NORTH CAROLINA OFFICE OF EMERGENCY MEDICAL SERVICES
EMERGENCY OPERATIONS PLAN (NCOEMS EOP)
BASE PLAN
AUGUST 2024

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Authorities

The North Carolina Division of Emergency Management (NCEM) is delegated the responsibility and authority to coordinate response to emergencies and disasters through the Governor of North Carolina to the Secretary of the Department of Public Safety who delegates that authority to the NCEM Director. Details of this authority can be found in The North Carolina Emergency Management Act found in **Chapter 166A** of the North Carolina General Statutes

In accordance with this statute, the North Carolina Emergency Operations Plan (NCEOP) is to describe a system for effective use of resources to preserve the health, safety, and welfare of those affected during emergencies. The NCEOP establishes responsibilities for state departments, private volunteer organizations, and non-profit organizations. According to the NCEOP, North Carolina Office of Emergency Medical Services (NCOEMS), is responsible for Disaster Medical Services as part of the Emergency Support Function – 8 Health & Medical Services (ESF-8).

Mission

In the State of North Carolina, according to the North Carolina Emergency Management Agency, health and medical services have been further organized under NCESF-8A (Disaster Medical Services) and NCESF-8B (Public Health). Under this organization, NCOEMS acts as the NCESF-8A Lead and has primary responsibility for coordinating statewide support for emergency medical care while the North Carolina Division of Public Health (NCDPH) act as NCESF-8B Lead with primary responsibility over public health services. NCOEMS responsibilities under Disaster Medical Services includes:

- Provide leadership in coordinating and integrating the overall state efforts that provide medical assistance to a disaster-affected area.
- Coordinate and direct the activation and deployment of state resources of medical personnel, supplies, equipment, and pharmaceuticals with Public Health as needed.
- Coordinate information gathering and sharing between federal, state, and local agencies in order to best guide the State Emergency Response Team's (SERT) decision making ability.
- Assist in the development of local capabilities for the on-site coordination of all emergency medical services needed for triage, treatment, transportation, tracking, and evacuation of the affected population with medical needs.
- Establish and maintain the cooperation of the various state medical and related professional organizations in coordinating the shifting of Emergency Medical Services resources from unaffected areas to areas of need.
- Coordinate with the SERT Military Support Branch to arrange for medical support from military installations.
- Coordinate the evacuation of patients from the disaster area when evacuation is deemed necessary.
- Coordinate the catastrophic medical sheltering response by implementing the Medical Support Sheltering Plan.

NCOEMS strives to manage these responsibilities through its Healthcare Preparedness Program (HPP) and provide the capabilities to meet them through State Medical Response System (SMRS) organizations.

Purpose and Scope

This NCOEMS Emergency Operations Plan (NCOEMS-EOP) has been developed as one means for NCOEMS, through its Healthcare Preparedness Program (HPP), to direct and coordinate various State Medical Response System (SMRS) organizations. These organizations can be activated in response to and/or recovery from a disaster or other emergency as part of the State Emergency Response Team (SERT) and enhance its ability to respond to medical emergencies due to all hazards.

This plan details the activation, organization, operation, and demobilization, of the NCOEMS, including the ESF8 Desk and its interactions with the SERT, SMRS organizations, and other ESF8 Health and Medical partners during emergent events and disasters. Although it may not cover all possible situations that may occur after activation, it is meant to provide NCOEMS staff who may be assigned to these areas with information essential for the successful set-up and operation of the positions described.

ESF8 Organization

North Carolina Office of Emergency Medical Services:

The North Carolina Office of Emergency Medical Services (NCOEMS) sits within the Department of Health and Human Service's Division of Health Service Regulation and has the mission to foster emergency medical systems, trauma systems and credentialed EMS personnel to improve in providing responses to emergencies and disasters which will result in higher quality emergency medical care being delivered to the residents and visitors of North Carolina. According to the North Carolina Emergency Operations Plan, NCOEMS is responsible for Disaster Medical Services as part of the State Emergency Response Team (SERT).

Healthcare Preparedness Program:

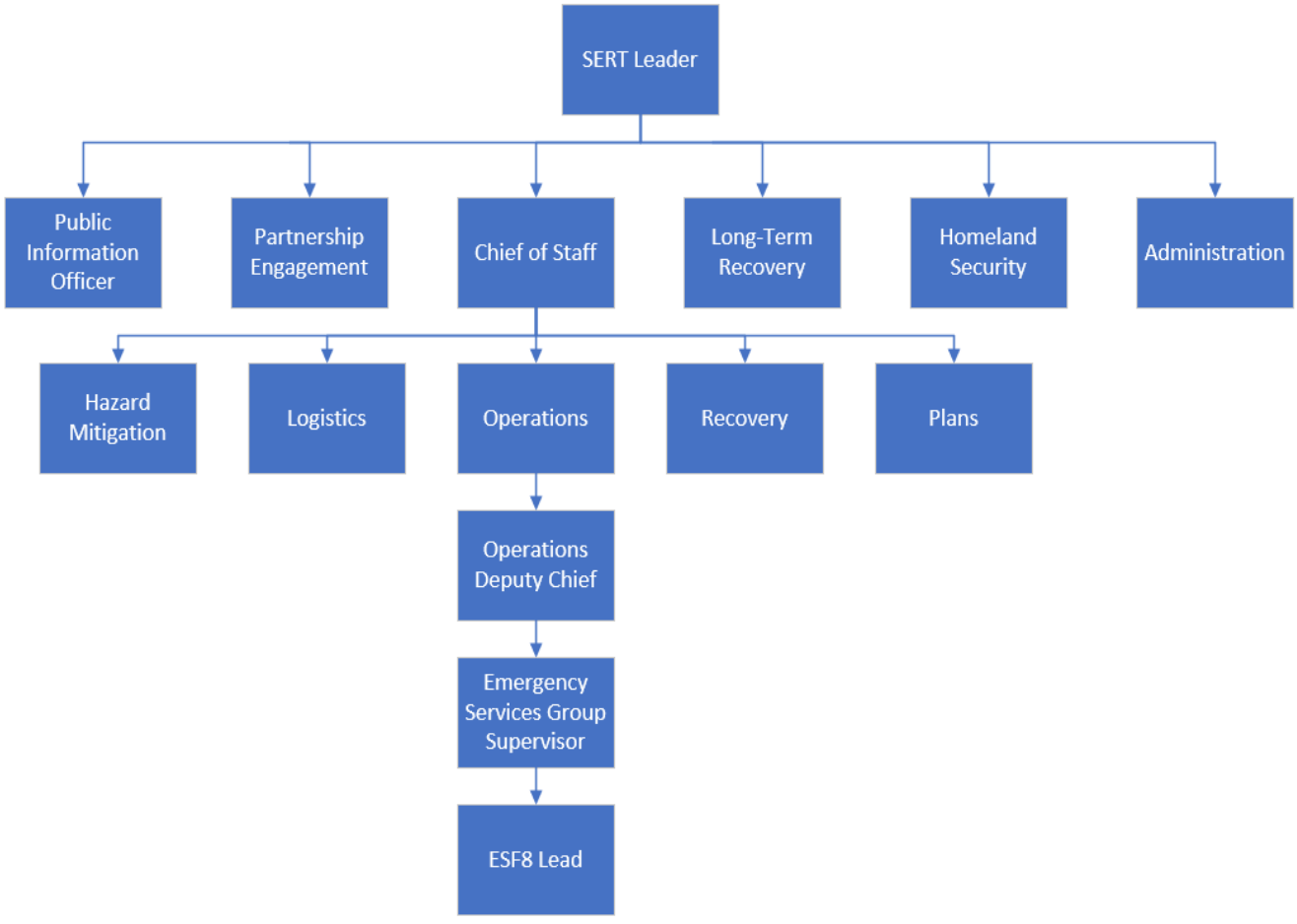
The North Carolina Healthcare Preparedness Program (HPP) sits within the Division of Health Service Regulation's North Carolina Office of Emergency Medical Services. HPP's mission is "We are a partner to the healthcare community, working to prepare for, respond to, and recover from emergencies and disasters across North Carolina." During emergencies and disasters, the HPP is responsible for managing NCOEMS responsibilities under the NCEOP including providing situational awareness, supporting continuity of operations, augmenting medical surge, coordinating healthcare resource allocation, coordinating statewide patient movement, and providing technical assistance. To fulfill these responsibilities, staff may be deployed to the ESF8 Desk at the State Emergency Operations Center (SEOC), the ESF8 Support Cell, to a state coordinated field operation, to provide support as part of a State Medical Response System (SMRS) organization or working remotely to support operations. As part of the Healthcare Preparedness Program, there are eight regional Healthcare Coalitions (HCCs) across North Carolina that have similar responsibilities during emergencies and disasters.

State Medical Response System:

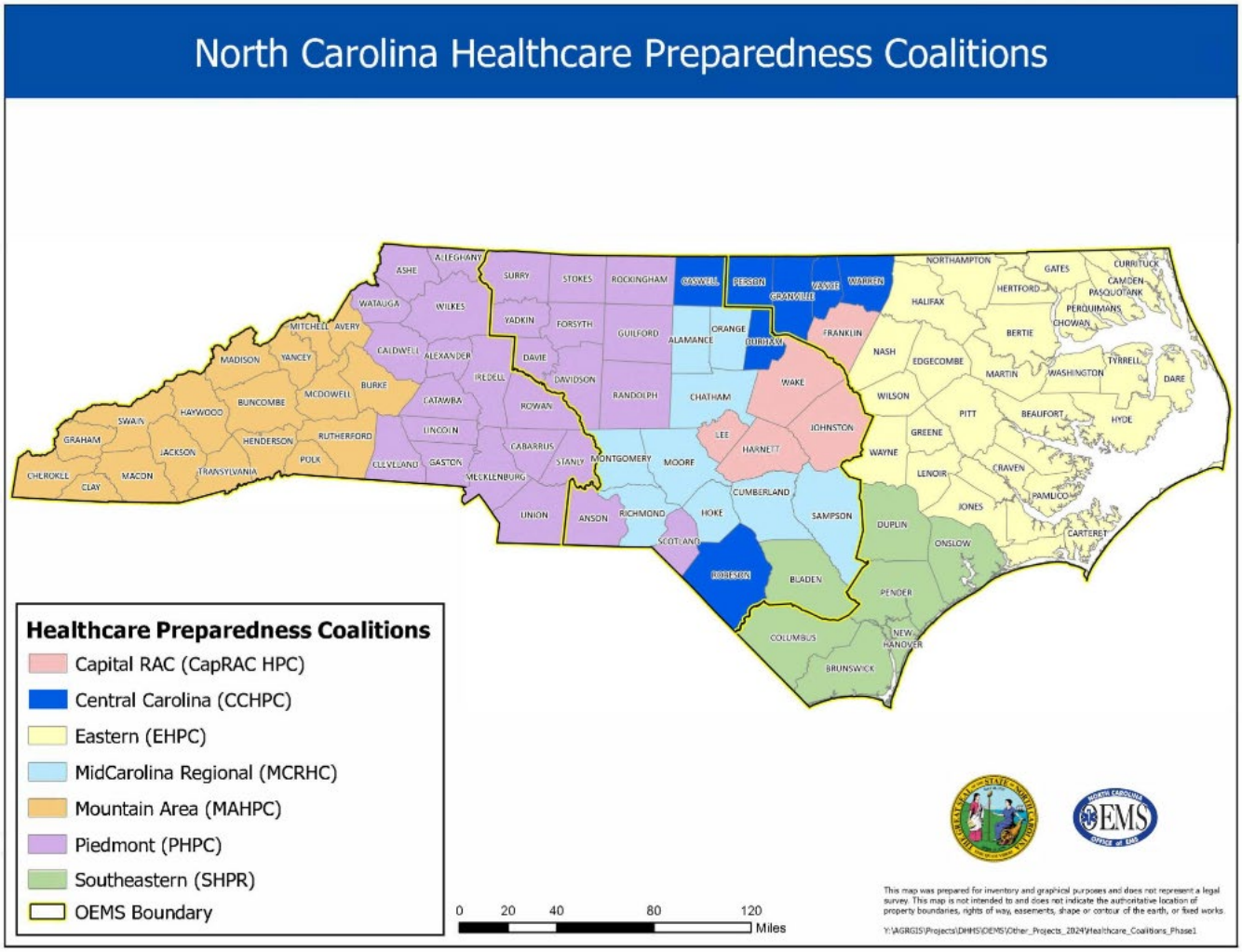
NCOEMS, as a member of the SERT and Lead Agency for ESF8, has facilitated the collaboration of local, regional, and state emergency response agencies in North Carolina to form the State Medical Response System (SMRS). The role of the SMRS is to support healthcare infrastructure when it is overwhelmed by an incident or event and when local and/or mutual aid resources are exhausted or inadequate. The purpose of the State Medical Response System (SMRS) is to provide support to that overwhelmed system by supplying the necessary equipment, assets, and/or personnel needed to provide medical care, and to ensure healthcare infrastructure continuity by facilitating the development of resilient systems through operational planning, training,

and exercises. The SMRS consists of State Medical Assistance Teams II (SMAT II), State Medical Assistance Teams III (SMAT III), Emergency Medical Services (EMS) Resources, the Mobile Disaster Hospital (MDH), Medical Reserve Corps (MRC) and contractual entities. **Refer to Annex H: State Medical Response System for additional information (note this annex is under construction).**

State Emergency Response Team (SERT): The SERT is comprised of senior representatives of state agencies, volunteer and nonprofit organizations, and corporate associates who have knowledge of their organizations' resources. SERT members provide technical expertise and have the authority to commit their organization's resources to support local, regional, and statewide emergency responses. During a response, these representatives may join the SERT Leader at the State EOC or remotely to coordinate relief efforts and provide support. As the situation develops or if additional assistance is required, SERT agency representatives may be deployed as All-Hazard Incident Management Teams (IMT) to affected counties to provide on-scene coordination and assistance.



Jurisdictions



Regional: Within North Carolina there are seven (7) defined Healthcare Coalition regions which are all led by a sponsor hospital. Healthcare Coalitions (HCCs) provide information sharing, healthcare system situational awareness, response coordination, logistical support, and augment medical operations to jurisdictions and healthcare facilities. They are comprised of members from healthcare organizations (e.g., hospitals, EMS agencies, public health, long-term care facilities, dialysis centers etc.) and their public and private sector response partners (e.g., emergency management agencies, volunteer organizations active in disaster etc.). Healthcare Coalition members are activated through region-specific preparedness and response plans developed and maintained in coordination with their Healthcare Preparedness Coordinator (HPC). During the activation of this EOP, NCOEMS has the ultimate authority and oversight of the HCC response as part of the State Medical Response System.

State: When activated for emergency response, NCOEMS provides statewide oversight, coordination, and support to county and regional entities, including the HCCs and their partners, for the sustained delivery of health and medical services in accordance with its obligations under the NCEOP. As the need for health and medical resources exceed the capacity or capability of the resources in any one

region, NCOEMS plans, coordinates and executes the delivery of needed support to those areas from other identified regional, state, or federal resources. Working as part of the SERT, NCOEMS coordinates statewide support through the Emergency Services Group of the State Emergency Response Team (SERT-ESG) at the State Emergency Operations Center (SEOC).

HHS Region IV UPC: The Region IV ESF8 Unified Planning Coalition (UPC) provides support during declared disasters where there is a need to provide or receive health and medical resources across state lines. The organization is comprised of ESF8 leadership from each of the FEMA Region IV states (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee) and federal ESF8 representatives. The UPC supports member states by assisting with the coordination of ESF8 planning and logistical/resource support. Prior to and during disaster response, the UPC assists impacted or potentially impacted member states with situational awareness, resource identification and acquisition via the Emergency Management Assistance Compact (EMAC), and coordination between member state and public health and medical (ESF8) systems.

