for up to three days (72 hours) or have a plan to be supported in the response area. The location and magnitude of the incident will determine the level of support services available. Requesting jurisdictions, regional coordinating entities or the ESF8 Desk will work to provide logistical support beyond the 72-hour mark for the deployed resources. However, Team Leaders should be prepared to:

- Utilize commercial services for food, fuel, lodging, and supplies until these logistical services are established.

- Work within the local EMS/healthcare structure to replenish medical supplies (when applicable).

Communications

Deployed EMS resources will utilize their assigned ICS 205 during their mission. Additional information on communications is outlined in State Medical Response System Initial Communication Guidance (under **Annex H: State Medical Response System –** under review) as a reference guide to determine radio frequencies to be used during a deployment.

Demobilization

Demobilization of dedicated EMS resources from a specific mission should be coordinated between the ESF8 desk, the requesting jurisdiction, and the Team Lead. When applicable, the requesting jurisdiction is responsible for the preparation and implementation of demobilization plans to ensure that an orderly and safe movement of personnel and equipment is accomplished from response areas. At no time should deployed ambulance teams or individual crews leave without receiving departure instructions from their Team Leader. Team Leader(s) is expected to work with the requesting jurisdiction to obtain necessary supplies to assure that ambulances demobilize in a "state of readiness" whenever possible. Report of any lost or damaged equipment and used supplies should be maintained by the team leader. The Team Leader is expected to notify ESF8 Desk representatives prior to demobilizing to see if additional missions are pending.

Team Leader(s) is also expected to:

- Collect and return all radios and equipment on loan for the incident.
- Collect all timekeeping records (214s) so they can be provided to the agency coordinating their deployment and the ESF8 Desk
- Debrief all deployed ambulance personnel prior to departure from the response area.
- Conduct vehicles safety checks prior to the departure of ambulance units from the response area and report any problems.

The Team Lead should notify the ESF8 Desk of ambulance release times, travel route, estimated time of arrival back at home base, and actual arrival time back at home base.

Cost Reimbursement of EMS Resources

EMS resources that are deployed on state-approved mission(s) during a North Carolina declared State of Emergency or to an out-of-state mission as part of an Emergency Management Assistance Compact (EMAC) mission may be eligible for cost reimbursement. This is accomplished through set policies and procedures, record keeping (travel logs, equipment logs, records, receipts, pictures, and documentation of damaged equipment), and completion of a reimbursement package after the mission has ended. This package should be completed within 45 days of demobilization. Additional information on reimbursement packets can be requested from NCEM.

EMS resources should not charge individuals for patient care and/or transport as this is covered under the state mission assignment and associated reimbursement packets.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB C1A

MINIMUM REQUIREMENTS FOR NC SMRS EMS PARTICIPATION

OCTOBER 2023

Minimum Requirements for NC SMRS EMS Participation

EMS Providers that agree to provide ground/air ambulance assets and personnel for deployment to fulfill approved State missions during declared disasters will ensure that the assets and personnel meet the following requirements.

General Requirements

- Ambulances will hold current licenses and be in good standing by the North Carolina Office of Emergency Medical Services (NCOEMS)
- Ambulance providers will be responsible for the deployment only of qualified personnel as described in this document.

EMS Personnel Requirements

- Be an employee/volunteer in good standing of the EMS Provider organization.
- Be currently certified and in good standing as an EMT, AEMT, Paramedic or Registered Nurse with the State of North Carolina
- Have completed ICS 100, 200, 700, 800.
- Have completed an up-to-date Respiratory Protection Program
- Be trained and able to work in a minimum of Level "C" personal protective equipment (in accordance with CFR 1910.120 APP B) in a cold zone assisting in secondary decontamination processes.
- Abide by the State Medical Response System (SMRS) Code of Conduct and Ethics Policy

EMS Team Leader Preferences

- Have completed ICS 300, 400
- Completion of the North Carolina Ambulance Strike Team Leader Course or equivalency as approved by NCOEMS.
- Capability and experience to manage, coordinate, and direct the actions of ambulance crews in emergency situations. Including maintaining all required records and ensuring the logistical needs of all personnel are met during the entire activation of the team.

EMS Resource Unit Leader Preferences

- Have completed All Hazards Incident Management Team (O3O5) or equivalent as approved by NCOEMS.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB C1B

EMAC DEPLOYMENT OF EMS RESOURCES

JUNE 2024

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Purpose

When EMS Resources are requested for an out of state mission, as part of the Emergency Management Assistance Compact (EMAC), North Carolina's intention is to provide EMS Resources through the fulfillment of Ambulance Strike Team/Ambulance Task Force (AST/ATF). The purpose of this TAB is to provide planning and strategic guidance to EMS Agency Administrators on the expectations and differences associated with an EMAC mission.

Pre-Activation

It is important that guidelines for the readiness of EMS personnel, logistics, and Mission Ready Packages (MRPs) for EMS resources, are developed and maintained. These processes are ongoing and take place before, during, and after the deployment of EMS resources.

Personnel Readiness: EMS personnel provided to deploy in support of an EMAC request must be properly trained and credentialed for the positions they will fill. Expectations for the readiness of personnel can be found under **Tab C1A: Minimum Requirements for NC SMRS EMS Participation**. Also refer to Ambulance Strike Team/Task Force Job Action Sheets.

Logistics Readiness: EMS resources deployed as Ambulance Strike Teams/Task Forces (AST/ATF) to support EMAC requests must have the equipment and supplies necessary to be self-sufficient for a 7-day period without resupply. Established standards for equipment and supplies, including Go Pack checklists, and a 7-day Logistics Package can be found under TAB C1C: **Recommended Standard Equipment and Supplies**.

Mission Ready Packages: ReadyOp will be utilized for the development and maintenance of Mission Ready Packages (MRP) for EMS resources that may be deployed via the EMAC process. Resource configurations are based on FEMA resource typing guidelines for Ambulance Strike Team/Ambulance Task Force (AST/ATF) (Resource Typing Definitions).

