NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX C:

MEDICAL SURGE

OCTOBER 2023

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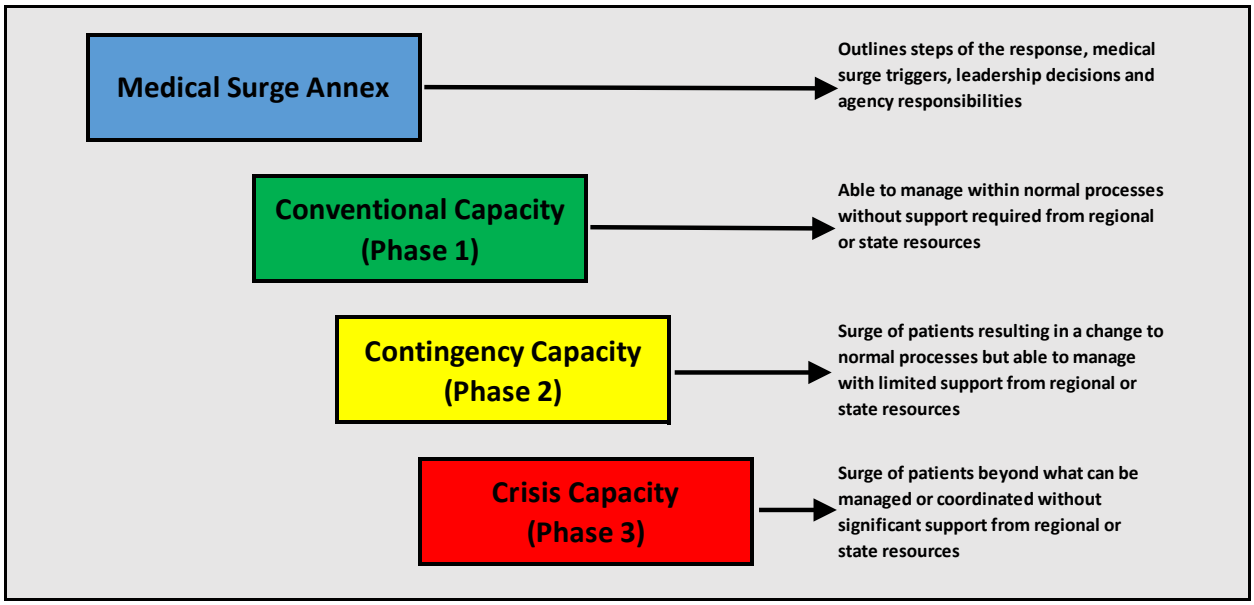
Overview

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.

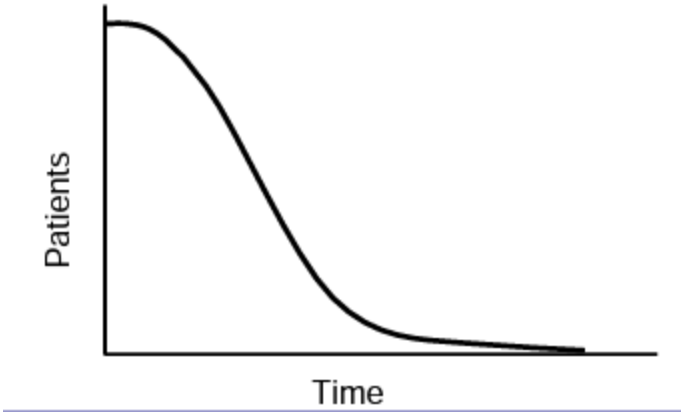
- Early recognition and a coordinated response to a medical surge incident is key to ensuring the healthcare system capacity does not become overwhelmed.

Medical Surge Incidents

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

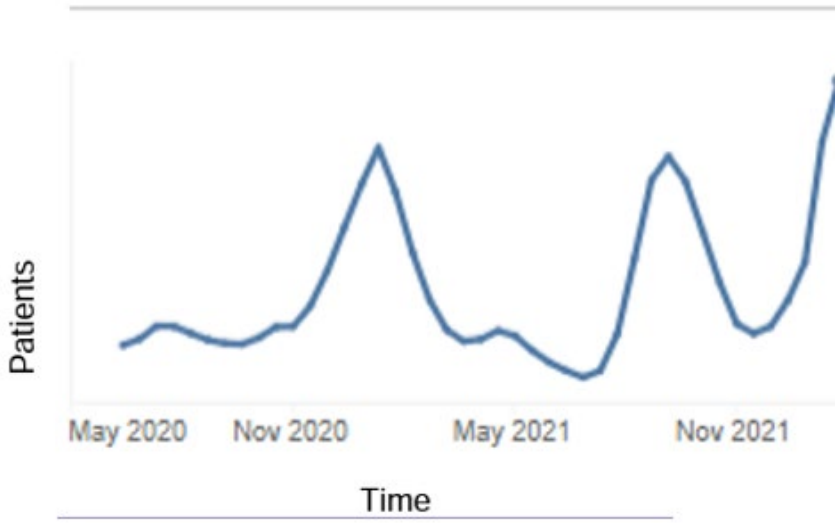
Immediate Impact

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

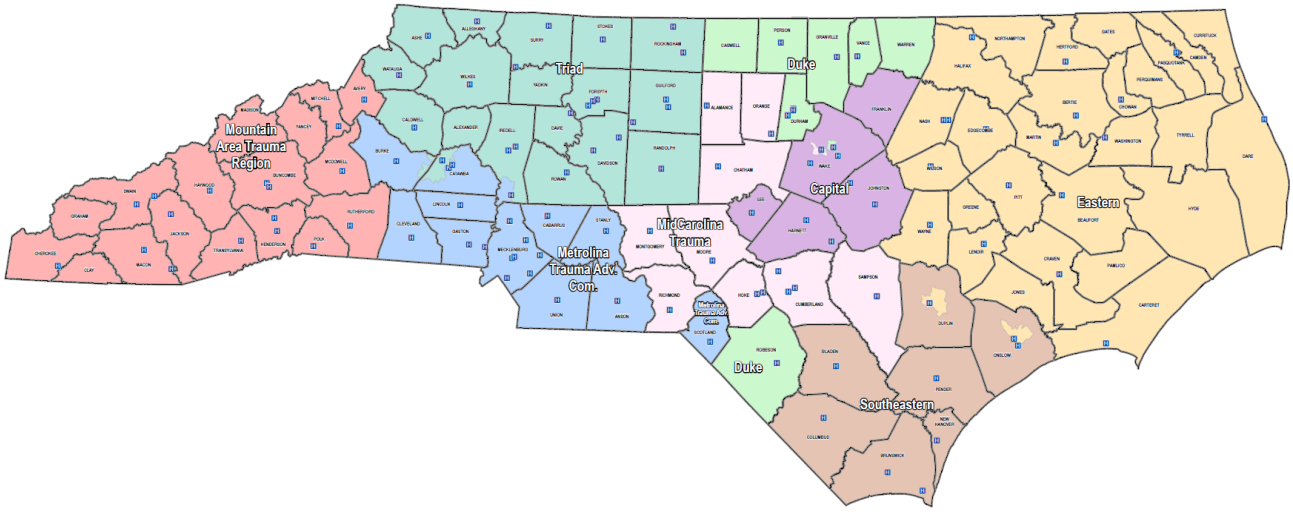
A medical surge incident that results in a sustained impact (highly infectious disease outbreak, high consequence pathogens outbreak etc.) have a gradual increase in number of patients impacting the healthcare system and can rise to a potentially catastrophic number with potentially multiple surges over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