Federal: The Robert T. Stafford Disaster Relief and Emergency Assistance Act provides the authority for the Federal government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. The U.S. DHHS-Administration for Strategic Preparedness and Response (ASPR) acts as the lead agency for federal ESF-8 Health and Medical assistance however other federal agencies such as the Centers for Disease Control and Prevention (CDC), United State Department of Veterans Affairs (VA) may also provide support. In the event that state health and medical resources are insufficient to maintain ESF-8 response or recovery operations and a State of Emergency has been declared by the governor of North Carolina, federal health and medical resources can be considered. This coordination will be done in conjunction with the ESF8 lead, NCEM ESG and ASPR Regional Emergency Coordinators (RECs) which are available to support the response physically or remotely. All federal response assistance will be based on State-identified priorities and must be approved by the SERT leader.

CONCEPT OF OPERATIONS

Activation: In general, ESF8 may be activated whenever an event (planned) or incident (unplanned) occurs, or is expected to occur, in which local or regional healthcare resources have become exhausted or are anticipated to become exhausted. Activation may be initiated in conjunction with a general activation of the SERT and SEOC or to provide direct support to SMRS organizations that may already be deployed. Depending on the situation, activation requests will usually be initiated by:

- The Emergency Services Group Supervisor of the North Carolina Division of Emergency Management (NCEM)
- The appropriate Healthcare Preparedness Coordinator (HPC) or their designee

The individuals holding the following positions within NCOEMS have the authority to activate this EOP:

1. HPP Program Manager
2. HPP Operations Manager
3. OEMS Chief
4. OEMS Assistant Chief
5. OEMS Regional Manager (East, Central, West)

Once activated, the ESF8 Lead, or their designee, will coordinate internally with appropriate senior staff, externally with NCEM, the NC Division of Public Health (NCDPH), and other NC Department of Health and Human Services (NCDHHS) organizations to inform decisions to activate and the appropriate level of activation. Refer to **EOP Appendix 2: ESF8 SEOC Activation Checklist** for items required as part of activation and **Refer to EOP Appendix 3: ESF8 SEOC/Support Cell Staffing and Sustainment SOG** for additional information covering staffing plans, battle rhythm, and the notification of personnel.

Over the course of an activation, the coordination of resources and support for NCOEMS coordinated field operations will begin at the ESF8 Desk and may expand to include the ESF8 Support Cell and/or other locations before contracting back to the ESF8 Desk. During this time, a portion of the duties and responsibilities held by the ESF8 Desk may be shifted to these other locations.

Activation Levels: NCOEMS activation will depend on the situation and may be independent of the activation level of the SEOC. For NCOEMS, these levels include:

- **Monitoring:** The Shift Duty Officer (SDO) is monitoring emergency communications statewide and engaging in information sharing with the healthcare system and emergency response organizations (Healthcare Coalitions, NCEM, PHP&R, etc.) as necessary. At this level, there is no known threat of impact and the coordination of SMRS assets by NCOEMS is not anticipated. **Refer to EOP Appendix 1: Shift Duty Officer SOG.**

- **Activated:** ESF-8 Lead, and other staff are actively involved in preparedness and response activities in anticipation of or due to the need for a deployment of state resources as part of the SMRS. At this level, the coordination may be conducted remotely or from a specific location (e.g., SEOC, Support Cell, etc.) and may involve one or more assets.

Sustainment of SEOC Operations: If NCOEMS involvement with disaster response and recovery operations extend to a 24-hour schedule, operations must be sustained. The sustainability of these operations is dependent on having adequate personnel, equipment (including communication equipment), facilities, meals, and lodging available as well as adequate support for these factors. **Refer to EOP Appendix 3: ESF8 SEOC/Support Cell Staffing and Sustainment SOG** for additional information addressing these issues.

Organization and Assignment of Responsibilities

General

Once notified, activated staff will support/coordinate ESF8 operations, handle associated requests for health and medical (ESF8) information and resources, represent ESF8 to local, state, and federal partner organizations, and provide reports to the SERT as requested. Key responsibilities and roles are detailed below.

ESF8 Responsibilities

SEOC ESF8 Desk: The ESF8 Desk at the SEOC is typically the initial and primary center for ESF8 coordination of State Medical Response System (SMRS) information and resources, and the authoritative source for response and recovery decisions as they pertain to disaster medical services in North Carolina. The functions of the ESF8 Desk may be conducted remotely depending on the

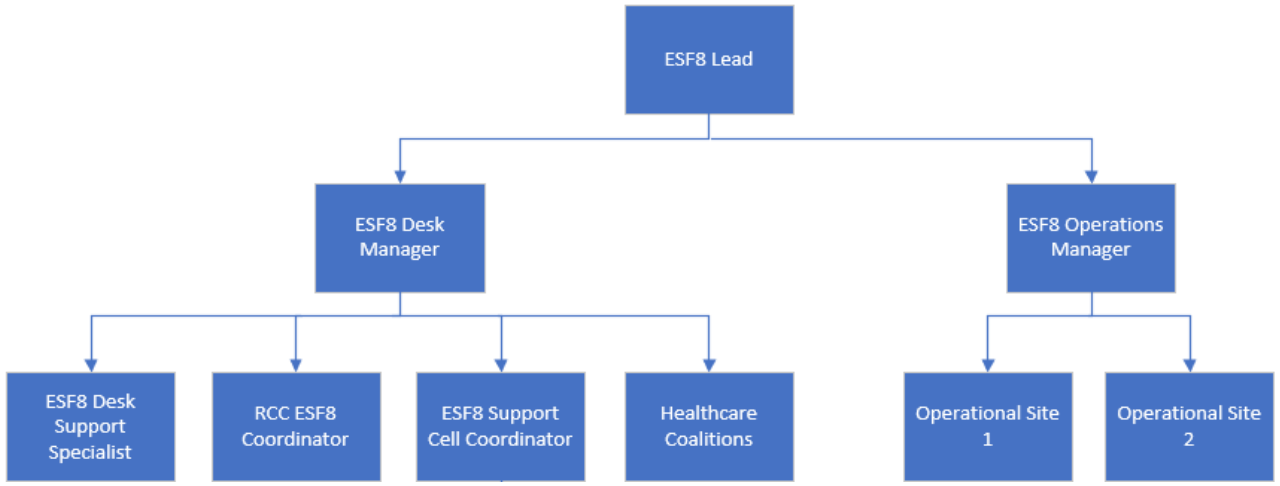
operational situation or nature of the event. Once activated, personnel assigned to the ESF8 Desk are responsible for coordinating medical resource management and supporting NCOEMS field operations, refer to **EOP Appendix 4: Medical Resource Management SOG**. The desk should coordinate directly with the NCEM Emergency Services Group Supervisor (ESG Supervisor) regarding potential and assigned ESF8 missions. As the response to a disaster expands, the ESF8 Lead may activate the ESF8 Support Cell and shift selected ESF8 Desk responsibilities to the support cell.

ESF8 Support Cell: The ESF8 Support Cell typically serves as a secondary center for the coordination of SMRS information and resources, primarily in support of the ESF8 Desk when it is necessary for operations to expand. However, these functions may also be conducted remotely depending on the operational situation or nature of the event. Once activated, the personnel assigned to these roles are responsible for the duties assigned to them as directed by the ESF8 Desk Manager.

HCC Operations Centers/Support Cells: Each HCC maintains an Operations Center/Support Cell as their initial and primary location for the coordination and support of healthcare facilities or ESF8 operations both within their regions and throughout the state. Once activated, HCC staff assigned to these areas, work as part of ESF8 and assist with the coordination of SMRS information and resources in support of local Emergency Management, their regional response partners, other HCCs, and the ESF8 Desk or ESF8 Support Cell. Like the ESF8 Desk and ESF8 Support Cell, these functions may also be conducted remotely depending on the operational situation or nature of the event.

Regional Coordination Centers (RCCs): RCCs operate under the direction of the NCEM Operations Chief and are directly managed by NCEM Regional Managers. They are activated as staging areas for personnel and equipment (from all Emergency Support Functions) necessary to support disaster response and recovery operations on the local and regional level when necessary. Once an RCC is activated the ESF8 Lead may be tasked with providing representatives to staff the RCC ESF8 Desk. If tasked, the ESF8 Lead, or their designee, will select staff from the NCOEMS Regional Offices (Eastern, Central, Western) to act as ESF8 representatives to the RCCs. NCOEMS Regional Managers and regional staff assigned to the RCCs operate under the ESF8 Desk Manager and are responsible for coordinating disaster information, facilitating ESF8 mission support and medical resource tracking, informing medical resource allocation decisions, and for coordinating and resolving operational issues between ESF8 agencies and government jurisdictions.

ESF8 Roles:



ESF8 Lead: Advises, sets priorities, and provides overall direction for ESF8 response and recovery activities. Represents ESF8 goals, objectives, and activities to local, state, and federal partners as part of the North Carolina SERT and authorizes the activation of state ESF8 resources. Coordinates with DHHS/NCOEMS Leadership, State Medical Response System, and NC SERT partners on the development and implementation of policies necessary to support ESF8 response activities and the release of information to the public.

SEOC ESF8 Desk Manager: Monitors available communication and information technology systems to maintain situational awareness of ESF8 response and recovery activities, refer to **EOP Appendix 5: Communications and Information Systems**. Develops situation reports and leads coordination calls for the purpose of sharing ESF8 situation and mission status information across ESF8 organizations and with local, state, and federal partners, as appropriate. Manages requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, and HPCs. The SEOC ESF8 Desk Manager works directly with the ESF8 Lead and is activated when assistance is necessary for developing situational awareness, managing resource requests, or coordinating the provision of ESF8 resource support with the Healthcare Coalitions (HCCs) and Regional Coordination Centers (RCCs). This position is usually at the SEOC to coordinate resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions. The position coordinates in a similar way with RCC ESF8 Manager and also works to identify ESF8 resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs.

ESF8 Operations Manager: Ensures pre-deployment readiness and planning for potential ESF8 operational mission requests. Conducts assessments of need with requesting jurisdictions/organizations and advises ESF8 Lead on approval of operational mission requests. Oversees operational site(s) coordination (site assessment, site plans) with response partners. Ensures necessary mission support is coordinated with the ESF8 Desk Manager. Oversees site demobilization when indicated. The ESF8 Operations Manager is activated when there is the potential for the activation and deployment of SMRS operational units (e.g., SMSS, MDH, Patient Transfer Centers, etc.) to meet health and medical resource needs both within and outside of North Carolina. Once activated, this position coordinates all aspects of the deployment of SMRS operational units into the field. The position coordinates directly with the ESF8 Lead and SEOC ESF8 Desk Manager to identify necessary IMT personnel, staffing, and logistics resources. Once SMRS operations have been established, this position provides direct support and leadership to the deployed IMTs and coordinates further support through the ESF8 Lead and SEOC ESF8 Desk Manager.

ESF8 Desk Support Specialist: Assist the ESF8 Desk Manager in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT.

RCC ESF8 Coordinator: Responsible for coordinating disaster information pertaining to affected health and medical facilities and services and facilitating ESF8 mission support at the RCC level. Provides direction and support to ESF8 resources assigned to the RCC. Conducts medical resource tracking, advises medical resource allocation decisions, and assists with the coordination and resolution of operational issues between ESF8 agencies and government jurisdictions. RCC ESF8 Coordinator may be activated when it is anticipated that an area or areas within an NCEM Region (East, Central, West) may be affected by an emergency or disaster with the potential to overwhelm ESF8 resources there. The positions may be requested by an NCEM Regional Manager and assigned by the ESF8 Lead. Once

activated, RCC ESF8 Leads work closely with the SEOC ESF8 Desk Manager and, in some cases, the ESF8 Support Cell Coordinator to coordinate ESF8 resources in support of health and medical facilities or local ESF8 operations within the RCC.

ESF8 Support Cell Coordinator: Coordinates directly with the ESF8 Desk Manager and ensures all assigned tasks to the support cell are completed. Potential tasks include, maintaining situational awareness, managing resource requests, supporting field operations, coordination of patient transfer operations and the vetting of medical supply requests during medical logistics operations. The ESF8 Support Cell Coordinator is activated when the ESF8 Lead or SEOC ESF8 Desk Manager needs assistance with the support and/or coordination functions that cannot be easily conducted from within the SEOC (e.g., SMSS patient movement coordination, etc.). Once activated, this position works directly with the ESF8 Desk Manager to define the staff and schedule necessary to support the situation. Once established, this position coordinates all aspects of the roles/functions assigned to the ESF8 Support Cell and works directly with the SEOC ESF8 Desk Manager to ensure that the needed support is provided.

Coordination: Personnel filling the roles listed above provide the leadership framework for ESF8 response and recovery actions in North Carolina. Although the situation will dictate the extent in which these positions are activated, the ability of the personnel in these positions to work together in an efficient manner is essential to the success of the ESF8 response. In the initial phases of a response, the ESF8 Lead may fulfill all the roles listed above but, as health and medical needs become better defined, the ESF8 Lead will activate one or more of the other leadership positions until, if necessary, all are active parts of the ESF8 response. These positions may be physically located at the SEOC, the Support Cell, Operational Sites and/or filled in a remote capacity depending on the situation.

Support for NCOEMS Coordinated Operational Sites: All established ESF8 field operations require support to help manage or provide direction for meeting operational and logistical needs that arise during deployment.

- Operational needs may include areas such as staffing, patient care, and the integration of ESF8 field operations with existing local health and medical operations.
- Logistical needs may include areas such as the resupply of medical equipment and supplies, establishment of IT and security support from partner organizations, and the integration of local services such as waste management, material handling, transportation, and janitorial services.

When ESF8 field operations have been established, support for all needs should be entered into WEBEOC by onsite staff and routed to the ESF8 desk for review and assignment. The assigned Incident Management Teams (IMTs) are expected to communicate their operational and logistical needs to the ESF8 Operations Manager.

Chain of Command: A clearly defined chain of command is necessary to ensure continuity of health and medical operations in response and recovery from emergency events and disasters. During these times, it is important that the line of succession be based on the knowledge, skills, and abilities of individuals and the established disaster response structure. For these reasons, once activated the following chain of command will be established:

1. ESF8 Lead
2. ESF8 Operations Lead
3. SEOC ESF8 Desk Manager
4. ESF8 Support Cell Coordinator

As needed ESF8 field operations are stood up, NCOEMS staff may be assigned many different roles within them to meet ESF8 mission requirements as part of the SERT. Each role includes a range of responsibilities necessary to ensure that the organization fulfills its operational or support mission successfully. **Refer to EOP Appendix 6: Organization and Assignment of Responsibilities** which provides additional information covering ESF8 organization by activation level, and responsibilities of staff assigned to the State EOC and Support Cell roles.

Demobilization

As response objectives are achieved and the emergency event or incident comes under control, Incident Command/emergency management leadership, in coordination with ESF8 leadership and representatives, will direct the demobilization of personnel and assets on-scene, at Regional Coordination Centers and the SEOC. **Refer to EOP Appendix 7: Demobilization SOG** for additional information covering the processes and procedures for the demobilization ESF8/SMRS operational and operations support organizations and teams.

Capabilities

Administrative Preparedness: Addresses the ability to conduct and maintain administrative functions necessary for the execution and proper documentation of ESF8 emergency response and recovery operations. Provides guidelines and information including the recording of responder time and activities, emergency purchase processes, and FEMA reimbursement. **Refer to HOLD PLANNED FUTURE ANNEX**

Healthcare System Recovery: Addresses the strategic priorities, organization, and concept of operations for recovery activities supported by the State Medical Response System necessary to provide continued delivery of essential healthcare services after a disaster or emergency. **Refer to ANNEX B: HEALTHCARE SYSTEM RECOVERY for specific plans and information utilized to meet this capability.**

Medical Surge: Addresses the ability to provide adequate medical coverage during incidents that severely challenge or exceed the normal medical infrastructure of an affected community (through numbers *or* types of patients). Covers plans and guidelines for support of the healthcare system during incidents resulting in medical surge conditions. **Refer to ANNEX C: MEDICAL SURGE for specific plans and information utilized to meet this capability.**

Patient Movement: Addresses the ability to triage and place patients in appropriate receiving facilities and develops a structure for the coordination of transportation for patients. Covers plans and processes for state-coordinated patient movement when local jurisdictions require regional, state, or federal assistance to manage patient movement including evacuation of existing healthcare facilities.