- Minimum Resource Configurations
  - (1) NCOEMS Liaison with Vehicle
  - (1) EMS Logistics Specialist with Vehicle & Logistics Trailer
  - Each AST/ATF:
    - (5) ALS and/or BLS ambulances
    - (10) Credentialled EMS personnel (minimum of 4 persons per ambulance for staffing to meet the two-personnel minimum for 12/7 operations)
    - (1) Ambulance Strike Team Leader (AST Leader) with Command Vehicle

FEMA-Typed Team Configurations:

- **Ambulance Strike Teams (AST)** (FEMA ID 3-508-1029)
  - 5 ground ambulances (either FEMA Type 2 – ALS, FEMA Type 4 – BLS, or SCT capable)
- **Ambulance Task Forces (ATF)** (FEMA ID 3-508-1030)
  - 5 ground ambulances (combination FEMA Type 2 – ALS, FEMA Type 4 – BLS, and/or SCT capable)
- **EMS Task Force (EMSTF)** (FEMA ID: 3-508-1236)
  - Ambulance Bus Team:
    - 1 ambulance bus (BLS)

        - 1 ground ambulance (FEMA Type 2 - ALS)
    - Ambulance Bus Strike Team:
        - 3 ambulance buses (BLS)
        - 1 ground ambulance (FEMA Type 2 - ALS)
    - Medical Transport Task Force:
        - 2 ambulance buses (BLS)
        - 5 ground ambulances (FEMA Type 2 - ALS)

FEMA-Typed Team Support Considerations: Additional, specialized, personnel and vehicles that may be considered to support team configurations include:

- EMS Logistics Officer (FEMA ID 3-509-1227): To manage logistical needs and the vehicle/trailer.
- Mechanic (FEMA ID: 7-509-1461): To service ambulances and with dedicated vehicle and equipment/supplies.
- Fuel Tender (FEMA ID: 4-508-1280): Capable of carrying enough fuel to support the mission.
- EMS Mass Casualty Trailer (FEMA ID: 12-508-12178): With generator and reserve fuel.

Activation

The ESF8 Lead has the authority to activate this plan in consultation with North Carolina Emergency Management. Processes for receiving and responding to EMAC requests will be coordinated through North Carolina Emergency Management (NCEM). The general intent is to not send resources out of state if there is a potential threat or active response in North Carolina. NCEM will indicate when/if resources can be considered for out of state missions. This plan will be activated when appropriate and based on the availability of resources aligning to requested EMAC missions.

EMAC Requests

The ESF8 Lead or designee, will review EMAC requests to determine availability and develop offers of assistance in coordination with NCEM and sending agencies. This process includes providing updated Mission Ready Packages (with cost estimates) to NCEM, who will communicate with the Requesting Emergency Management Agency to finalize the mission details and complete an EMAC Resource Support Agreement (RSA).

The EMAC Resource Support Agreement should outline the mission details to include the logistical support provided by the requesting entity. This will aid in preparing for the operational mission and determining what logistical support must be provided by the sending EMS Agency and NCOEMS.

Mission Details

- Mission Duration: For out of state missions, EMS Agencies should be prepared for deployments lasting a minimum of 7-day periods.
- Emergency Management Support: One or more Liaison Officers may be deployed through NCEM or NCOEMS to help manage the integration of EMS resources into the Requesting EMAs operations. These personnel should have their own vehicles and equipment prepared to deploy for a minimum of 7-day periods, and access to a Purchase Card.
- Staging and Incident Base/Camp Areas: EMS resources should be secured and housed within a secure parameter when not in use.

- Lodging: Lodging for personnel deployed on an EMAC mission may include the use of hotels, base camps, EMS stations, or tent structures with cots. All attempts will be made to coordinate these details prior to departure on the mission. Personnel should remain flexible as changing situations will likely necessitate the need to adjust this plan throughout the mission.
- Meals: Meals for personnel deployed on an EMAC mission will range from the reimbursement of per diem meal rates, coordination of group meals, onsite feeding, or Meals Ready to Eat. Personnel should be prepared to provide for any specific nutritional needs during the deployment.
- Purchase Card: Strike Team Leaders and assigned liaisons should have access to their agency issued Purchase Cards with emergency purchasing powers to cover emergency maintenance, fuel refill, meals, hotels, and any other unforeseen needs for the team.
- Medical Equipment/Supplies and Re-Supply: EMS resources will deploy with 7-day supply medical equipment, supplies, and pharmaceuticals. An Ambulance Strike Team Trailer or equivalent should be sent with the team to provide a way to transport these supplies and equipment. A resupply process must be coordinated between the ESF8 Desk and the Requesting EMA prior to deployment. **Tab C1C: Recommended Standard Equipment and Supplies.**
- Fuel Sources: EMS resources should be prepared to utilize their agency issued P-Card for fuel purchases.

Deployment of EMS Resources: The deployment of EMS resources for an out-of-state mission will be the same as the process established for in-state missions with the following differences:

- Initial Assembly & Convoy: All assigned resources will be directed to assemble at a designated staging area for pre-deployment briefing prior to convoying to the mission assignment.
    - Pre-Deployment Briefing:
        - Review of the mission assignment
        - Role of the deploying team
        - Expected work conditions
        - Expected behavior
        - Check-in & Reporting expectations
        - ICS 205 plan
        - Logistical support plan (food, fuel, lodging, etc.)
        - Approved mission costs

Communications & Reporting: Timely communication between EMS Resources and their AST Leader is expected whenever there are changes to mission, loss of capabilities, or unusual events. Daily situation reports are required of the AST Leader or NCOEMS/NCEM Liaison for each 24-hour period deployed. Deployed EMS resources will utilize the radio communications plan (ICS 205) assigned to them for use in the mission area. Radio systems assigned by the Requesting EMA or cell phones should be utilized for communications.

Demobilization of EMS Resources: The expectations for demobilization of EMS resources following completion of the assigned mission are the same as those established for in-state missions with the following differences. Prior to beginning the demobilization process, the Team Leader should:

- Verify that the mission has been completed with their requesting state point-of-contact.
- Coordinate check-out through their assigned staging area.
- Participate in post-mission debriefings as requested.