Refer to ANNEX D: PATIENT MOVEMENT for specific plans and information utilized to meet this capability.

Healthcare Preparedness Program Continuity of Operations: Addresses the implementation and management for the Healthcare Preparedness Program's Continuity of Operations. This plan outlines the essential functions of the program and plans to ensure their ability to be maintained during various emergencies and disasters. **HOLD PLANNED FUTURE ANNEX**

Situational Awareness & Information Sharing: Addresses the ability to provide and maintain situational awareness and share information regarding ESF8 response/recovery operations during an emergency or disaster. Covers guidelines for the collection and dissemination of information, use of briefings and conference calls, and use of messaging systems. **Refer to ANNEX F: SITUATIONAL AWARENESS & INFORMATION SHARING for specific plans and information utilized to meet this capability.**

Healthcare Services in Shelters: Addresses the ability to maintain continuity of healthcare through the establishment, operation, and/or support for healthcare services in state-run shelters. Covers plans and guidelines for State-Operated Shelters (SOS) and State Medical Support Shelters (SMSS). **Refer to NCOEMS ANNEX G: HEALTHCARE SERVICES IN SHELTERS for specific plans and information utilized to meet this capability.**

State Medical Response System: Addresses the ability of the North Carolina State Medical Response System to support overwhelmed healthcare infrastructure by supplying the necessary equipment, assets, and/or personnel needed to provide medical care during emergencies and disasters. Covers plans and guidelines for the components of the State Medical Response System (SMRS). **HOLD PLANNED FUTURE ANNEX**

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 1: SHIFT DUTY OFFICER STANDARD OPERATING GUIDELINE

OCTOBER 2023

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Purpose

To ensure the efficient provision of emergency medical support and direction in response to emergent events with the potential for affecting the health and medical welfare of North Carolina residents and visitors.

Scope

This SOG identifies the primary on-call staff, defines on-call duty, and outlines the initial actions of these individuals upon notification of an incident in which NCOEMS is a lead or supporting agency.

Operating Guideline

The Shift Duty Officer (SDO) will be available 24/7 to provide support, as requested, for emergency activations or responses across the state and to acknowledge and respond to requests for information. The SDO will be available via phone and email:

- Phone: 919-855-4687
- E-Mail: DHSR.NCOEMS.SDO@dhhs.nc.gov

The Admin on Call (AOC) is a leadership position to provide internal direction, advice, support, and backup for the SDO in a 24/7 capacity.

General Duty Responsibilities

- The expected response time to messages is within 15 minutes. Greeting messages on phones utilized during SDO duty and which may be received by callers contacting the SDO for assistance must, at a minimum, confirm that the caller has reached an HPP staff member and that their call will be returned as soon as possible.
- Staff scheduled for duty must be able to maintain availability to meet response time expectations. For this reason:
    - Staff scheduled to be out of state during their rotation cannot serve as SDO.
    - Staff that are committed to activities that may temporarily cause them to be unable to meet the expected response time (e.g., training, conference presentations, etc.) must coordinate with other HPP SDO staff to temporarily cover the duty and notify the AOC.
- SDO will contact the AOC if assistance is needed in responding to a request for support or if there may be an unforeseen break in coverage of the SDO phone.
- When the response to ongoing incidents results in the activation of the State EOC, the SDO may be responsible for the initial opening of the ESF8 Desk:
    - During major activations (24/7 operations), the SDO, should be integrated into the regular NCOEMS staffing plan for the SEOC and the SDO line transferred to the ESF8 Desk with all responsibilities for the SDO integrated into the ESF8 role.
    - During minor activations (daytime operations) or during planned activities (exercises, etc.), the SDO should not be integrated into the staffing plan for the SEOC, when possible, and should expect to maintain their responsibilities as SDO outside the State EOC
    - If due to low staffing it is not possible for the SDO to maintain their role separate from the SEOC the staffing plan should consider rotation of the ESF8 desk and SDO

responsibilities to ensure that staff receive adequate time away from being in response mode

Staffing

1. SDO duty will rotate between identified staff every week on a schedule maintained by the HPP Program Manager or their designee. All changes to the established shift schedule due to illness, previous commitments, or other reasons will be coordinated through the AOC and are the responsibility of the SDO to coordinate coverage.
2. AOC duty will rotate between the HPP Program Manager and the HPP Operations Manager every four (4) weeks on a schedule maintained by the HPP Program Manager or their designee.

Shift Times & Shift Change

SDO shifts will run over a one-week period and AOC shifts will run over a four-week period. Shift changes will take place every Monday at 0900. At that time, the SDO coming off shift is responsible to:

- Provide an informal briefing to the oncoming SDO. At a minimum this briefing should outline any ongoing responses that required SDO action and include:
  - Emergency medical resources alerted/activated (organization, type, and quantity)
  - Date/time of activation/response, SDO actions, and resolution
  - Current situation and any required follow-up actions for the oncoming SDO
- Provide any documents, maps, etc. to the oncoming SDO that are pertinent to current activities.

The SDO coming on shift is responsible to:

- Forward the SDO phone - (919) 855-4687 – to their NCOEMS-issued mobile phone. The SDO phone is in the Wright Building. Test the SDO line to ensure that it is working appropriately after the transfer.

Situational Awareness and Reporting

During the duty period the SDO is expected to maintain situational awareness through the active monitoring of:

- All phone calls and email to the SDO contact number and email address. Overnight (1700-0800) the SDO can shift to phone only monitoring.
- The SDO is also expected to always maintain access to the VIPER 800MHz radio system.
- ReadyOp will be utilized for formal situation reporting purposes. Situation reporting forms (i.e., SDO Notification forms) are specific for each Healthcare Coalition (HCC) and found under the Forms tab of each HCC's ReadyOp page.
- Situation reporting will be coordinated between the SDO and the affected Healthcare Preparedness Coordinator (HPC) or their designee. In general, when notification of an incident or request for support originates with the SDO, the SDO will be expected to initiate and update situation reporting. When an incident notification or support request originates with an HPC, they will be expected to initiate and update situation reporting.

Resources: The SDO should be provided/have access to and may utilize the following equipment and supplies in performance of their duties.

Communication:

- Portable VIPER 800mhz radio with charger and extra battery
- NCOEMS-issued smart phone with car and wall chargers.
- GETS card.

Transportation:

- NCOEMS staff vehicle with portable VIPER capable radios and plug-in power inverter (for running laptop, etc. off vehicle battery)

Operation:

- NCOEMS-issued laptop with appropriate emergency management programs and applications and chargers.
- NCOEMS-issued Wi-Fi-enabled hotspot or smart phone with chargers.
- Plans/access to plans, paper, pens, calculator, and other supplies necessary for planning and reporting

Notification and Initial Actions

Notification for emergent or potential incidents involving emergency response may be via:

1. NCEM 24-Hour Operations Center/Warning Point – (Usually a notification of a potential incident and delivered via e-mail)
2. NCEM Emergency Services Group Supervisor of the State Emergency Response Team (SERT) – (Usually a notification of an emergent incident and delivered via phone call or text)
3. Regional Healthcare Preparedness Coordinators – (Usually a phone/email/ReadyOp notification of an issue that the HPC is already involved with and foresees the need for additional support)

Upon receiving notification of a potential or actual incident or request for support through one of these routes, the SDO is expected to assess the need and determine what type of action is necessary, if any.

- If no state resources are requested and there are no expected changes to the situation (i.e., train struck a pedestrian and the situation has ended) acknowledge that the notification has been received and take no further action.
- If no state resources are requested but there is a potential for a change in the situation thereby necessitating resources in the future (i.e., A skilled nursing home has lost power and county emergency management is investigating the need for HVAC/Generators), acknowledge that the notification has been received and:
    - Forward the notification and information to the Healthcare Preparedness Coordinator (HPC) responsible for the affected facility/jurisdiction for their awareness (Note: If a hospital system is involved, similar notification should be made to the HPC associated with that hospital system. The SDO may ask the regional HPC to make this additional notification.)
    - Submit an initial situation report in ReadyOp for the affected HCC.
- If the notification is for the coordination of health and medical resource support, acknowledge that the notification has been received and:
    - Contact the Healthcare Preparedness Coordinator (HPC) responsible for the affected facility/jurisdiction and/or utilize the on-call number for the HCC found in ReadyOp.
    - Ensure the HCC is willing and able to handle the request for assistance. If they are unwilling/unable, then contact the HPP Program Manager or designee for additional support.

- Forward the notification and information to the HPC or their designee responsible for the response and request that they:
    - Verify the reported information with local partner organizations to confirm what is needed,
    - Utilize HCC resources to meet the requested need (this includes resources from other HCCs)
    - Provide initial situation report back to the SDO within 30-60 minutes or when reasonably able to do so via ReadyOp, Text, Phone or Email.
    - Post situation reports in ReadyOp utilizing their HCC-specific SDO Notification form every 8-12 hours depending on the situation. For quickly evolving situations the need may be more frequent and may be provided via ReadyOp, Test, Phone or Email.
- Maintain contact with HCC designee, monitor email for ReadyOp situation updates, and be available to expand/support HCC requests.
- Submit initial situation report/update in ReadyOp for the affected HCC within first 60-90 minutes based on the information provided by the HCC designee and other official sources to, at minimum the:
    - Activated HPCs, and
    - Regional NCOEMS Manager for the affected location
    - Ongoing Situation Reports should be sent out every 8-12 hours based on the situation. For quickly evolving situations the need may be more frequent.

- If the notification is for the coordination of health and medical resource support, and the HCC designee has determined that the need is greater than what the HCC of the affected facility/jurisdiction is capable of handling with the resources available:
    - Notify the HPP Program Manager, or their designee, to provide a brief situation report, discuss the situation, and coordinate further action including, if necessary:
        - Activating additional HPP/HCC staff and assets
        - Activating the NCOEMS-HPP EOP or other plans
        - Request posting a separate event in NCSPARTA WebEOC

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 2: ESF8 STATE EOC ACTIVATION CHECKLIST

OCTOBER 2023

Notification of Activation Received from NCEM

This checklist is specifically created for when NCOEMS receives notification that the SEOC/SERT is activating and NCOEMS is expected to staff the ESF8 Desk physically or virtually. Notification of an activation is typically received by email in advance of an anticipated incident but can occur without notice with an immediate response to the SEOC expected. The tasks listed below should be considered as the initial items necessary at the time the activation is received. Consideration for virtual staff to support these tasks should also be considered.

Initial SEOC Activation Items

- ✓ ***Acknowledge Activation from NCEM***
- ✓ ***Determine Initial Staffing Plan***
    a. Responsibility of the ESF8 Lead or designee with an initial 72-hour staffing plan. Staffing plan should be sent to NCEM Emergency Services Group (SERTEmergencyServices@@ncdps.gov) with NCOEMS SDO Email Copied (DHSR.NCOEMS.SDO@dhhs.nc.gov)
- ✓ ***OEMS Admin Creates Folder in OwnCloud specific for this incident and shares with OEMS Response group.***
    a. This folder is used to organize situation reports, staffing plan, and other response specific documents for easy reference and recall.
- ✓ ***Activation Email to OEMS staff to request availability from all staff.***
    a. Detail on reason for activation
    b. Date and time of initial activation
    c. Initial staffing plan
    d. For any response the staff should be polled for availability to support the activation. Some of these positions may be remote or physical depending on the size of incident and anticipated need. Initial availability should be for 1 week. For larger incidents we typically poll for 2 weeks.
        i. Consider text message to staff about activation through ReadyOp to increase awareness of activation and need for staffing availability.
- ✓ ***Initial Activation Email to Regional HPC List-Serv & Partner Agencies***
    a. Detail on Reason for Activation
    b. Date and time of initial activation
    c. Anticipated Timeline for more information to be released.
    d. Direct to Website for more information
- ✓ ***Update ReadyOp forms and Dashboards***
    a. Patient Movement (Hospital & SMSS)
        i. Planning Form
        ii. Individual Form
        iii. Bulk Upload Form & Template
    b. Transport & Tracking
        i. Transportation Resource Form
        ii. Resource Assignment & Tracking Form
    c. SMSS Intake Forms – one per anticipated shelter
    d. Essential Elements of Information

        i. Pre-Incident
        ii. Post-Incident
    e. 214
    f. Situation reports
    g. Quick AAR form
    h. Unusual Event Report
    i. Daily Schedule Updated
    j. Operational Site Info Sheet
- ✓ ***Update Website***
    a. Put announcement about activation on the main page.
    b. Create a page specific to this activation and ensure all links for ReadyOp forms needed by partners are linked.
    c. Details on Activation
    d. Guidance as Appropriate
- ✓ ***Activation Email to Regional HPCs***
    a. Detail on Reason for Activation
    b. Date and time of initial activation
    c. Initial staffing plan
    d. Links & Website Details for Sharing with Partners
    e. Request all Healthcare Coalitions update their Mission Ready Packages in ReadyOp ASAP with set deadline (e.g., 4 hours)
    f. Healthcare Coalitions are requested to begin coordination with their regions:
        i. Information Sharing – setup coordination calls
        ii. Request for Counties / Hospitals to complete SMSS and Hospital Planning Forms if Anticipated Need
        iii. Situation Reports are due to ESF8 desk via ReadyOp at 1730
        iv. Poll their stakeholders for any potential resources needs/concerns.
        v. Poll for available personnel and assets that can be deployed.
        vi. Pre-Incident Essential Elements of Information (if applicable)
- ✓ ***Update DHHS Email List Servs (see Annex F)***
- ✓ ***Schedule Coordination Call Cadence***
    a. OEMS Response Staff Call (1330)
    b. Healthcare Coalition Regional Call (1000)
    c. Other potential calls (Region IV, SEOC etc.)
- ✓ ***Update ReadyOp Contacts (agency 13)***
- ✓ ***Forward SDO Phone to SEOC***
- ✓ ***Build SEOC Schedule and post in ownCloud response folder & email to ESG, staff etc.***
- ✓ ***Turn off forwarding of phones at SEOC.***
- ✓ ***Start Importing Mission Ready Packages***

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 3: ESF8 SEOC/SUPPORT CELL STAFFING AND SUSTAINMENT SOG

OCTOBER 2023

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Scope

These guidelines cover the development and dissemination of staffing plans, notification of activated

personnel, battle rhythm, and the sustainment of ESF8 SEOC/Support Cell operations over a 24-hour schedule.

Staffing Plans

Once activation is decided, the ESF8 Lead, or their designee, will be responsible for the development, dissemination, and management of the Staffing Plan for the SEOC ESF8 Desk, Support Cell, and other ESF8 operational locations. Staffing plans should be initiated and completed as soon as possible after notification of an event/incident that may result in the activation of the SEOC ESF8 Desk. Initial staffing plans should cover the first 72 hours of operations and should be provided to the SERT-ESG Supervisor when requested.

Staffing Plan Development:

The following planning factors need to be considered in the development of any staffing plan:

- Personnel: The NCOEMS staff listed below should be considered first for positions upon initial activation. If additional personnel are needed to meet staffing requirements, it should be coordinated between the ESF8 Lead, or their designee, and the appropriate manager.
    - NCOEMS Shift Duty Officers
    - NCOEMS Managers,
    - Other staff meeting NCOEMS training requirements in the Training, Exercise, Response Management System (TERMS)
- Staffing Levels: Will vary according to the situation and NCOEMS Activation Level. Once established, levels may be adjusted by the ESF8 Lead or their designee.
- Rotation: Once established, the staffing of the SEOC ESF8 Desk will rotate on a schedule maintained by the ESF-8 Desk Manager or their designee.
- Shift Times: SEOC ESF8 Desk Shift times will vary according to the situation. The first hour of every shift will be used to brief and orient oncoming personnel to the current operational situation and mission support issues. In general:
    - 12-hour Operations:
        - Day shift - 0700-1900
    - 24-hour Operations:
        - Day shift – 0600-1600
        - Swing shift - 1200-2200
        - Night shift - 2100-0700

Staffing Availability Survey and Plan

Utilizing the ReadyOp program (https://nc.readyop.com/), the ESF8 Desk Manager, or their designee, will develop a survey to capture personnel availability (refer to ReadyOp User Guide). The survey will be disseminated via email to NCOEMS deployable personnel (DHSR.EMS.ESF8@lists.ncmail.net) and the results of the survey will be used to develop the staffing plan. Staff sending the survey should monitor ReadyOp for returned availability surveys. The content of surveys will vary depending on the situation, but the survey and the resulting staffing plan should include the following essential elements of information:

- Incident/Event Name
- Date Prepared
- Staff Name (Full Name)
- Staff Contact Information (Phone, E-mail, etc.)

- Day (of week) and Date (Month/Day) staffing is needed.
- Shift Times
- Comments (issues affecting availability, optional)

Staffing Plan Dissemination

Staffing plans, once complete, should be posted to ownCloud and emailed to:

1. DHSR.EMS.ESF8@lists.ncmail.net
2. DHSR.OEMS.Regional.HPP@lists.ncmail.net
3. SERTEmergencyServices@ncdps.gov

Any incident specific information (reporting time, location, applicable maps, meal plan and specific equipment that may be required etc.) should be emailed out with the staffing plan. A map to the SEOC is listed at the bottom of this plan for individuals that may not be familiar with the location.

Staffing Plan Management

Once staffing plans have been developed and disseminated, SEOC ESF8 Desk staff will update and/or initiate the extension of these plans as necessary beyond the initial 72-hours of response/recovery operations or to otherwise meet the requirements of the situation. Update and expansion of these plans will be conducted in coordination with the ESF8 Lead or their designee.

BATTLE RHYTHM: The schedule for ESF8 operations (e.g., personnel work shifts, times for situation reporting and conference calls, etc.) will be determined by the ESF8 Lead. Once determined, selected ESF8 Desk staff will be responsible for managing and maintaining the established battle rhythm, refer to Operational Activity and Reporting Schedule below.

Operational Activity/Reporting Schedules NCOEMS State Emergency Operations Center (SEOC) Schedule Day Shift: 0600 – 1600; Swing Shift: 1200 - 2200, and Night Shift: 2100 - 0700	
ESF8 Desk/Support Cell Schedule	
0700	ESF8 Sit-Rep/NCOEMS objectives information due to SEOC ESF8 Desk Rep. Reports assembled. Conduct shift change.
0900	SERT Shift Briefing
0930	ESF8 Situation Report completed, forwarded to SERT ESF Supervisor, Regional HPC List-Serv, OEMS Response Staff and partners.
1000	NCOEMS Conference Call with SEOC ESF8 Desk Representative, regional healthcare coalition staff, and invited ESF8 partners. Led by ESF8 Lead, ESF8 Operations Manager or designee
1330	NCOEMS all Staff Call
1700	SERT Shift Briefing
1830	ESF8 Situation Report completed, forwarded to SERT ESF Supervisor, Regional HPC List-Serv, OEMS Response Staff and partners.

Sustainment of SEOC Operations

STAFFING: During 24-hour operations the acting ESF8 Lead may adjust the staffing levels of active sections in consideration of the activation level and their judgment of the operational situation.

SHIFT CHANGES: Staggered shifts support operational continuity and the accurate transfer of operational information within each active section. To facilitate this, each active section must maintain a situation report and, in preparation for a shift change, the ESF8 Desk Manager, ESF8 Support Cell Coordinator, or other staff designated, will:

- Update the Situation Report in ReadyOp
- Brief the updated Situation Report to on-coming staff and ensure that on-coming staff are aware of:
    - Current operational schedule
    - Past missions, open missions, and planned missions
    - Open actions, deadlines, and expectations
    - Anticipated staffing requirements

EQUIPMENT & SUPPLIES: Staff are expected to utilize equipment regularly assigned to them (e.g., laptops, smart phones, radios, vehicles, etc.) during their active shifts. Staff should notify the ESF8 Desk Manager or ESF8 Support Cell Coordinator, as appropriate, for any additional equipment or supply needs. Requests for resupply will go through the NCOEMS administrative staff and follow established NCOEMS procedures as appropriate.

MEALS & LODGING: These services may need to be coordinated and provided for SEOC and Support Cell staff involved in extended or 24-hour operations. Typically, NCEM Logistics provides meals for all staff working at the SEOC without formal request. However, meals for staff working at the Support Cell and lodging for staff at both locations usually require a formal request from the ESF8 Desk. In these situations, the ESF8 Desk Manager and ESF8 Support Cell Coordinator, in coordination with the ESF8 Lead, are expected to arrange for meals and/or lodging for staff through the ESF8 Desk. ESF8 Desk will coordinate with NCEM Logistics to provide these services.

The Wright Building provides designated areas for meals, food storage (dry, refrigerated), and food preparation (cook, reheat, water, and beverage ice), personal care (sink, toilet), and facility maintenance (mop sinks).

FACILITIES: The sustainment of operations at the SEOC and Support Cell are dependent on 24-hour access to secure work areas with adequate space and personnel support facilities (kitchen, showering, sleeping, etc.), and the continued function of communication (internet, radio, cell, etc.) and utility systems (power, water, HVAC, etc.) provided at the Joint Force Headquarters and Wright Building respectively. The amenities provided by the Wright Building and the Joint Force Headquarters (maintained by NCEM) support most of these needs however, food services are not available at the Wright Building, and specific areas for lodging (e.g., showering and sleeping) are not available at either location. If needed, these services should be coordinated through NCEM Logistics, refer to Meals & Lodging above.

Support Cell Facility Sustainability Matrix

The capabilities and limitations of the Wright Building for sustainment of 24-hour operations are provided in the matrix below. The matrix identifies essential operational and utility systems, their

purpose/service, vulnerability to power outage, and contacts for maintaining these systems during operations.

Resource	Type	Service	Notes	Back-Up Power
Back-Up Power Sources	Generator	Equipment on red electrical outlets Rooms: 107 (Support Cell) & 124 lighting Building emergency lighting UPS (connected to red outlets)	Dedicated to building Starts automatically when power drops. Run time: 1 week, tested monthly No local access.	Fuel
	UPS (Battery)	Local Area Network (D wall jacks) VIPER Control Station Satellite phone system	Comes on at power loss before generator starts up. Run time: 14 minutes	N/A
FAX	Standard Send/Receive unit	Normal, non-secure facsimile transmission	Located in room 129	No
HVAC	Complete air handling system with AC and heat	Services entire building.	Dedicated to building, controls housed locally but local temperature control limited and system access restricted	No
Local Area Network	Servers	Internet access including access to remote internet servers (UNC). All local network operations for computers and printers	Located in the Harvey building. Dedicated back-up power system provided by UPS and generator	Yes
	LAN Switch	Connect servers, computers, and printers in the network.	Located in Room 137	Yes
	Computers	Use of internet/cloud-based services	Multiple units individually assigned.	Yes, if: Plugged into a red outlet or with battery.

		Local data handling, data storage (local drives)	Additional units dedicated to the Support Cell (Room 107) are available.	
	Network Printers	Printing (b/w and color), copying, scanning	Located in rooms 121, 123, 129, and 139.	No
Radio Comms Systems	VIPER Control Station	Allows connection with VIPER medical network talk groups	Located in room 137, remotely controlled from Room 124	Yes
Telephone Comms Systems	Voice Over IP	Primary telephone communication system for the Support Cell	Accessed through D wall jacks. Available in all offices, work areas, & conference rooms.	No
	Copper Wire Phone	Secondary telephone communication system for the Support Cell	Located in Support Cell (Room 107) and accessed through wall jack V9. Requires pulse-dial telephone to operate. Pulse-dial telephone stored in Room 124 (Comm.) Service runs through line from FAX machine in Room 129.	
	Satellite	Tertiary telephone communication system for the Support Cell	Active unit in Communications Room (Room 124)	Yes
		Allows for communication with regional offices and disaster scenes where satellite units have been deployed and HCC regions	Regional units are not live and must be notified with activation instructions.	
Water	Municipal Water Supply	Services entire building.	Steam Plant provides hot water campus-wide. No local control.	No

Emergency support or facility maintenance for the above items should primarily run through normal processes as outlined below:

1. Power, Utilities and HVAC:
    a. Normal business hours: DIX Facility Maintenance (919) 855-4740
    b. After hours: State Capitol Police (919)733-3333
2. Local Area Network, Telephones (exception Satellite phones), Fax lines:
    a. Normal business hours: Service Now Ticket: https://ncgov.servicenowservices.com/sp_dhhs
    b. After hours: Elevate request through ESF8 Lead to NC DHHS Leadership for support.
3. Radios & Satellite phones:
    a. Normal business hours & After hours: NCOEMS Communications Director (919) 855-3955

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 4: MEDICAL RESOURCE MANAGEMENT STANDARD OPERATING GUIDELINE

OCTOBER 2023

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Purpose

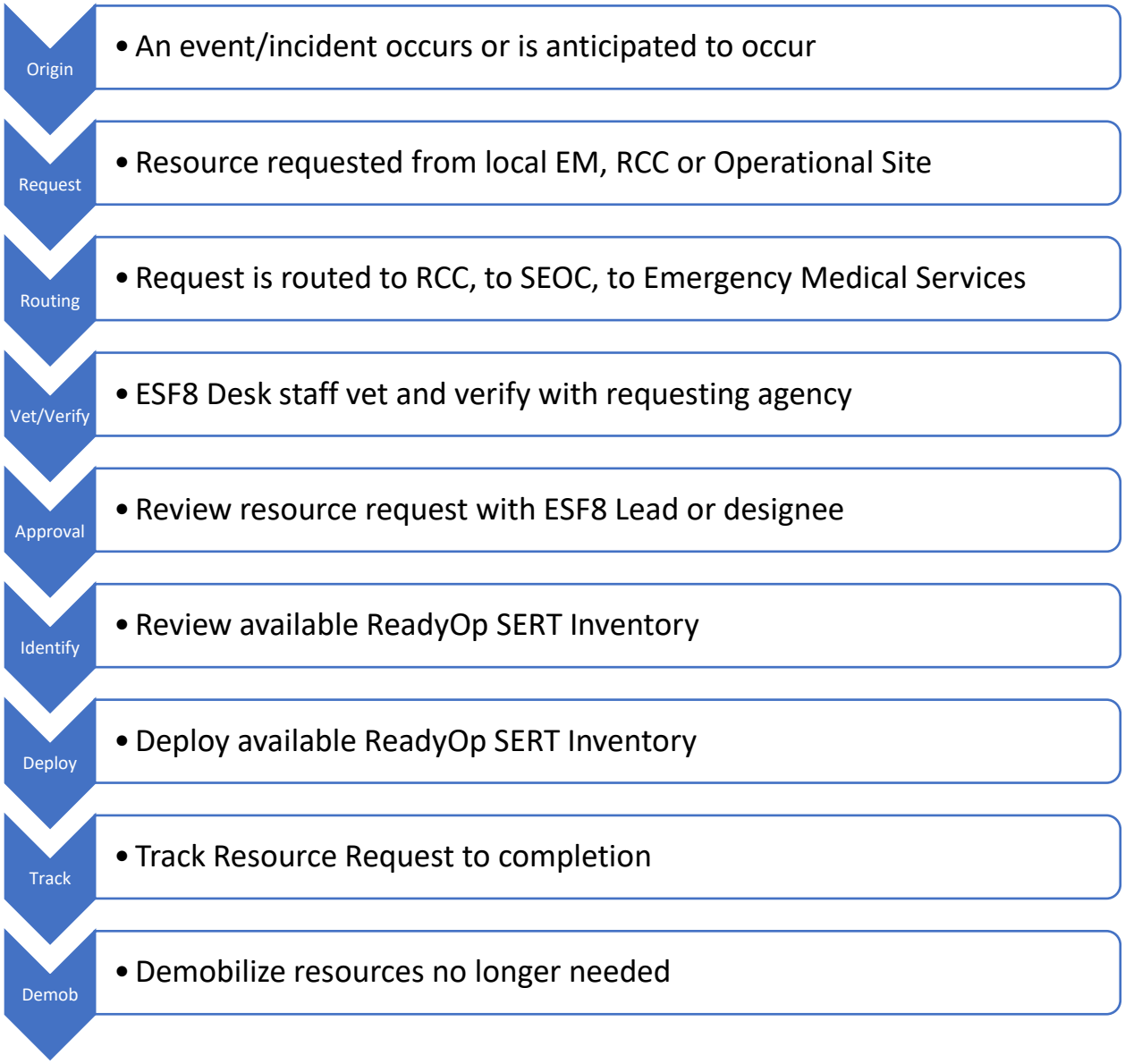
To provide greater understanding of the processes and procedures for handling requests for ESF8 resources.

Scope

Requests for resource support (personnel, equipment, supplies) can come to staff assigned to the ESF8 Desk or Support Cell through different pathways and may require different actions to manage and ensure that resources are delivered as quickly and efficiently as possible. The processes outlined here cover requests for resources during a statewide activation.

Resource Request Process

In most cases, the management of resource requests from receipt to closeout will be documented in the Resource Request Form (RRF) on the Resource Tracker Board of the NCSPARTA WEBEOC system.



General Procedures

The following procedures outline the steps that should be taken by ESF8 staff to manage medical resource requests assigned to ESF8:

Origin of Need

- An event/incident occurs or is anticipated to occur, that requires additional resources beyond the local capability. Local officials activate existing mutual aid agreements.

Resource Requested

- Local Emergency Management will request additional resources through NCSPARTA WEBEOC to their Regional Coordination Center. Regional Healthcare Preparedness Coalitions (HCC) may request additional resources to support the Healthcare System if the Local Emergency Manager is unable or unwilling to enter the request. Local Emergency Managers should be made aware of all requests entered by the HCCs on behalf of their county.
- Regional Coordination Center will request resources on an ICS 215 in NCSPARTA WEBEOC in anticipation of potential needs and/or to fulfill local county requests within their region.
- NCOEMS Incident Management Teams needing support should enter the resource request into NCSPARTA WEBEOC with details on the resource needed and routing instructions to assign to Emergency Medical Services.
- State EM is responsible to coordinate ESF8 resource requests from other North Carolina State Agencies, requests from other states and/or federal support requested through FEMA, these resource requests will be routed from NCEM ESG to Emergency Medical Services

Resource Routing

- Regional Coordination Center (RCC): NCEM RCCs receive the initial resource request from county partners to fill the request based on their available resources (regionally owned assets or assets that have been pre-deployed to the RCC). If no resources are available, then the request will be routed to the State Emergency Operations Center (SEOC).
- SEOC: SERT-ESG Supervisor reviews the resource request and makes appropriate assignment.
- Emergency Medical Services: Healthcare support resource requests are assigned to Emergency Medical Services in NCSPARTA WEBEOC for processing.

Resource Vetting & Verifying

- Determine if resource request should be handled by ESF8 Desk
    - If yes, continue the vetting process.
    - If no, make notation in NCSPARTA WEBEOC and “Assign to Lead.”
- Vet the need and purpose for the resource requested with Requesting Agency
    - Determine current situation.
    - Determine the gap needing to be filled.
    - Identify other potential mitigating factors.
- Confirm NCSPARTA WEBEOC request details with Requesting Agency
    - Number and kind of resource
    - Use of the resource
    - Days of deployment
    - Reporting location/time

- Point of Contact (POC) at location (name/contact info)
- Logistics (food/lodging/fuel)
- Any additional relevant information

ESF8 Lead Resource Approval

- Review resource request with ESF8 Lead or designee.
  - Consider the situation and known / anticipated ESF8 needs or obligations.
  - Determine if resources are readily available.
  - If resource request is approved, update notes in NCSPARTA WEBEOC and move to identify resource.
  - If resource request is not approved, notify ESG Lead.