Ambulance Strike Team/Task Force Job Action Sheets

AST/ATF Leaders:

AST/ATF Leaders are responsible for managing and supervising all aspects of a mission, both operational and managerial, from the time of activation through the return to their home EMS agency. This includes all personnel and equipment resources, as well as overseeing and directly supervising the strike team. The AST-L is responsible for the development and completion of all AST/ATF objectives in conjunction with appropriate ICS staff as well as the proper reporting, record keeping, and after-action requirements.

General Duties and Responsibilities of the AST-L:

- Supervises tactical assignments assigned to the Task Force/Strike (Resource) Team.
- Serves as the point-of-contact for the Division/Group Supervisor or Operations Section Chief. Having a single point of contact for a team saves time and reduces the chance of miscommunication (maintains unity of command).
- Reviews common ICS responsibilities with personnel.
- Reviews assignments with subordinates and assigns tasks.
- Reviews safety hazards and mitigations to address them.
- Monitors work progress and making changes when necessary.
- Coordinates activities with adjacent Strike (Resource) Teams, Task Forces, and single resources.
- Travels to and from the assignment area with assigned resources.
- Retains control of assigned resources while in available or out-of-service status.
- Completes and maintains the associated ICS Forms and collects the **ICS Form 214** – Activity Log completed by each AST-Responder.
- Submits situation and resource status information to the Division/Group Supervisor.

Also refer to the FEMA Resource Typing Library Tool for the following position specifications:

- AST Leader - ID: 3-509-1224
- EMS Task Force Leader – ID: 3-509-1350
- Medical Team or Task Force Leader – ID: 3-509-1009

AST/ATF Responders:

AST/ATF Responders are responsible for operational preparedness and deployment aspects of a mission, from the time of activation through the return to their home EMS agency. This includes properly maintaining and using all equipment and resources, as well as participating in assignments as part of the AST mission. The AST-R is responsible for fulfilling assigned AST/AFT objectives in

conjunction with appropriate ICS staff as well as the proper reporting, record keeping, and after-action requirements.

General Duties and Responsibilities of the AST-R:

- Reviews and completes tactical assignments assigned by the AST-L.
- Reports to the AST-L. Having a single point of contact for a team saves time and reduces the chance of miscommunication (maintains unity of command).
- Reviews common ICS responsibilities with AST-L.
- Reviews safety hazards and recommends mitigations to address them to the AST-L.
- Monitors work progress and reports the need to make changes when necessary to the AST-L.
- Works on activities in conjunction with adjacent Strike (Resource) Teams, Task Forces, and single resources as directed by the AST-L.
- Travels to and from the assignment area with assigned resources.
- Retains responsibility of assigned resources while in an available or out-of-service status.
- Submits resource requests as needed through the AST-L.
- Completes and submits the required ICS Forms to include **ICS Form 214** – Activity Log for each Operational Period as and **ICS Form 221**.
- Submits situation and resource status information to the AST-L.

Also refer to the FEMA Resource Typing Library Tool and the NCOEMS Rule in 10A NCAC 13P for more information on the following position specifications:

- Paramedic - ID: 3-509-1015
- AEMT - ID: 3-509-1000
- EMT - ID: 3-509-1010
- EMS Logistics Officer – ID 3-509-1227

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB C1C:

RECOMMENDED STANDARD EQUIPMENT AND SUPPLIES

OCTOBER 2023

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Standards listed are recommendations based on the FEMA Resource Typing Library Tool and NCOEMS Rule in 10A NCAC 13P. Modifications to resources and terminology may be made to allow for scalability and flexibility and to ensure resources and personnel are able to accomplish mission specific assignments or objectives.

AST Personnel (Responders and Team Leaders):

Personal 7-day "Go Pack" for AST members should contain the following:

- Official EMS agency photo I.D.
- Weather appropriate clothing for climate
    - Heavy coat
    - Jacket
    - Rain gear
- Extra clean uniforms
- Socks & underwear
- Closed toe safety boots preferred (EMS agency approved)
- Hearing protection (ear plugs)
- Sunglasses
- Toiletries
- Other personal hygiene items
- Sunscreen
- Bug spray
- Toilet Paper
- Personal medications
- Personal medical equipment (e.g., CPAP)
- Potable water for 7 days
- Meals Ready to Eat (MREs)
- Special dietary needs
- Sleeping bag
- Petty cash

Ambulance Strike Team Vehicles – Command Vehicle:

AST command vehicles that will respond to calls for service while deployed on a mission must be equipped in compliance with NCOEMS regulations for EMS Non Transporting Vehicles to the AEMT or Paramedic standards as defined by Rule in 10A NCAC 13P .0213 based on the NCOEMS credential level the AST Leader will respond.

At a minimum, AST Command Vehicles will contain the following:

- Maps for impacted area
- Compass and/or portable GPS
- Wireless capable laptop, vehicle, or wall charger,
- Printer
- Office supplies
- Capability to purchase fuel locally (Credit Cards, Cash)
- Equipment capable of communicating with the AST during response and deployment:
    - Cell Phone
    - VIPER radios
    - Extra batteries and chargers
- 50 Triage Tags
- 2 helmets
- 2 pairs work gloves
- 2 flashlights
- ICS Forms
- EPCR capability with backup of mobile or paper PCR to document patient encounters

Ambulance Strike Team – 7-Day Logistics Package:

To ensure unit self-sufficiency for a planned 7-day deployment prior to resupply/replacement EMS resource providers will ensure the following equipment will be supplied by the regional HCC or participating EMS agencies:

- 24-foot enclosed trailer, or similar support vehicle, for the secure transportation of all necessary supplies and equipment.
    - Affixed generator and climate control so that trailer can serve as a base of operations.
    - Fuel storage capable of holding a minimum of 300% capacity of the affixed generator's fuel tank.
    - 1 smoke carbon monoxide detectors (combined or separate)
    - Minimum 5lb ABC fire extinguisher
    - Space for storing and deploying cots for sleeping all AST members.
- Drinking water capable of providing each AST member a minimum of 2 gallons per person per day for 7 days
- Food provisions capable of sustaining each member for 7 days.
- Storage space for each AST member supplied Go Pack
- Storage space for restock items provided by the lead and participating EMS agency.
- ICS Materials: AST appropriate vesting, signage, and ICS form set.
- Communications equipment (VIPER Radios):

- 1 VIPER mobile radio, programmed for statewide operation, functional off the generator 110VAC power.
- 6 VIPER portable radios at a minimum programmed for statewide operation.
- 1 spare battery per radio
- 1 rapid charger per radio or capability with gang chargers for a minimum of 15 batteries

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX C2

HIGH CONSEQUENCE INFECTIOUS DISEASE CONCEPT OF OPERATIONS

JULY 2024

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Purpose

The purpose of this concept of operations is to provide a strategic high-level overview of the concept of operations for a High Consequence Infectious Disease response in North Carolina.

A High Consequence Infectious Disease refers to a contagious illness that poses significant risks to public health, often due to its potential to cause widespread illness, death, social disruption, and economic impact.

This plan provides a concept of operations (ConOps) for the safe detection, information sharing, and transportation of suspected and/or confirmed cases of High Consequence Infectious Diseases (HCID). The coordination between Local, State, Federal, and private organizations and resources is key to being able to prepare for, respond to and recover from potential outbreaks from HCIDs. To keep up with shifting priorities, emerging threats and new guidance, this plan is intended to be a dynamic document that can be modified as new information becomes available.

Authorities

The North Carolina Department of Health and Human Services (DHHS) is the lead agency for disease prevention, treatment, and control. Per the State Emergency Operations Plan (EOP) developed and coordinated by the North Carolina Division of Emergency Management (NCEM), the North Carolina Division of Public Health (DPH), Public Health Preparedness & Response Branch is the lead technical agency for Infectious Disease responses with support from many State Emergency Response Partners including the North Carolina Office of Emergency Medical Services (OEMS).

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

Scope

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

Note: This ConOps primarily addresses specific activities related to the response to a viral hemorrhagic fever outbreak or similar type illness. The overall concepts outlined in this plan can be used for a variety of different known and unknown high consequence infectious diseases. The agencies and facilities involved in this type of response each have their own emergency operations plans to facilitate the response and coordination of all types of emergencies and will be used concurrently with this plan.

Roles and Responsibilities

North Carolina Public Health System

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

North Carolina State Laboratory of Public Health (SLPH) can perform testing for many of the suspect biological threat agents identified by the CDC Laboratory Response Network (LRN) as emerging infectious diseases. The laboratory also has the capacity to expand testing once approved and released by the LRN. The SLPH also maintains a laboratory response network within the state comprised of both hospital and private clinical laboratories that coordinates testing protocols and processes throughout the state. Within that program is a robust training program for safe packaging and transportation of samples to the SLPH. For current information and guidance regarding laboratory testing, specimen collection, packaging and transport, please refer to the **State Laboratory of Public Health website or call the 24/7 duty phone at 919-807-8600.**

Emergency Medical Services System

The Emergency Medical Services (EMS) systems across all local jurisdictions should be prepared and capable of transporting a patient with a High Consequence Infectious Disease. EMS systems should have access to an initial cache of personal protective equipment to utilize once a potential HCID patient has been identified and should undergo annual training on the identification, isolation and inform processes for HCID outlined in this plan. Transportation of an emergency incident in the community will be the responsibility of the local EMS agency according to applicable local jurisdictional plans. For individuals that are under monitoring in the community and are not emergent or those who have not activated the 911 system should be transported through a non-911 option such as hospital-based critical care services, privately owned vehicle, or other transportation method with the least likely method for spread of the HCID.

North Carolina Office of EMS

The North Carolina Office of EMS has the following responsibilities during a potential HCID response:

1. Provide Situational Awareness and Information Sharing amount the Healthcare System regarding HCID outbreaks
2. Augment medical surge

3. Coordinate healthcare resource allocation
4. Provide guidance for HCID patient transportation when requested

North Carolina Tiered Healthcare System

To align more closely with the levels outlined by the American College of Surgeons (ACS) Trauma Guidelines, the National Special Pathogens System has identified four levels of healthcare facilities for the triage, assessment, and treatment of HCID patient. According to this plan, North Carolina has accepted these levels as outlined below:

Level 4: Frontline Healthcare Facilities (FHF) are any healthcare facility (e.g., physician's office, urgent care, outpatient clinic, emergency department, in-patient hospital.) to which a patient with HCID symptoms may initially seek care. Frontline healthcare facilities should be prepared to:

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

It is expected that the transport/transfer of suspected HCID patients from the community or FHF will follow each individual health system's normal referral patterns or established catchment area unless preference by the patient or clinical expertise changes this decision. Additional screening should be done in real-time based on guidance from local and state public health entities and the receiving HCID assessment or treatment hospital. Inter-facility transport will be made by appropriate vehicles with staff trained and equipped specifically for the transport of persons suspected of having a high consequence infectious disease.

Level 3: Assessment Hospitals (AH) in North Carolina are tertiary care hospitals that have the capacity to conduct limited basic laboratory testing or coordinate the delivery of such tests to the State Lab of Public Health (NC SLPH) and stabilize and coordinate transportation of HCID patients to appropriate treatment hospitals. These capabilities should include a plan for adequate stabilizing treatment areas, skilled and trained staff, appropriate equipment and demonstrated proficiency in infection control procedures. Each Assessment Hospital should be prepared to:

- Meet all the requirements of the Frontline healthcare facilities.
- Receive and Isolate potential HCID their facility area within 8 hours of receiving activation from NC HPP and/or NC DPH

- Stabilize and begin care for the potential or confirmed HCID patient for up to 96 hours or until a diagnosis can be confirmed or ruled out and/or until discharge or transfer is completed.
- Initiate or coordinate HCID testing and testing for alternative diagnoses.
- Coordinate with NC HPP and NC DPH the potential transfer of the individual to a Regional Emerging Special Pathogens Treatment Center or RESPTC (if indicated)
- If HCID is ruled out as a potential diagnosis, then the Assessment Hospital is responsible to continue caring for the patient based on their normal protocols.