Resource Identified

- Review available inventory in ReadyOp to determine if resource is already activated and readily available for deployment.
  - Section 7, Mission Ready Packages, for SMRS-maintained resources
  - Section 13, Emergency Operations Plans, Transportation Resources Form, for EMS-maintained resources (e.g., ambulance units)
    - If yes, proceed to resource deployment.
    - If no, consider direct coordination with SERT Partners (DPH, OSFM, Business EOC, Logistics, etc.) that may have resources that would meet the request.
      - If SERT Partners have the resource available, add comment in NCSPARTA WEBEOC indicating a reassignment to the specific SERT partner along with a brief summary of communication regarding resource request. Change resource request to “Assign to Lead.”
      - If no SERT Partners have the resource, discuss with ESF8 lead the possibility of EMAC or Federal contracts for fulfillment of resource request.

Resource Deployment

- Upon confirming that a resource is available for deployment:
  - Contact the associated Healthcare Coalition and/or the organization providing the resource to confirm the assignment.
  - Update the status of the resource in ReadyOp and update the resource request in NCSPARTA WEBEOC, and complete ICS 204 if appropriate.
    - In ReadyOp:
      - For EMS resources (Emergency Operations Plans (13)): Update the assignment status of the available resource to “Assigned.”
      - For all other resources (Mission Ready Packages (7)): Update the resource status to “Deployed.”
    - In NCSPARTA WEBEOC:
      - Change status to “In Progress”
      - Add any notes concerning the deployment into the Notes section.
      - Assign the resource to the appropriate Emergency Services User
- The Emergency Services User is responsible for status updates for deployed resources by entering notes in NCSPARTA WEBEOC and statuses in ReadyOp.

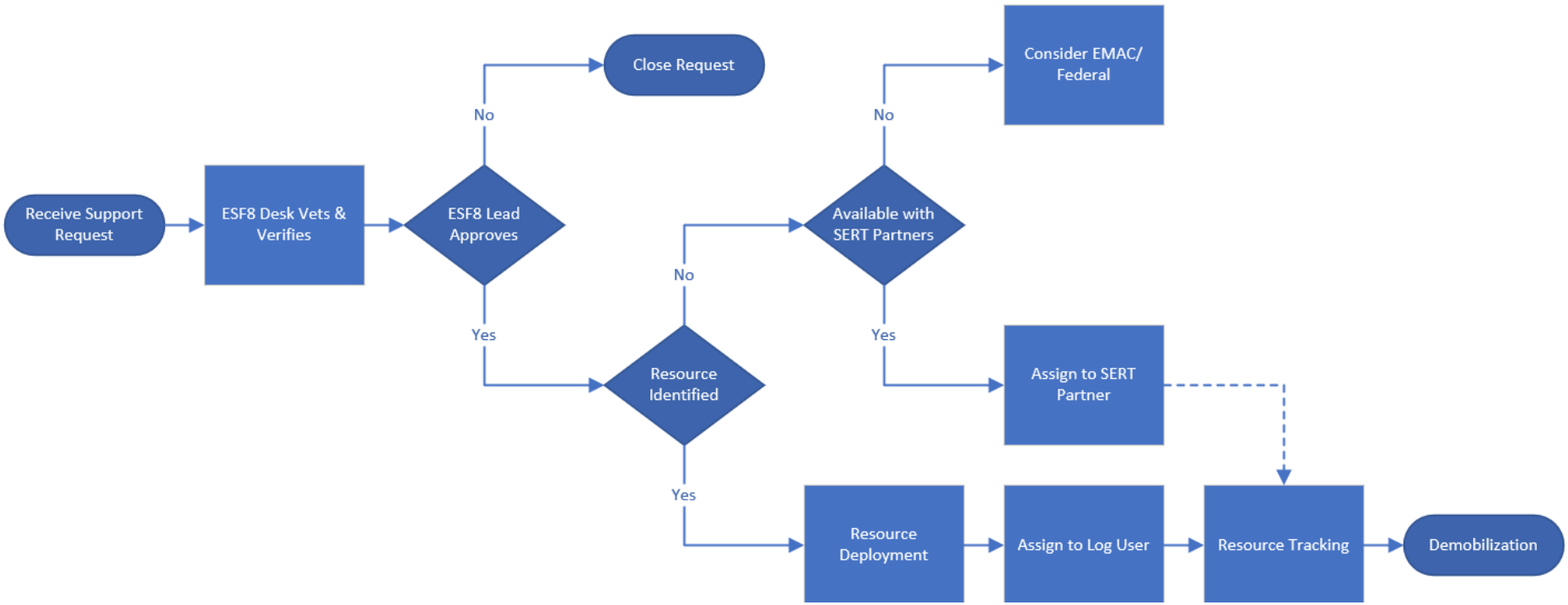
Resource Tracking

- The ESF8 Desk is responsible for monitoring resource statuses in NCSPARTA.
    - Assigned to User – ESF8 Desk should act within 30 minutes of assignment.
    - In Progress – ESF8 Desk should review at least once per shift to track progress of assigned resource / team / contract to resolution.
    - Need More Information – ESF8 Desk should act within 30 minutes of assignment.
    - Information Added – ESF8 Desk should act within 30 minutes of assignment.
    - Enroute – ESF8 Desk should monitor to track progress of assigned resource.
    - On Scene – ESF8 Desk should monitor to track progress of assigned resource to replace or demobilize. If resource needs to be replaced, then the process should start at resource vetting and verifying.
- Any outstanding resource requests should be relayed at shift change to ensure ongoing resolution.

Demobilization

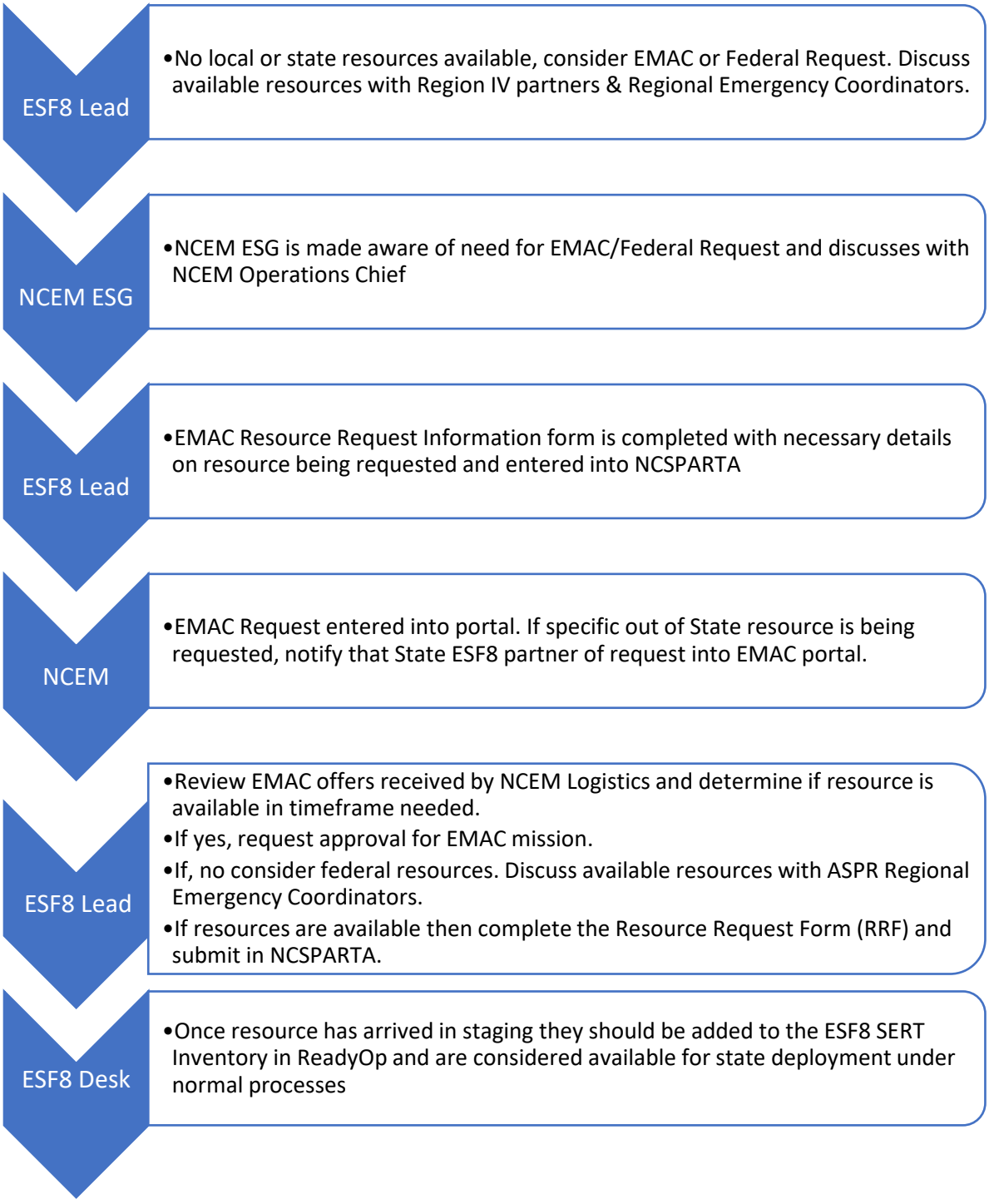
- Once a resource is no longer needed for original resource request then a determination should be made by ESF8 Lead if the resource should be reassigned to another request or returned to staging. If yes, refer to resource identification step, if no, then refer to **EOP Appendix 7: Demobilization SOG** for additional information covering the processes and procedures for the demobilization ESF8/SMRS operational and operations support organizations and teams.

Resource Request Routing Flowchart



Emergency Management Assistance Compact (EMAC)/FEDERAL Resource Requests

The general process for the ESF8 "EMAC" or Federal Resources is diagramed below:



NCOEMS Emergency operations Plan (NCOEMS – EOP)
APPENDIX 5: Communications and information management systems
October 2023

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Purpose

To provide NCOEMS personnel responsible for staffing the SEOC ESF8 Desk, Support Cell, and other operational sites, a more complete understanding of the purpose and use of the various information and communication systems available and actions necessary to maintain these systems and the capabilities they provide in the event of interruptions that impact their use.

Scope

This document identifies essential NCOEMS communications functions, the supporting communications platforms, describes the basic purpose, use, and access to each communication and information management system, and procedures and plans to maintain the continuity of NCOEMS communications functions despite disruptions to the platforms and/or systems on which they depend.

Communications Functions

These are the essential communications functions that NCOEMS personnel conduct during disaster response as well as day-to-day activities. These require communications platforms and the systems they support to be effective and timely. Functions include:

1. NCOEMS ESF8 priorities include planning, response, and decision points.
2. Requesting, notifying, and mobilizing resources.
3. Interacting with Healthcare Coalitions and healthcare partners.
4. Sharing information with partner State agencies.
5. Sharing information with Federal agencies.

Communication Platforms

These are the means through which the essential communication functions are conducted. Platforms can be hardware or software based. Platforms include:

1. Voice Communications
    a. Cellular or landline telephone systems.
    b. Internet based calling methods.
    c. Radio
        i. Public safety bands (VIPER)
        ii. Amateur bands
    d. Face to Face
2. Data Communications
    a. Internet (Terrestrial based connections).
    b. Internet (Cellular based connections).
        i. Commercial broadband
        ii. Public Safety broadband
    c. Satellite
        i. Phone / Push-to-talk (MSAT)
    d. Radio – Amateur radio (AUXCOM)
        i. Information sharing via access to the internet via radio frequencies (Winlink)

Communication and Information Management Systems

These are the systems that NCOEMS personnel interface with directly to carry out their assigned communications functions. Each system, their purpose(s), use, and access are summarized below. The

use of these systems is dependent on the integrity of either the voice-based or data-based platforms that support them. If use of any of these systems is lost, refer to **Continuity of Communications Platforms and Systems** section below to regain or identify alternative communication methods.

Telephone Communication Systems

Telephone and FAX resources available for use at the SEOC and Support Cell are listed below.

a. *Voice-Over-the-Internet-Protocol (VOIP) telephones - SEOC:*
    i. Incoming calls use telephone: (919) 825-2427
    ii. Outgoing calls use telephone: (919) 825-2426
b. *Voice-Over-the-Internet-Protocol (VOIP) telephones – Support Cell:*
    i. All calls use telephone: (919) 855-4688
c. *Facsimile (FAX) telephone - SEOC:*
    i. FAX: (919) 733-7554 (in Operations Center)
d. *Facsimile (FAX) telephone – Support Cell:*
    i. FAX: (919) 733-7021 (in Room 129)
e. *NCOEMS-Assigned SMART Phones:*
    i. See OEMS Directory on OwnCloud (DHHS – SDO Resources – OEMS Telephone Listings)
f. *NCOEMS Conference Line:*
    i. Dial-in: (919) 233-7092
g. *NCOEMS Satellite Telephones:*
    i. This emergency telephone/radio system is provided through Light Squared. These phones allow for communication with regional offices and disaster scenes where satellite units have been deployed when the power is out, or other communications systems fail. Unit in the Wright Building Communications Room (Room 124) is active, regionally based units are not live and must be notified with activation instructions.

E-mail Communication Systems

Staff should utilize the DHHS e-mail accounts through Microsoft 365 as primary means for e-mail communication. https://outlook.office365.com/mail/inbox

Information Management Systems

Information Management systems available for use at the SEOC and Support Cell include the following.

a. *CONTINUUM:* Primary database for NCOEMS Regulatory components to include EMS Systems, EMS Agencies, Personnel, EMS Credentials, EMS Vehicles, EMS Educational Institutions, EMS Patient Care Reports, EMS Compliance components and one-way email communication to EMS. https://continuum.emspic.org
b. *ICAM SYSTEM:* Inventory Control Asset Management (ICAM) system is used for inventory and resource tracking of State Medical Response System (SMRS) equipment and supplies. http://ncoems.icamservice.com/login
c. *MICROSOFT TEAMS:* Workplace hub for team collaboration, chat, videoconferencing, and file storage. The program is hosted locally on NCOEMS assigned laptops and SMART phones.
d. *MULTI-HAZARD THREAT DATABASE (MHTD):* GIS application providing information on all North Carolina Division of Health Service Regulation (DHSR) licensed facilities (hospitals, nursing homes, mental health, intermediate care facilities, home health, long term, and

adult care facilities). Used for gathering facility info, mapping facilities, weather, and hazards. https://www.ncmhtd.com/oems/

e. *NCSPARTA – WEBEOC:* Web based interface between the State EOC and State Emergency Response Team (SERT) partners. Primarily used for emergency management operations, maintaining situational awareness, coordination of ESF8 resource requests, reporting (IAP, situation reports, ICS forms) and file library for response / recovery documents. https://www.ncsparta.gov/eoc7/default.aspx
f. *NORTH CAROLINA TRAINING EXERCISE RESPONSE MANAGEMENT SYSTEM (NCTERMS):* Web based interface between the State EOC and SERT Partners for response team rostering, deployment and tracking during statewide activations. Database for SERT training and exercise offerings as well as providing registration with reporting utilities. https://terms.ncem.gov/TRS/
g. *OWNCLOUD:* A secure cloud service used primarily as a file library for the storage of SMRS emergency response information (e.g., plans, guidance documents, etc.). https://www.ncmhtd.com/owncloud/index.php/login
h. *READYOP:* A secure cloud service used primarily for situational reporting, daily activity logs, customized information gathering, two-way communication, and roster of SMRS personnel and partners by organization with contact information. SMRS Mission Ready Package information and availability status. Hospital diversion status board updates. https://nc.readyop.com/

Radio Communication Systems – VIPER Medical Network (VMN)

These systems are used to monitor and communicate with North Carolina SERT Partners and SMRS organizations, and other organizations utilizing the VIPER (Voice Interoperability Plan for Emergency Responders) radio system and as a redundant communication system in the event of the loss of voice-based and/or data-based communications platforms due to a general commercial communications system failure. For additional information:
https://www.ncmhtd.com/owncloud/index.php/s/NPwXglQe1FQgEOy

The following VIPER-compatible radio equipment will be available and/or can be requested to fulfill operational needs:

1. Portable (hand-held) Radios
    a. Incoming/outgoing calls for NCOEMS set one radio to **VMJ59101** talk group – (official communications)
    b. Incoming/outgoing calls for NCOEMS set one radio to **OEMS SECURE** talk group – (internal communications, AES-256 Encrypted)
2. VMN Reference Information Guide
    a. For VMN radio channels, talk group, and use guidance. Refer to: https://www.ncmhtd.com/owncloud/index.php/s/NPwXglQe1FQgEOy
    b. *Talk Groups – Purpose and Use:*
        i. External ESF8 Coordination - SEOC ESF8 Desk (SMRS Disaster) to Partner Agency/Unit:
            1. Find VMN channel of agency in the VMN Reference Information Guide
        ii. Internal NCOEMS Coordination/Conference - NCOEMS Staff to NCOEMS Staff:
            1. **OEMSSTAFF** and **OEMS SECURE**

iii. ESF8 Operational Assignments: Request for these talk groups should be sent to the ESF8 desk for assignment. If any communications resources are activated (contingency or assigned), the ESF8 desk or designated comms personnel, will produce an ICS205 form for each operational period. Each ICS205 should be shared with the ESF2 desk for situational awareness and conflict resolution. Initial VIPER Medical Network (VMN) talk groups available for assignment are:

1. **VML79600**
2. **VML79601**
3. **VML79700**
4. **VML79701**
5. **VML79800**
6. **VML70801**

c. *Redundant Communication with the ESF8 Desk:* During disaster response, primary communication methods to contact the ESF8 Desk will be via telephone or email. In the event of a commercial communications failure, resulting in the inability to contact the ESF8 desk, contact the NCEM 24-Hour Watch Center on VIPER talk group "**EM EOC**" located in the VIPER "Statewide" zone. Advise the watch center that you are experiencing a commercial communications failure and need to contact the ESF8 Desk. Once advised by the watch center, the ESF8 Desk will contact you on the "**EM EOC**" talk group and advise you which VIPER Medical Network (VMN) talk group to utilize for direct communications with the ESF8 Desk (typically this will be "**VML79501** Medical Statewide Disaster Contact"). You will then switch to this ESF8 assigned talk group and contact the ESF8 Desk with your traffic.

Continuity of Communications Platforms and Systems

In the event that the ability of NCOEMS personnel to fulfill assigned communications functions are interrupted by disruptions to communication platforms and essential systems, the following procedures and plans will be utilized to attempt to restore and maintain these functions. For additional information regarding response to disruptions related to cybersecurity issues, refer to **APPENDIX B1 NCOEMS Cybersecurity Incident Response Plan (CIRP)**.

Single Platform Disruptions - Platforms affected: Voice or Data

Voice Communications: If there is a loss of voice communication(s) pathway noted above, they may present themselves in the following manner.

1. Loss of cell phone service.
    a. Users cannot use a cell phone to make a phone call and note "No Service" on their device.
    b. Voice networks are overwhelmed, and user receives an "All Circuits are Busy, Please Try Again."
2. Loss of landline telephone service.
    a. Users cannot access landline dial tone.
3. Loss of radio system coverage.
    a. The primary radio system is in a failure state:
        i. Site Trunking Failsoft

ii. Complete system failure

ACTIONS

- Report any outage to the Communications Unit (919-302-0794 or Dale.Sutphin@dhhs.nc.gov) if greater than 1 hour in length.
- If personnel are engaged in activation activities, they should notify ESF8 lead of the outage immediately.
- For cellular devices, users should attempt to turn on their "Wi-Fi Calling" feature and re-attempt the call.
- For overwhelmed networks, users should attempt Wireless Priority Service (WPS) or Government Emergency Telephone System (GETS) platforms.
- Radio system coverage outages should be reported to the communications unit for interaction with North Carolina State Highway Patrol Technical Services Unit. (NCSHP TSU).
- Switch radio off the affected network, if capable, and attempt contact.

Data Communications: If there is a loss of data communications pathway(s) noted above, they may present themselves in the following manner.

1. Loss of access to the internet and therefore common information sharing platforms.
    a. A user cannot access the internet due to a failure of hardware or local internet provider.
    b. The infrastructure has become damaged.
    c. A cyber event has occurred.
    d. There is a prolonged period of no power.

    ACTIONS

    - Attempt to connect via another means (MiFi, Hotspot, Wi-Fi)
    - Attempt to contact via landline telephone.
    - Attempt to contact via mobile radio system (VIPER).
    - Attempt to contact via satellite phone.
    - Attempt contacts via amateur radio.
2. Internet access not interrupted but with loss of access to information sharing and/or resource coordination pathways.
    a. Users cannot access government networks for email/messaging or file sharing.

    ACTIONS

    - Report any outage to the DHHS IT (via DHHS Service Portal- https://ncgov.servicenowservices.com/sp_dhhs/ , telephone- 919-855-3200
    - Utilize alternate communications pathways until the network is restored.
    - If SDO, notify admin on call.
    - If personnel are engaged in activation activities, they should notify ESF8 lead of the outage immediately.

    b. Internet access not interrupted but with loss of any of the following information sharing and resource coordination platforms: ReadyOp, OwnCloud, WebEOC, NC TERMS, Continuum, or iCAM.

    ACTIONS

- Notify HPP Systems Support Team (via email: HPPSystemsSupport@dhhs.nc.gov or phone 919-302-0794 or 919-971-7477
- Utilize alternative information sharing platforms.
- Utilize alternative communication pathways.
- If SDO, notify admin on call.
- If personnel are engaged in activation activities, they should notify ESF8 lead of the outage immediately.

Multi-Platform Disruptions - Platforms affected: Voice and Data
In the event of a multi-platform communications disruption your ability to communicate will be extremely difficult and/or not available at all. Immediate steps to attempt **Primary, Alternate, Contingent and Emergency (PACE)** plan contact should be taken based on the equipment available.

NCOEMS ESF8 PACE Plan: PACE plans can be specific based on situation, communications function, or communications platform and current incident missions at hand. All situations are different; therefore, this plan is scalable and adaptable. Personnel should use their best judgement in always maintaining continuity of operations. It is important that this PACE plan is exercised frequently. This plan will ensure that communications with essential personnel can be maintained should primary communication methods become compromised. The table below shows the plan for various situations.

NCOEMS ESF8 Basic PACE Plan

Essential Function	Primary *Routine, most effective*	Alternate *Another common method with limited impact*	Contingent *Method not as convenient or efficient, but available*	Emergent *Method of last resort that may incur delays*	Notes
Routine information sharing	Email	Cellular Telephone (Voice or Text)	Web based application (Voice or Data)	Land mobile radio (VIPER)	Day to day activities
SDO Operations	Cellular Telephone (Voice or Text)	Email	Web based application (Voice or Data)	Land mobile radio (VIPER)	This includes SDO notification communications and admin on call communications
Response Activations	ReadyOp/WebEOC	Email	Cellular Telephone (Voice or Text)	Land mobile radio (VIPER)	This includes general information, resource requests and other actionable/ICS requirements
OEMS/DHHS Leadership-Command a	Face to Face	Cellular Telephone (Voice or Text)	Web based application (Voice or Data)	Land mobile radio (VIPER) - Encrypted Talk Group	This includes situation reports and critical/sensitive notifications

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 6: ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

OCTOBER 2023

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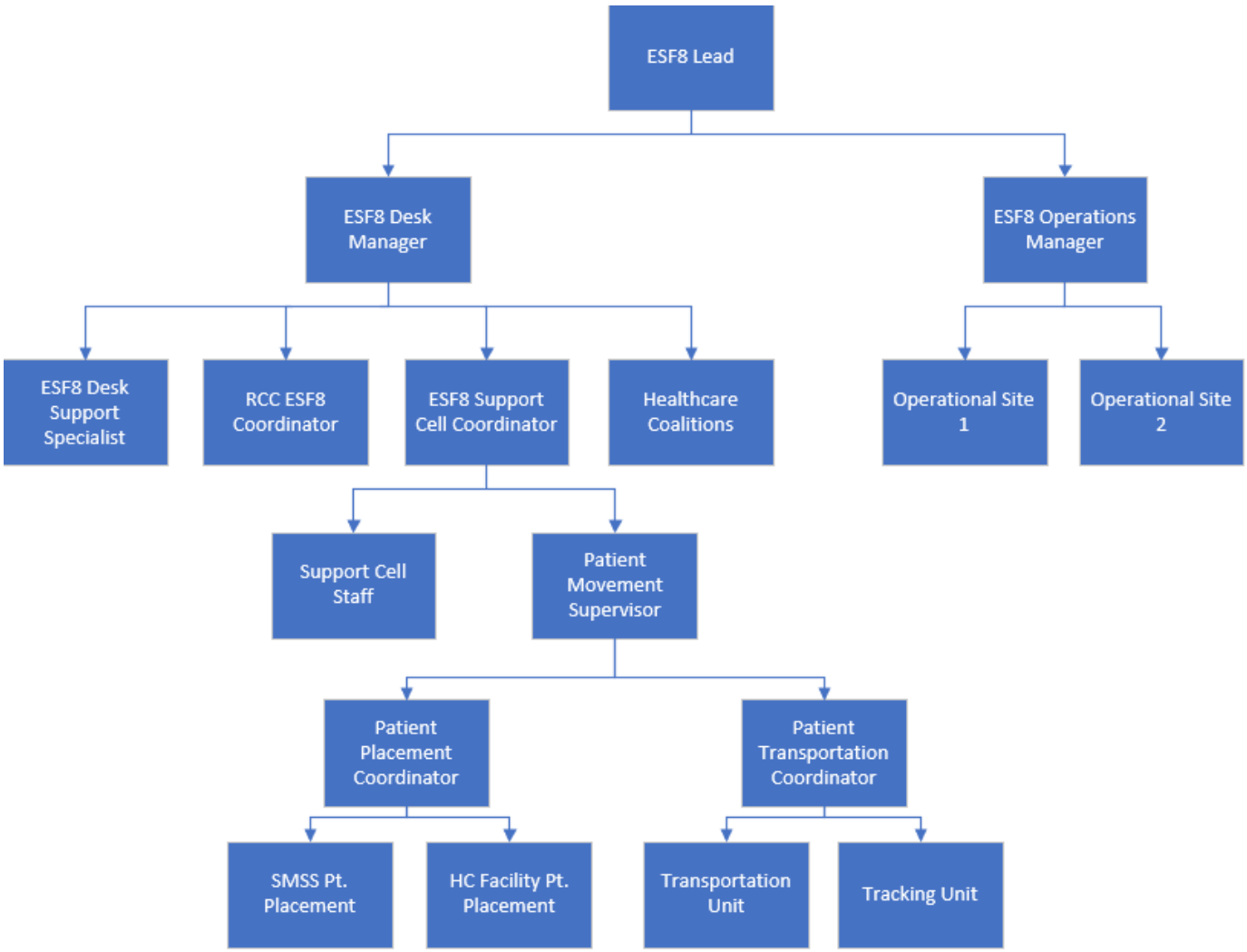
Purpose & Scope

To provide greater understanding of the organization and assignments of NCOEMS personnel activated to oversee and coordinate the ESF8 response to emergency events and disasters. These guidelines detail the SEOC and Support Cell roles and responsibilities.

Organization

The organization of NCOEMS staff will change to meet necessary oversight and coordination requirements as operations expand to meet health and medical support needs and trigger increases in activation level.



Roles and Responsibilities

NCOEMS staff may be assigned different roles to meet ESF8 response and recovery requirements as part of the SERT. Each role includes a range of responsibilities necessary to ensure that the organization fulfills its operational or support mission successfully. These organizations are listed below with major role responsibilities identified. For positions outlined below the corresponding job action sheets can be found at the end of this appendix.

Support Organizations:

ESF8 SEOC

Maintain overall situational awareness of ESF8 response and recovery activities statewide, act as the HPP ESF8 representative to the SERT and federal partners, manage health and medical resource requests, and oversight/support of ESF8 field operations.

- ESF8 Lead – Oversight for all ESF8 response & recovery activities
- ESF8 SEOC Desk Manager – Oversight for all ESF8 SEOC Desk responsibilities
- ESF8 SEOC Desk Support Specialist – Position supports the ESF8 Desk Manager with roles and responsibilities as assigned.
- ESF8 Operations Manager - position provides direct support and leadership for all NCOEMS coordinated field operations.

ESF8 Support Cell

Assist staff assigned to the ESF8 Desk in meeting their responsibilities for maintaining situational awareness, managing resource requests, and supporting field operations. Including the coordination of patient transfer operations and the vetting of medical supply requests during medical logistics operations.

- ESF8 Support Cell Coordinator - Oversight for all ESF8 Support Cell responsibilities
- ESF8 Support Cell Staff – Provide support to the ESF8 Support Cell Coordinator
- Patient Movement Supervisor - Oversees all patient movement operations (coordination/placement, and transport)
- Patient Placement Coordinator - Provides overall support to the Patient Coordination Center Lead (Healthcare Facility) and Patient Movement Supervisor when North Carolina Patient Movement Guideline is activated.
- Patient Transportation Coordinator - Oversees all patient transportation activities (with exception of standard procedures for emergent patient transfer from a healthcare facility)
- Transportation Unit: Provides support to the Patient Transportation Coordinator
- Tracking Unit: Provides support to Patient Transportation Coordinator

Job Action Sheets

Position: ESF8 Lead

Objective: Provide oversight and direction for all ESF8 response & recovery activities

Reports to: SERT Leader

Supervises: ESF8 Desk Manager, ESF8 Operations Manager

Actions:

- Advise, set priorities, and provide overall direction for ESF8 response and recovery activities
- Develop and represent ESF8 goals, objectives, and activities to local, state, and federal partners as part of the North Carolina SERT
- Authorize the activation and deployment of state ESF8 resources
- Activate the ESF8 Desk Manager, ESF8 Operations Manager, and other ESF8 organization positions as necessary to meet the objectives of this position
- Coordinate with DHHS/NCOEMS Leadership, State Medical Response System Advisor, and NC SERT partners on:
    - Development and implementation of policies necessary to support ESF8 response activities and the
    - Release of health and medical information to the public
- Lead or participate in various briefings concerning ESF8 response and recovery activities involving the SERT, response partners, and SMRS organization including incident command staff calls
- Authorize the demobilization of state ESF8 resources upon completion of response and recovery activities including the conduct of team debriefings and development of After-Action Reports (AARs)

Position: ESF8 Desk Manager

Objective: Assist the ESF8 Lead in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT

Reports to: ESF8 Lead

Coordinates with: RCC ESF8 Coordinator, Healthcare Coalitions, SERT-ESG Supervisor

Supervises: ESF8 Desk Support Specialist, ESF8 Support Cell Coordinator

Actions:

- Monitor available communication and information technology systems to develop and maintain situational awareness of ESF8 response and recovery activities
- Develop situation reports and lead coordination calls (NCOEMS/HCC) for the purpose of sharing ESF8 situation and mission status information across healthcare organizations and with other local, regional, state, and federal partners, as appropriate
- Manage requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, RCC ESF8 Coordinator, and Healthcare Coalitions (HCCs) as appropriate.
- Coordinate with the SERT-ESG Supervisor regarding resource missions assigned to the ESF8 Desk to ensure they fit within ESF8 responsibilities, their provision, and resource options if the resource cannot be provided by the state.
- Coordinate ESF8 resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions
- Coordinate ESF8 resources needed within an RCC area with RCC ESF8 Manager and identify resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs
- Coordinate support for ESF8/SMRS field operations with the ESF8 Operations Manager and ESF8 Support Cell Coordinator
- Field and resolve questions concerning ESF8 response and recovery activities in coordination with the ESF8 Lead
- Delegate position responsibilities to the ESF8 Desk Support Specialist and the management of large ESF8 functions (e.g., patient movement) to the ESF8 Support Cell Coordinator as necessary to meet the objectives of this position
- Conduct the demobilization of ESF8 Desk operations upon completion of response and recovery activities.

Position: ESF8 Operations Manager

Objective: Assist the ESF8 Lead in maintaining oversight and management of ESF8 field operations when there is the potential for the activation and deployment of SMRS operational units (e.g., SMSS, MDH, Patient Transfer Centers, etc.)