The healthcare organizations that have indicated the capability of HCID Assessment Hospitals for their specific referral areas: Mission Hospital (Asheville, NC), Atrium Health Wake Forest Baptist (Winston-Salem, NC), Atrium Health (Charlotte, NC), Cone Health Moses Cone Hospital (Greensboro, NC), Duke University Medical Center (Durham. NC), WakeMed (Raleigh, NC), ECU Health (Greenville, NC), and Novant Health New Hanover Regional Medical Center (Wilmington, NC).

If HCID is confirmed, patients will be considered for transfer to a Regional Emerging Special Pathogens Treatment Center (RESPTC). This transfer coordination should involve the NCOEMS and NC DPH to ensure patient, staff, and public health. If the patient is being transported out of state, NC DPH is responsible for ensuring it follows the guidelines outlined in the Region IV HCID Patient Transportation and Coordination Plan to ensure notification of all applicable partners (e.g., NC DPH, NCOEMS, and the receiving State's Department of Health, Federal Partners etc.).

Level 2: Special Pathogen Treatment Centers (SPTC) are hospitals that have the capacity to deliver specialized care to patients with HCID but typically do not serve as a regional hub. North Carolina does not have any Level 2 facilities.

Level 1: Regional Emerging Special Pathogens Treatment Centers (RESPTC) are hospitals that serve as a resource hub within their regions and have adequate designated treatment areas, skilled and trained staff, appropriate equipment, and infection control procedures matching requirements for HCID. These facilities have the capability to manage a confirmed HCID patient for the duration of necessary medical treatment. These types of facilities also include specialized biocontainment facilities. The HHS Region IV RESPTCs are Emory University Hospital in Atlanta, GA, Children's Healthcare of Atlanta, GA, and the UNC Hospital in Chapel Hill, NC.

Concept of Operations

The concept of operations for all healthcare workers in North Carolina is to be prepared to identify potential person(s) with a suspected or confirmed high consequence infectious disease, rapidly and appropriately isolate the patient, and inform appropriate authorities (e.g., leadership, internal team members, State Epi On-Call, local health department, external stakeholders_. The concept of operations for NC DPH, NCOEMS, NCEM, and other state-level partners is to effectively identify and treat patients, keep healthcare staff safe, and minimize the potential spread of HCIDs in North Carolina through the mobilization of local, state, and federal resources as needed for the response.

Surveillance

Surveillance is a routine activity, encompassing the tasks of identification, tracking, and monitoring of persons at-risk of infectious diseases. In most cases of a high consequence infectious disease, a population may be suspected of being at risk but individuals within that population in North Carolina

may not be known.

Assessment Phase

The assessment phase begins with the receipt of a notification to CDB and/or EPI On-Call of a patient within North Carolina with relevant exposure history and signs or symptoms consistent with an HCID or through the notification of a returning traveler from areas with an active high consequence infectious disease.

Potential HCID Patient Notification:

Public Health & Healthcare facilities across North Carolina who identify a patient with a potential HCID should contact NC DPH EPI On-Call for consultation and assistance with completing a risk assessment, to determine next steps and what laboratory testing is indicated.

EPI On-Call is a 24/7 monitored voicemail line that is checked by CDB staff. Every effort is made to return calls quickly, but public health & healthcare facilities should be prepared to wait 15-30 minutes to receive a call back. For emergent concerns, PHP&R can be contacted at 888-820-0520 or NCOEMS at 919-855-4687, however the notification still must be made to EPI On-Call to facilitate the risk assessment.

North Carolina Epidemiologist On-Call **(919) 733-3419**

If specific testing for high consequence infectious disease is indicated, this will trigger the Response Phase of this ConOps. If no testing is indicated, then public health and healthcare facilities should continue assessment and treatment of the patient to determine a potential diagnosis. If additional support is needed from CDB and/or NCOEMS then the healthcare facility is responsible for requesting this additional support to receive technical assistance and/or resource support.

Returning Travelers

Notification of returning travelers from an area with an outbreak of a HCID is received through a variety of ways (e.g., emails/calls directly from Non-Governmental Organizations (NGOs), emails/calls from the Centers for Disease Control and Prevention (CDC), in addition to emails/calls directly from local health departments). Determination for providing information on returning travelers from areas with an active outbreak is made by the CDC Division of Global Migration and Quarantine (DGMQ). When this occurs, information on returning travelers is provided to NC DPH Communicable Disease Branch. Protocols will be set up regarding what follow-up will be completed through state and local health departments. It is expected that CDB will make notification to PHP&R what these procedures will be. PHP&R will ensure this information is shared with NCOEMS who in turn shares with the healthcare system via email and directly through a phone call with the UNC RESPTC.

The assessment of a returned traveler will trigger an evaluation by CDB to determine if a patient is considered “No Known Exposure,” “Low-Risk Exposure,” or “High-Risk Exposure.” If a patient is considered High-Risk Exposure, then testing for the specific HCID is considered indicated. If a patient is a Low-Risk or No Known Exposure, then a review of the case with the relevant partners (LHD, DPH, UNC Hospitals, CDC etc.) will be completed to determine if further testing is indicated.

If HCID testing is indicated this will trigger the Response Phase of this ConOps. If no HCID testing is indicated, then the returning traveler will receive information from the local health department on monitoring for symptoms and who to contact should they begin to experience symptoms. Notification of these returning travelers will not be made to partner agencies aside from the initial notification that the process has begun.