Reports to: ESF8 Lead

Coordinates with: ESF8 Desk Manager, ESF8 Support Cell Coordinator, Healthcare Coalitions

Supervises: Incident Commanders of NCOEMS Incident Management Teams deployed to establish and maintain ESF8 field operations

Actions:

- Ensure pre-deployment readiness and planning for potential ESF8 operational mission requests
- Conduct assessments of need with requesting jurisdictions/organizations and advise ESF8 Lead on approval of operational mission requests
- Oversee operational site(s) coordination (site assessment, site plans) with response partners
- Coordinate directly with the ESF8 Lead and ESF8 Desk Manager to identify necessary IMT personnel, staffing, and logistics resources
- Provide direct support and leadership to the deployed IMTs and coordinate further support through the ESF8 Lead and ESF8 Desk Lead
- Assign all responsibilities for the operational period and ensure they are completed: (e.g., Operations Tactics Meeting, Command & General Staff Call, and submission of IAP & situation reports
- Act as medical Point-of-Contact for response partners (e.g., Public Health IMTs, NCEM, etc.) and responds to all messages and request for medical information
- Ensure necessary mission support is coordinated with the ESF8 Desk Manager
- Oversee operational site demobilization when authorized

Position: ESF8 Desk Support Specialist

Objective: Assist the ESF8 Desk Manager in maintaining oversight and management of ESF8 responsibilities assigned as part of the SERT

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Support Cell Coordinator, Healthcare Coalitions

Actions:

- Monitor available communication and information technology systems to develop and maintain situational awareness of ESF8 response and recovery activities

- Develop situation reports and lead coordination calls (NCOEMS/HCC) for the purpose of sharing ESF8 situation and mission status information across healthcare organizations and with other local, regional, state, and federal partners, as appropriate

- Manage requests for ESF8 resources as necessary and in coordination with the ESF8 Lead, SERT-ESG Supervisor, RCC ESF8 Coordinator, and Healthcare Coalitions (HCCs) as appropriate.

- Coordinate with the SERT-ESG Supervisor regarding resource missions assigned to the ESF8 Desk to ensure they fit within ESF8 responsibilities, their provision, and resource options if the resource cannot be provided by the state.

- Coordinate ESF8 resources needed within an HCC as well as manage any resource requests assigned to the HCCs for support of needs outside their regions

- Coordinate ESF8 resources needed within an RCC area with RCC ESF8 Manager and identify resources that can be tasked directly to the RCCs for fulfillment of regional health and medical needs

- Coordinate support for ESF8/SMRS field operations with the ESF8 Operations Manager and ESF8 Support Cell Coordinator

- Field and resolve questions concerning ESF8 response and recovery activities in coordination with the ESF8 Lead

- Participate in the demobilization of ESF8 Desk operations upon completion of response and recovery activities.

Position: RCC ESF8 Coordinator

Objective: Assist the ESF8 Desk Manager in coordinating the provision of ESF8 resources in support of health and medical facilities or local ESF8 operations within an area under jurisdiction of a Regional Coordination Center (RCC)

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Desk Manager, ESF8 Support Cell Coordinator

Actions:

- Manage ESF8 resources in support of health and medical facilities or local ESF8 operations within the RCC
- Coordinate information pertaining to affected health and medical facilities and services
- Facilitate ESF8 mission support at the RCC level
- Provide direction and support to ESF8 resources assigned to the RCC
- Conduct medical resource tracking
- Advise medical resource allocation decisions
- Assist with the coordination and resolution of operational issues between ESF8 agencies and government jurisdictions.

Position: ESF8 Support Cell Coordinator

Objective: Assist the ESF8 Desk Manager in managing ESF8 responsibilities assigned as part of the SERT particularly when the support and/or coordination functions needed cannot be easily conducted from within the SEOC due to volume or complexity (e.g., SMSS patient movement coordination, etc.)

Reports to: ESF8 Desk Manager

Coordinates with: ESF8 Desk Manager, ESF8 Desk Support Specialist

Supervises: Patient Movement Supervisor, Support Cell Staff

Actions:

- Coordinate with the ESF8 Desk Manager to define initial ESF8 Support Cell responsibilities and the staff and schedule necessary to support the situation.

- Coordinate all aspects of the roles/functions assigned to the ESF8 Support Cell to ensure that the needed support is provided. Potential tasks include:
  - Maintaining situational awareness
  - Managing resource requests
  - Coordinating logistical support for ESF8 field operations
  - Coordination of patient movement operations
  - Vetting of medical supply requests

- Provide support to the Patient Movement Supervisor/Coordinator when activated

- Conduct the demobilization of ESF8 Support Cell upon completion of response and recovery activities.

Position: ESF8 Patient Movement Supervisor

Objective: Assist the ESF8 Support Cell Coordinator in managing patient movement responsibilities. Provides oversight for all ESF8 operations that involve patient movement activities that include Patient Identification, Placement, Transportation and Tracking (e.g., healthcare facility evacuations, medical support shelter, FCC operations etc.).

Reports to: ESF8 Support Cell Coordinator

Coordinates with: ESF8 Desk Manager

Supervises: Patient Placement Coordinator, Patient Transport Coordinator

Actions:

- Receive and coordinate the review of Patient Movement Planning forms to estimate total number of patients needing placement and inform decisions on SMSS and transportation needs.

- Provide patient movement information to the ESF8 Support Cell Coordinator necessary for the completion of Support Cell Situation reports. Required information includes the SMSS Patient Overview, Healthcare Facility Patient Overview, and Transportation Resources Overview sections of the situation report.

- Respond to entities submitting patient movement requests via phone/email to assist them with the process and follow-up on the status of specific patients.

- Monitor and report scheduling, staffing, and other needs necessary to maintain patient movement operations to the ESF8 Support Cell Coordinator.
    - Increase or decrease in personnel needed to support the patient movement operations over the course of an event.
    - Meal and lodging support necessary to meet the needs of assigned staff.
    - Expansion or demobilization of facilities necessary to conduct the coordination of patient movement operations during the current and subsequent Operational Periods.

- Provide support to the Patient Placement Coordinator and Patient Transport Coordinator when activated.

Position: ESF8 Patient Placement Coordinator

Objective: Assist the Patient Movement Supervisor and the Patient Coordination Center Lead, when the Healthcare Facility Patient Placement Unit is active, with the oversite and management of patient identification and placement processes.

Reports to: Patient Movement Supervisor

Coordinates with: Patient Transportation Coordinator

Supervises: Medical Support Shelter Patient Placement Unit, Healthcare Facility Patient Placement Unit

Actions:

- Coordinate all aspects of patient identification and placement processes. This position is expected to be aware of the:
  - Total number of patients that need placement.
  - Location of patients needing placement.
  - Type of patients needing placement and;
  - Total number of patients that have been placed.

- Receive, vet, and process all requests for patient placement submitted to the Support Cell including:
  - Bulk Patient Movement forms
  - Individual Patient Placement Request forms
  - State Medical Support Shelter Patient Intake forms
  - Other documentation necessary to determine patient placement.
  - Assignment of patients to State Medical Support Shelters.
  - Coordination of patient information and SMSS assignment status with County agencies.
  - Facilitation of assignment of patients to healthcare facilities.

- Monitor patient placement operations and report scheduling, staffing, and other needs necessary to maintain patient placement operations to the Patient Movement Supervisor.
  - Request activation/deactivation of a Healthcare Facility Patient Placement Unit as needed to support the coordination of patient placement to healthcare facilities.
  - Request activation/deactivation of a Medical Support Shelter Patient Placement Unit as needed to support the coordination of patient placement to SMSS facilities.

- Provide support to the Medical Support Shelter Patient Placement Unit and/or the Healthcare Facility Patient Placement Unit when activated.

Position: ESF8 Patient Transportation Coordinator

Objective: Assist the Patient Movement Supervisor with the oversite and management of all patient transportation assets (e.g., EMS resources, Ambulance Buses, non-medical patient transport resources etc.) and missions (with exception of standard procedures for emergent patient transfer from a healthcare facility).

Reports to: Patient Movement Supervisor

Coordinates with: Patient Placement Coordinator

Supervises: Transportation Unit, Tracking Unit

Actions:

- Monitor the need for and availability of transportation resources for state coordinated patient movement missions. This position is expected to be aware of the:
  - Number of assets currently deployed.
  - Number of assets available for deployment.
  - Time constraints to the movement of assets (weather, distance, etc.)

- Advise ESF8 leadership on the type and quantity of patient movement assets that need to be activated to support expected patient transportation missions.

- Receive, process, and/or initiate, and closeout of all forms necessary to initiate and complete the transportation of patients to State Medical Support Shelters and healthcare facilities (if necessary) including:
  - Vetted Individual Patient Placement Requests.
  - Transportation Resources,
  - EMS Resource Assignment and Tracking.

- Coordinate with agencies sending patients to collect and verify information necessary to process and complete patient transportation requests.

- Assign and coordinate with available transportation assets (Dedicated and Non-Dedicated) to execute and complete patient transportation missions.

- Monitor patient transportation operations and report scheduling, staffing, and other needs necessary to maintain operations to the Patient Movement Supervisor.
  - Request activation/deactivation of Transportation and/or Tracking Units as needed to support the transportation of patients,

- Provide support to the Transportation Unit and Tracking Unit when activated.

Position: ESF8 Support Cell Staff

Objective: Assist the ESF8 Support Cell Coordinator in managing ESF8 responsibilities assigned to the Support Cell.

Reports to: ESF8 Support Cell Coordinator or Patient Movement Supervisor (when activated)

Coordinates with: ESF8 Desk Support Specialist, Submitting/Requesting Organizations, Patient Transportation Organizations, SMSS Incident Management Team

Actions:

- Execute roles/functions assigned by the ESF8 Support Cell Coordinator to ensure that the needed support is provided. Potential tasks include:
    - Maintaining situational awareness
    - Managing resource requests
    - Coordinating logistical support for ESF8 field operations
    - Coordination of patient movement operations
    - Vetting of medical supply requests
- Provide support to SMSS Facility Patient Placement and Transportation operations by fulfilling the following roles/tasks:
    - Individual Patient Placement Request Review
        - Review of placement requests utilizing the SMSS Patient Guidance and verify that the placement of individuals into an SMSS is appropriate.
        - Consult with the Medical Provider position to resolve requests for additional guidance and resolution of the placement of individuals as needed.
        - Forward approved requests requiring transportation to the Patient Transportation Coordinator for resolution.
        - Provide resolved placement requests to Submitting/Requesting Organizations with SMSS location and contact information.
        - Confirm with Submitting/Requesting Organizations, patient point-of contact and Estimated Time of Arrival (ETA) information.
        - Ensure that patient status through the placement, transportation, and tracking processes is updated appropriately in ReadyOp.
    - Medical Provider
        - Review placement requests to determine proper placement and make the final determination on patient placement.
        - Discuss patient placement with Submitting/Requesting Organizations
        - Consult with the ESF8 Support Cell Coordinator to identify appropriate transportation for SMSS patients requiring transport to the established SMSS.
- Participate in the demobilization of ESF8 Support Cell upon completion of response and recovery activities.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX 7: DEMOBILIZATION STANDARD OPERATING GUIDELINE

OCTOBER 2023

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Purpose

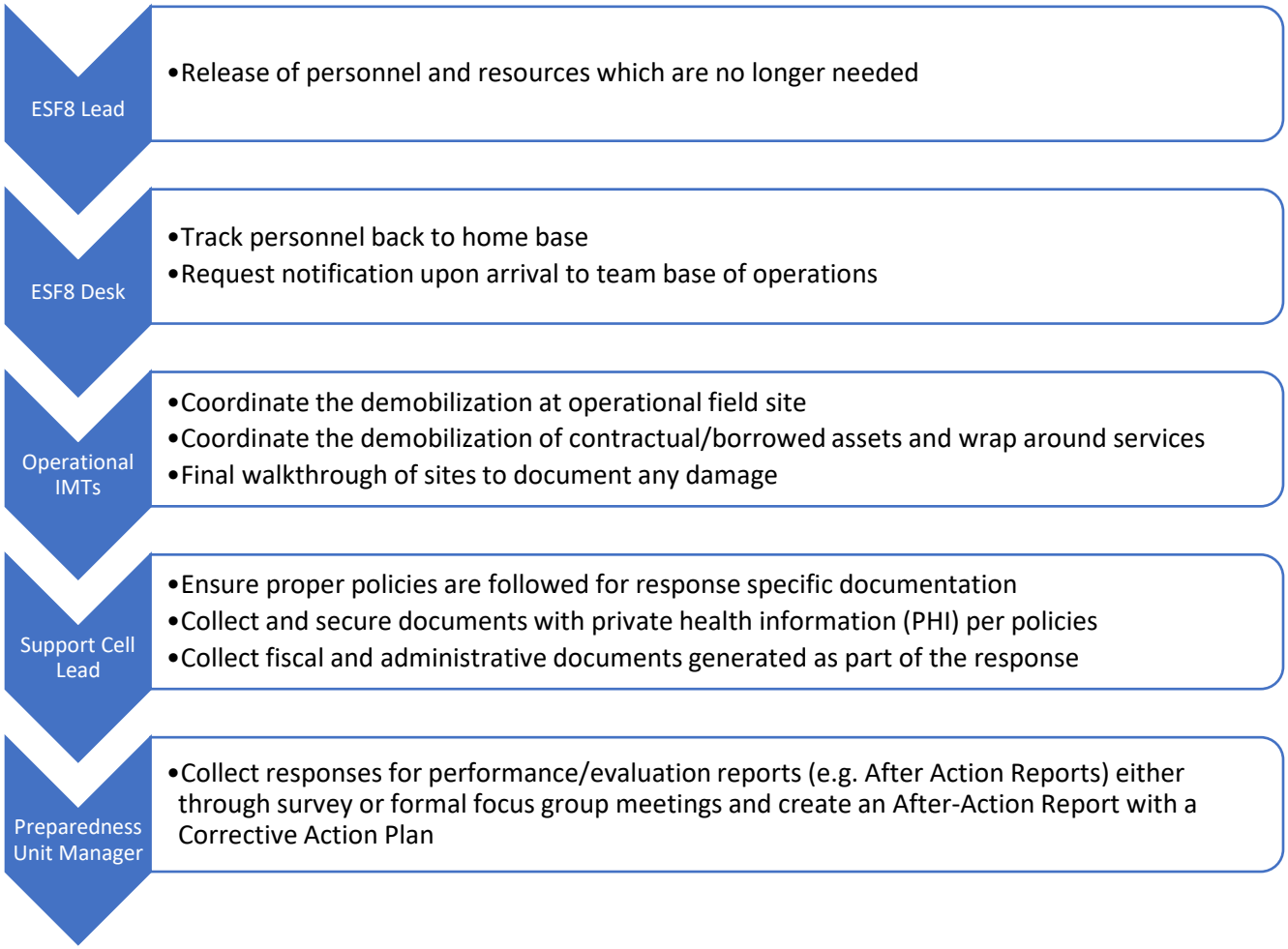
This document is meant to assist the ESF8 Lead and NCOEMS staff by providing a protocol for the smooth and efficient recovery from emergency operations back to normal daily operations. An efficient recovery is essential for ensuring that the transition back to regular operations is safe, controlled, and cost-effective.

Scope

This document provides guidance for the phased demobilization and recovery from emergency response operations in which North Carolina Office of Emergency Medical Services is the coordinating agency.

Concept of Operations

As response objectives are achieved and the emergency comes under control, the ESF8 Lead may direct the demobilization of various response elements. Much of this decision is driven by the release of resources from local partners and declining census in shelter locations. This process includes:



Release of Personnel and Resources

At the beginning of every new operational period the ESF8 Lead, along with the ESF8 Operations Manager and other appropriate ESF8 leadership, will make an assessment of the remaining response objectives and determine what response elements should be demobilized. Much of this decision is based on the release of resources from local partners, decline in support needed from ESF8 operational locations, or leadership decisions to scale back resources due to increased availability for local resources to be utilized. Discussions with local partners, operational incident management teams and North Carolina Emergency Management (NCEM) Emergency Services Group (ESG) should occur to determine anticipated resource need timeline as part of this decision-making process.