Risk Assessment Coordination Call

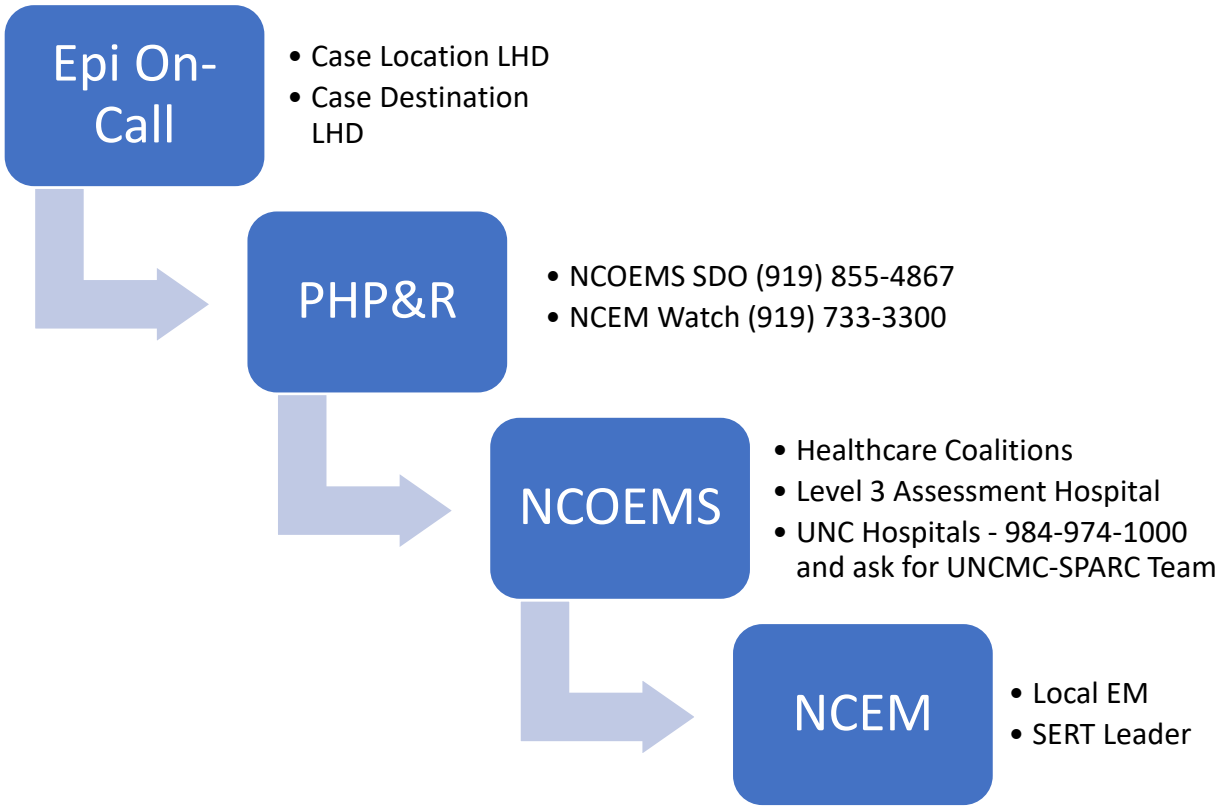
A key component of the assessment phase is a coordination call between the agencies involved in the risk assessment. These agencies include but are not limited to: Notifier/Monitor, EPI On- Call, State Epidemiologist, or designee, CDB Representative, the SLPH, and PHP&R Representative. EPI On-Call staff may choose at their discretion to include additional partners (e.g., CDC, UNC Hospitals, NCOEMS etc.) based on the situation but this is not the standard procedure.

The purpose of this call is to gather information on the situation, confirm if a case meets the threshold of the case definition, and determine further actions (e.g., HCID testing, ongoing monitoring, other diagnostic tests, etc.). A decision must be made whether to move to the response phase on this call.

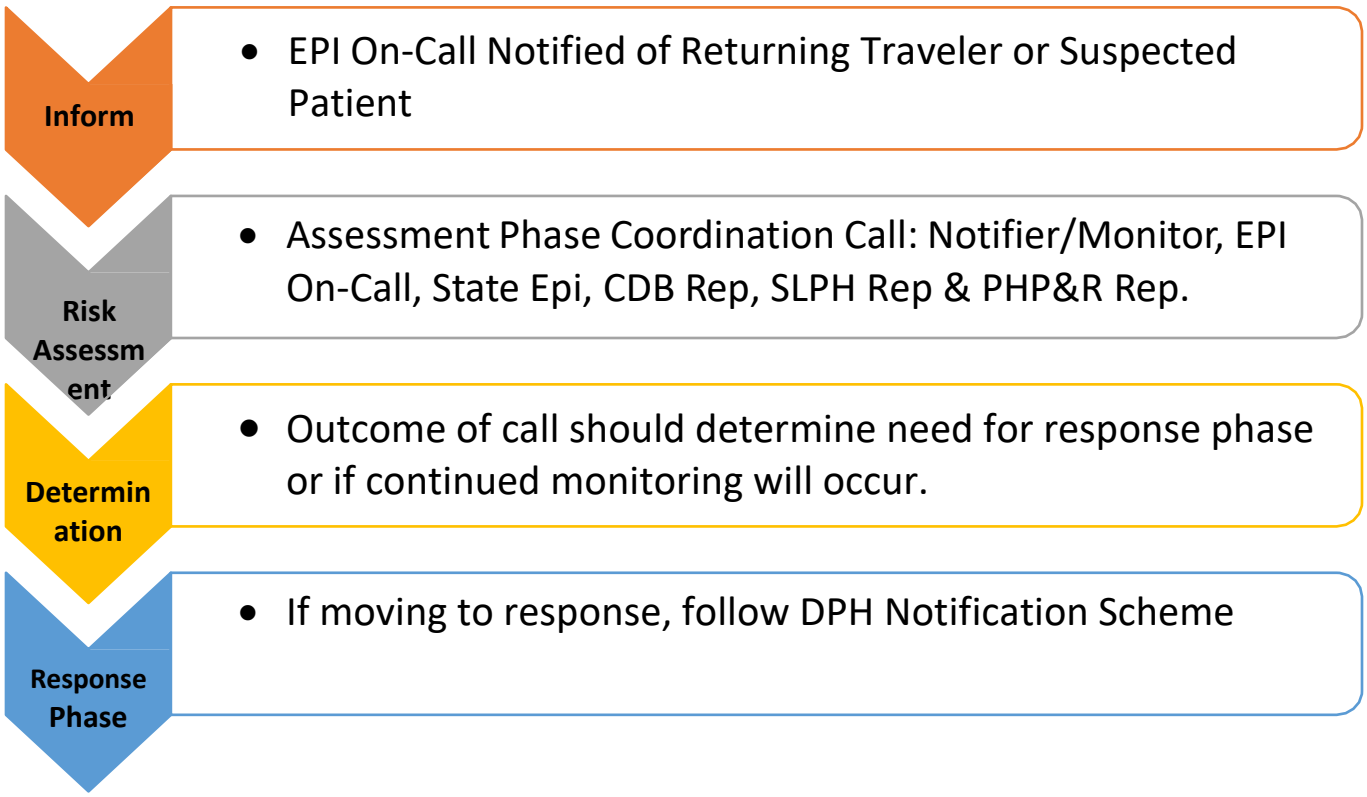
Notification Plan:

Upon decision to move into the response phase the following notifications are required:

- State Epidemiologist, or designee is responsible for notifying PHP&R, Case Location LHD and Case Destination LHD
- PHP&R is responsible for notifying NCOEMS Shift Duty Officer and NCEM Emergency Services Lead
- NCOEMS is responsible for notifying Case Location and Destination Healthcare Coalition and Case Destination Level 3: Assessment Hospital and Level 1: UNC Hospitals (if not already notified)
- NCEM is responsible for notifying Case Location EM and Case Destination EM and SERT Leader



Assessment Phase Steps



Response Phase

The response phase begins when it is determined by NC State Epidemiologist, or designee, that a patient within North Carolina has met the threshold of the case definition and requires testing for a HCID. The patient's health and wellbeing along with protecting the public's health and the first responder's and healthcare worker's safety should be top priorities during the response phase.

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

The response phase starts with a coordination call between all agencies outline in the notification tree. The purpose of this call is for CDB/PHP&R to brief stakeholders on the situation and determine a plan for the medical management of the patient while ensuring the safety of the public and those involved in the care.

PHIMT

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

Differential Diagnosis

The main goal of this step is to ensure the patient can be medically assessed for different HCIDs and other potential diagnoses. This step may involve the coordination of patient movement to an Assessment Hospital's or RESPTC depending on the situation. It is anticipated that the coordination of transportation assets will be a key component of this step. NCOEMS has the responsibility to ensure strong coordination and communication between the involved healthcare facilities and the transportation agencies. Notification, information sharing, and coordination with ASPR Regional Emergency Coordinators (RECs) should also be initiated at this stage.

Laboratory Testing

The main goal is to ensure that a specimen from the patient suitable for testing is obtained in a timely and safe manner. Transportation of the specimen to the State Laboratory of Public Health (SLPH) will be coordinated by SLPH. Support and guidance for the healthcare facility will be provided by SLPH and PHP&R.

Laboratory Results

Once HCID testing has been completed by SLPH, the results will be communicated to the PHIMT and the healthcare facility caring for the patient. Based on the suspected HCID, there are different outcomes from the initial results. For example, the following outlines the three possible outcomes for a

Viral Hemorrhagic Fever result: 1. Confirmed Negative; 2. Retesting required (a second sample collected 72 hours after onset of symptoms is required to definitively rule out VHF) and or 3. Presumptive Positive Result (confirmation required by CDC). SLPH will communicate with the CDC regarding any tests needed at CDC. It is anticipated that a coordination call will occur regardless of the results to discuss next steps.

Transportation to Regional Emerging Special Pathogens Treatment Center

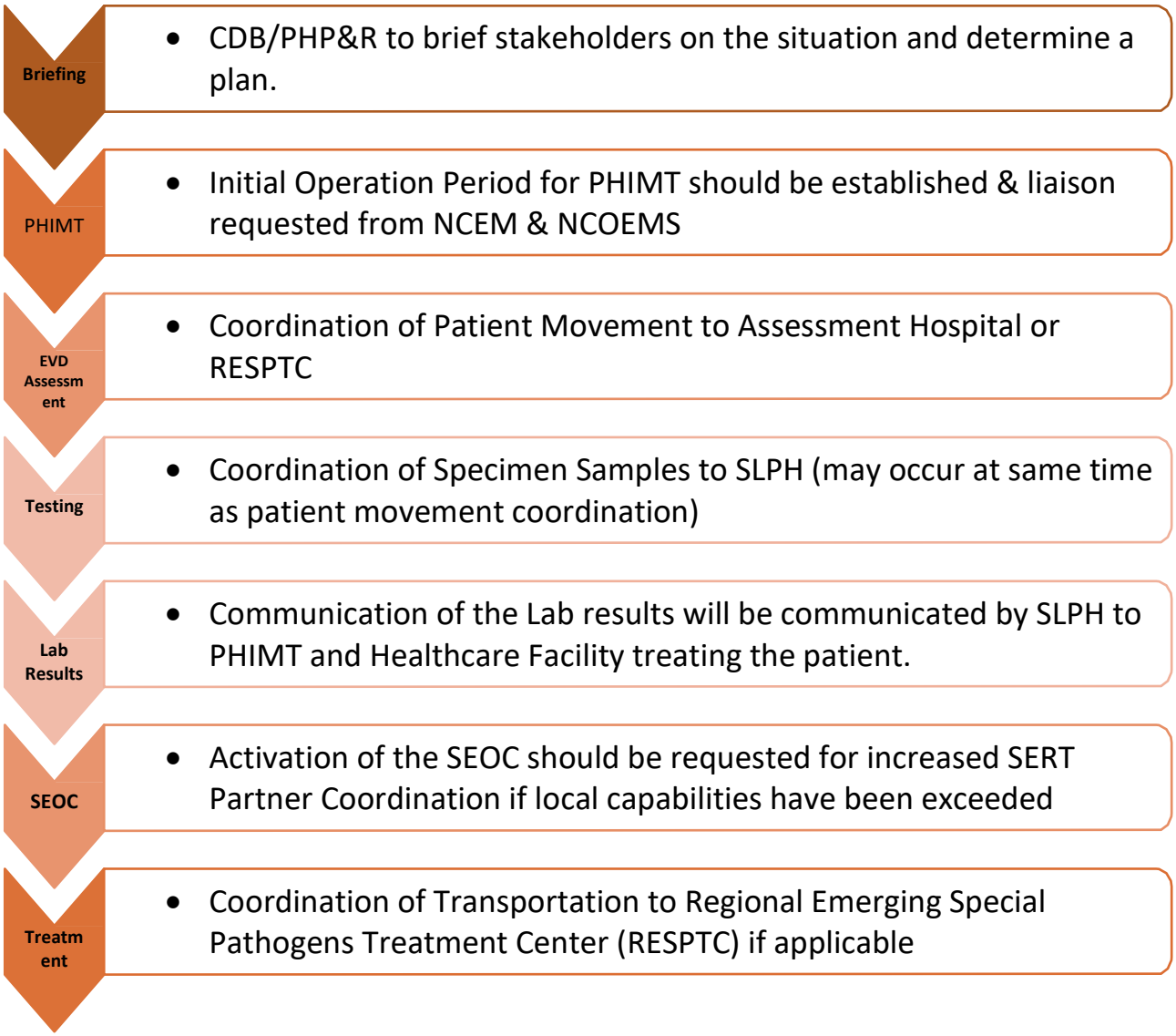
HCID patients within North Carolina will mostly likely be transferred from a Level 3 or Level 4 facility to the UNC Hospitals unless there are other reasons barring that placement (e.g., previous agreement with a different RESPTC, UNC Hospital is unable to accept patient(s) due to capability limitations, patient preference, or clinical decision etc.). Placement of patients to UNC Hospitals can occur directly between the two healthcare facilities or can be supported through NCOEMS, but either way notification should involve NC DPH as outlined in the Inform step of this plan.

In the case of the placement of a patient from a North Carolina hospital into an out of state RESPTC, the transportation should be coordinated between NC DPH and the receiving state's Public Health Department, NCHPP, the sending and receiving facility and ASPR Regional Emergency Coordinators as outlined in the Region IV HCID Transportation and Coordination Plan.

Medical Countermeasures (MCMs)

Whenever possible, treatments and/or prophylaxis for HCIDs should be acquired, by agencies in need, through traditional commercial pathways. However, many MCMs for HCIDs are not commercially available due to their limited commercial applications and/or investigational regulatory status. The Strategic National Stockpile (SNS), managed by ASPR, contains a variety of MCMs intended for use during public health emergencies, including HCID response. When MCMs are not commercially available, or, are commercially available, but not in the quantity or timeframe needed, a request can be submitted to the SNS for assistance. The PHP&R MCM unit is responsible for gathering the essential elements of information necessary for NC DHHS to submit a formal SNS request. It can take up to 24-48 hours for MCMs to arrive, following approval of an SNS request by ASPR. To ensure rapid acquisition of MCMs, the assessment phase coordination call should discuss potential MCM needs.

Response Phase Steps



Environmental Care & Waste Management

Healthcare Settings

Within the local healthcare organizations, solid waste generated during the identification, assessment, and treatment of a patient in whom a HCID is suspected or confirmed is managed through that facility's existing hospital waste management and environmental care procedures. Healthcare organizations should coordinate with local public waste management agencies to assure compliance with local standards. If support is needed with waste management, then a request for state support can be submitted through the local emergency management office. It will depend on each individual situation what level of support can be provided.

Non-Healthcare Settings

Contamination of the environment will be assessed case-by-case based on the patient's status and symptoms. If the patient is determined to have the potential to be contaminating the environment,

then the area will be secured and decontaminated by a previously vetted private vendor with oversight by state public health and emergency management. If the patient is determined not to be contaminating the environment, then the patient is transported, and the area is released.

Patient Discharge Back to the Community

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

Fatality Management

Fatality management and the handling of remains will be guided by recommendations from CDC. Facilities for handling of multiple fatalities will be identified early in the event so that preparations can be made for infection control practices and appropriate handling of remains. This will be accomplished through state, local and public-private partnerships. This process will be coordinated through DPH, local, and private entities. More details can be found here: https://www.cdc.gov/viral-hemorrhagic-fevers/hcp/infection-control/guidance-for-safe-handling-of-human-remains

Federal Agency Support

Responsibilities at the federal level are divided within the U.S. Department of Health and Human Services (HHS), to include Centers for Disease Control and Prevention (CDC) and the Administration for Strategic Preparedness and Response (ASPR). The CDC may provide consultation and expertise for clinical care and subject matter experts for patient management. The ASPR and the HHS Secretary's Operation Center will be responsible for coordination and logistical considerations of any transport and treatment involving federal resources. Additionally, the ASPR Regional Emergency Coordinator (REC) can be requested to support communication and coordination between states when necessary.

CDC

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

ASPR

- Acts as a liaison and manages federal agencies engaged in interstate transport.
- Requests air transport services from the U.S. Department of State (DOS) if necessary.
- Provides interstate and interagency communications about the need for transfer of potential HCID patients with federal resources.
- Assists with air and ground transportation logistics when federal resources are involved.
- Facilitates conference calls with all parties involved when arrangements are complete and prior

to arrival when multiple states and/or federal resources are involved.

Joint Information System

It is anticipated that the need for a Joint Information System between the many involved agencies will be necessary to support public messaging and to provide incident specific that is timely, consistent, and accurate to the public and involved stakeholders. The JIS should include representation from all agencies and organizations involved in the assessment and response phases of this ConOps.

The Joint Information Center (JIC) can be either a physical or virtual operation setup to support the response. If a physical JIC is determined to be necessary, it should be coordinated through the PHIMT at the PHCC or through the SERT at the SEOC.

Early activation of a Joint Information System is necessary to ensure early proactive and accurate messaging can be prepared and shared.