Communication to all parties involved with the resource (local partner, regional coordination center, incident management team, home agency etc.) should be engaged in the decision on the demobilization timeline to ensure no gap in operations and wrap around services occurs. Notes should be placed in the NCSPARTA WEBEOC resource request. Prior to demobilization of any resources ensure all mission assignment tasks and related documentation have been completed.

Tracking Personnel Back to Home Base

Upon release of personnel and resources, the ESF8 Desk should ensure that tracking occurs back to home base to ensure safe arrival and ongoing support until completion of the mission. Notes should be added to the NCSPARTA WEBEOC as applicable to update the status tracking. This includes contact when heading back to home base, midpoint check (if applicable) and safe arrival back. This can be accomplished via text, phone, radio etc.

Coordinate the Demobilization at Operational Field Sites

Each field operational site Incident Management Team (IMT) is responsible for ensuring that all assets and wrap around services in use at their sites are demobilized appropriately:

a. Make notes in the NCSPARTA WEBEOC resource request when an asset/wrap around service is able to be demobilized including the specific date and time agreed upon in the demobilization timeline.
b. Coordinate directly by phone or email for the release and return of contractual or borrowed assets and wrap around services. This may include physical pickup of assets (e.g., shower trailer) or notification that service can be stopped (e.g., waste management).
    i. If the asset is owned by a SERT partner (e.g., HCC, NCDPH etc.) contact them directly to coordinate pickup or return.
    ii. Majority of contractual items that need to be demobilized should be coordinated with NCEM Logistics
    iii. If NCOEMS owned asset, coordinate directly with ESF8 Operations Manager
c. Once all assets have been released/returned a final walk through of the operational site should occur and any potential damage that is noted should be documented, pictures taken and sent to the NCOEMS Support Cell.

Follow Policies for Response Specific Documentation

During the activation, response specific documentation will be generated at field operational sites, the SEOC ESF8 desk, and the NCOEMS Support Cell. The NCOEMS Support Cell is responsible for ensuring that all documents that are generated are properly collected and managed as outlined below:

a. Collect and secure documents with private health information (PHI) according to NC DHHS policies and manuals: https://policies.ncdhhs.gov/departmental/policies-manuals/section-viii-privacy-and-security
b. Ensure completion of and collection of fiscal and administrative documents generated as part of the response. These documents should be placed in response specific folder on OwnCloud. These documents include expenditure reports, medical support shelter records, patient movement records, incident reports, activity logs, and rosters.
c. Collect any documentation and pictures from operational field site demobilization walk throughs and place them in a separate file name by operational site on OwnCloud.

After-Action Report

Information for an After-Action Report (AAR) should be collected throughout a response while the incident actions are still fresh in responder's minds. This information is critical to improving future response performance and enhancing the morale of responders and their teammates. A ReadyOp form should be created for each new incident and a link to provide the feedback shared at the beginning of an incident, throughout an incident and at the end of an incident.

Main purpose is to capture:

1. What went well?
2. What needs improvement or noted response gaps?
3. What lessons were learned?

The following framework is suggested for the After-Action Report:

1. Report
    a. Accumulation of all incident documentation.
2. Discussion or Survey collection of information that needs to be included for the AAR.
    a. Significant events and actions taken.
3. Analysis
    a. In-depth examination of successes and deficiencies: planning, operational, and organizational.
4. Follow-up
    a. Present recommendations to correct the identified deficiencies.
    b. Designation of required actions and responsible parties.

NCOEMS will complete an AAR within ninety days of incident closeout along with a corrective action plan. The completed report will be distributed to all NCOEMS staff, Healthcare Coalition staff, stakeholders, partners, and grantees. The report should be used to help prioritize future plans, training, exercises, grant purchases and strategic planning.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX B:

HEALTHCARE SYSTEM RECOVERY

AUGUST 2023

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Purpose

The purpose of the North Carolina Office of Emergency Medical Services (NCOEMS) Healthcare Continuity Annex is to establish the procedures and activities used by the NCOEMS, in its role as the Lead Agency for Disaster Medical Services (ESF8), and its affiliated regional Healthcare Coalitions (HCCs) across the state of North Carolina, for the recovery of healthcare services following a disaster.

Scope

This annex describes the strategic priorities, organization, and concept of operations for recovery activities necessary to maintain healthcare continuity during the initial stages, supported by the State Emergency Response Team (SERT), State Medical Response System (SMRS), and the SERT Recovery Section following activation, and the longer-term stages, administered by both North Carolina Emergency Management (NCEM) and the North Carolina Office of Recovery and Resiliency (NCORR) during the recovery phase.

Mission and Strategic Priorities

Mission: To return essential healthcare services to pre-disaster conditions as quickly and efficiently as possible following a disaster and facilitate coordination and collaboration of recovery activities among state, federal, local, and nongovernmental partners toward that end.

- **Assessment:** Assess the status of all licensed healthcare facilities and their ability to render healthcare care to their communities' post incident. This includes EMS Systems, hospitals, long term care facilities, behavioral health facilities, assisted living facilities, group homes, community health centers, rural health centers, university health centers, school health centers, patient management services, and state-supported medical support shelters.
- **Assistance:** Assist affected healthcare facilities recover lost resources and services. This includes both initial assistance efforts involving immediately available response resources through Healthcare Coalitions and coordination with disaster recovery services through local Emergency Management, as well as long-term efforts involving strategic planning with Healthcare Coalitions, other Divisions of Health Service Regulation organizations, and SERT partner organizations to develop strategies and processes necessary to re-establish safe care in healthcare facilities.
- **Advocacy:** Evaluate progress of re-establishment of healthcare facilities and services and advocate for appropriate changes to established recovery plans and processes necessary to complete the recovery of affected healthcare facilities. Continue to provide guidance and technical assistance to the affected healthcare community and report the ongoing evaluation to the Director of Health Service Regulation.

Situation

- Healthcare facilities and the services they provide are susceptible to disruption from at least the sixteen (16) different natural and technological hazards listed in the North Carolina Disaster Recovery Framework. This annex addresses the recovery of healthcare services from all hazards.
- Healthcare facilities and the services they provide located in the "Piedmont Crescent" (Charlotte to Winston-Salem to Greensboro to Raleigh) serve over half of the population of North Carolina. While the loss of healthcare services in these areas have the potential to impact a large portion of North Carolina's population, these areas contain many redundant and complementary healthcare resources that may be capable of alleviating impacts to healthcare continuity and shortening time to recovery.
- Healthcare facilities and the services they provide located in the Coastal Plain (east of I-95) and Mountain (west of I-77) areas of North Carolina serve smaller and more dispersed populations of North Carolinians and are themselves dispersed more widely without the service density found in the Piedmont Crescent. While the loss of healthcare services in these areas have the potential to impact a smaller portion of North Carolina's population, these areas may need greater assistance, and more

immediately, from healthcare resources outside of their areas to maintain healthcare continuity and recovery times may be longer.

- NCOEMS-ESF8 and our affiliated regional HCCs, working as part of the North Carolina SERT and with the assistance of other Emergency Support Function (ESF) and Recovery Support Function (RSF) groups, their partner organizations, and federal partner agencies, have the capabilities necessary to support the recovery of the state's healthcare infrastructure and services from disasters and maintain healthcare continuity.

Planning Assumptions

The following planning assumptions were made during the development of this annex:

- There are three organizational separations for governmental recovery actions: local, state, and federal. Recovery is a general responsibility of all governments working together.
- City and county governments develop plans to recover their healthcare services using resources to the extent of their capabilities. Regional planning should work in concert with local planning efforts to reduce redundancy and duplication of services while facilitating a fast and effective response.
- State agencies have emergency resources and expertise beyond the capabilities of local government and may be used to assist in disaster recovery.
- Federal agency resources and expertise can be mobilized to augment local and state efforts in the recovery of healthcare services that are beyond the state and local government capacities.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for Disaster Medical Services and is responsible for the maintenance, planning, coordination, and execution of the NCOEMS Healthcare Continuity (NCOEMS HC) Annex.
- This Annex will be used in conjunction with the NCOEMS Emergency Operations Plan and is supported by the actions and operations outlined in the plans organized under it.
- The Concept of Operations outlined in this plan can be used for all types of state supported recovery scenarios regardless of the examples provided in this plan.
- Recovery operations are dependent on the coordination of multiple organizations across multiple jurisdictions (e.g., local, state, federal) and support disciplines (e.g., response (ESF), recovery (RSF)), access to those organizations, and may be slow moving. Early notice of lost services, with detailed information concerning the resources necessary to restore them, and knowledge of the appropriate processes for obtaining needed support are essential to timely recovery operations.
- The coordination of recovery activities in this Annex assumes activation of the State Emergency Operations Center (SEOC) and a request for support from a local or regional partner for an HCC and/or NCOEMS to assist during and following a disaster.
    - HCCs will work directly with affected healthcare facilities and coalition stakeholders (e.g., local Emergency Management, Public Health, Human Services, etc.) to assess, assist, and advocate for the restoration of healthcare services lost within their regions.
    - NCOEMS will work directly with HCCs to support recovery efforts, direct and/or facilitate any state or federal level support, and coordinate healthcare services recovery efforts statewide, as necessary to meet the mission and strategic priorities set out in this Annex.
- In most cases, the first step for healthcare facilities in requesting assistance should be through notification to their local Emergency Management agency. The plans and processes described in this Annex support and attempt to ensure that local Emergency Management agencies are notified of needs within their jurisdictions.
- Ideally, all North Carolina healthcare organizations and facilities should maintain and execute their own plans for recovery. Additionally, those plans should be integrated with or recognized within the larger recovery plans of the jurisdictions that they directly serve to maximize the chance for efficient and effective restoration of healthcare services.

Concept of Operations

Activation

This Annex will be activated concurrently with the activation of the NCOEMS Emergency Operations Plan.

Assessment

Processes utilized to assess impacts to healthcare facilities and their services are complementary and occur before, during, and after disasters. They include conference calls, situation reporting, and impact assessments conducted by both NCOEMS and each regional Healthcare Coalition (HCC) in accordance with their response plans. Immediately prior to and during disasters, this information is collected via conference calls and situation reports directly from healthcare facilities by their associated HCC and then shared with NCOEMS via ESF8 conference calls and situation reports. Post-disaster, this information is collected primarily through post-disaster impact assessments via ReadyOp and/or other HCC-specific methods in accordance with their response plans. While NCOEMS and the HCCs have developed standard essential elements of information (EEI) to be utilized for these assessments, these EEI are expected to be modified to the specific disaster situation as necessary. Additional information addressing situational awareness and information sharing processes between HCCs and NCOEMS can be found under **ANNEX F: Situational Awareness & Information Sharing** of the NCOEMS EOP.

On-Scene Assessments and Strategic Planning

In situations in which on-scene damage assessment is necessary, NCOEMS, in coordination with the Division of Health Service Regulation (DHSR) Construction section, may take part in the on-scene assessment of the damaged healthcare infrastructure. These assessments may be utilized for developing strategic plans for assistance in reestablishing lost healthcare facilities and services and/or the development of changes in regulatory requirements to reestablish safe care. Strategic planning efforts will include representation from affected facilities, relevant SERT partners, and relevant healthcare partner agencies including:

- NC Healthcare Facilities Association
- NC Association, Long Term Care Facilities
- NC Community Health Association
- NC Association of Home Care and Hospice
- NC Office of Rural Health
- NC Healthcare Association
- NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- NC Division of Aging and Adult Services

Progress in the development and implementation of strategic plans toward the recovery of affected healthcare facilities and services will continue to be assessed over time, shared with HCCs, and with the SERT Leader, Secretary of DHHS, and Director of DHSR as necessary and requested.

Assistance

Processes addressing assistance provided to healthcare facilities for the recovery of lost services include those conducted initially to prevent or minimize the immediate loss of healthcare services in an area as well as those conducted over a longer-term which focus on the return of healthcare facilities/services to their pre-disaster levels. Initial assistance efforts are meant to provide only temporary support, available over a limited period time, while long-term assistance efforts are meant to address the healthcare need permanently by repairing or replacing what was lost, in accordance with regulatory requirements (see, **On-Scene Assessments and Strategic Planning** above). Requests by healthcare organizations for both initial and long-term recovery assistance typically begin at their local Emergency Management agencies. HCCs may assist healthcare organizations with

the request process. NCOEMS and HCCs may also provide, or facilitate the provision of, any initial or long-term assistance deemed necessary according to strategic plans developed from on-scene assessments.

Initial

Impacts to healthcare facilities and their services captured through an assessment process will be addressed initially through standard resource request processes utilizing WebEOC primarily and ReadyOp in some cases. These processes are outlined in each HCCs response plan as well as **Appendix 4: Medical Resource Management SOG** of the NCOEMS EOP.

As necessary, HCCs will work with healthcare organizations and local Emergency Management agencies to facilitate the submission of requests for resources. As requests are received, NCOEMS will attempt to connect each request with a proper resource, including appropriate HCC and NCOEMS resources. NCOEMS and HCCs can provide a wide range of resources to meet the operational needs of healthcare facilities. Collectively, through their maintenance of medical supply warehouses, support for Medical Reserve Corps units, the Mobile Disaster Hospital, and other affiliations through lead hospitals (HCC), and DHSR (NCOEMS). The following types of resources may be available:

- Operational space (e.g., trailers, tents, FORTS units, etc.)
- Medical equipment/supplies (e.g., ventilators, patient monitors, dialysis, oxygen, morgue, etc.)
- Support personnel (medical, emergency management, cybersecurity)
- Support equipment (e.g., generators, lights, HVAC, water treatment, communications, etc.)
- Medical Department Modules (e.g., Emergency Department, X-Ray Room, etc.)

Long-Term

Long-term recovery assistance processes involve the acquisition of funds needed to rebuild or replace lost healthcare infrastructure and resources. These processes are complex and involve connecting healthcare facilities with the various state-level recovery agencies/sections responsible for managing and disbursing disaster recovery funds in the form of grants or loans. The main agencies/sections involved include the SERT Recovery Section, their various Recovery Assistance Programs (RAP), North Carolina Office of Recovery and Resiliency (NCORR), and the Small Business Administration (SBA). The table below summarizes each program, the resources they can be provided, general eligibility, and application contact.

State/Federal Disaster Recovery Assistance:

State/Federal Disaster Recovery Funding Resources			
Agency/Section-Program	**Resource and Use**	**Eligibility***	**Application - Contact**
NCEM/Recovery - Public Assistance	Provides access to State and FEMA Public Assistance (PA) grants to reimburse costs of the repair/replacement of disaster-damaged infrastructure.	State & local governments, private, non-profit groups	Requester applies directly - https://www.ncdps.gov/our-organization/emergency-management/disaster-recovery/public-assistance
NCEM/Recovery - Hazard Mitigation	Provides access to FEMA Disaster Recovery (DR) grants to support recovery efforts including hazard mitigation for disaster-damaged infrastructure.	State & local governments, private, non-profit groups	Requester applies through their county government - https://www.ncdps.gov/our-organization/emergency-management/disaster-recovery/hazard-mitigation
NCORR - ReBuild NC	Provides access to HUD Community Development Block Grant-Disaster Recovery (CDBG-DR) grants and loans to repair, rebuild, or develop new public	Local governments	Requester applies directly - https://www.rebuild.nc.gov/

	buildings and infrastructure, cover operating expenses, and build capacity.		
SBA - Disaster Assistance	Provides access to low-interest loans to businesses to repair or rebuild their property and to recover from loss of wages and income.	Non-governmental and private, for-profit groups	Requester applies directly - https://www.sba.gov/funding-programs/disaster-assistance
*NOTE: Availability of all funding sources, except PA, is dependent on a federally declared disaster. PA funds may also be available for state declared disasters			

Access Requirements and Considerations: Access to most disaster recovery funds by healthcare organizations requires them to meet the specific requirements of the recovery agency/section providing the funds however, the following basic requirements usually will apply:

- Applicant – Healthcare organization meets eligibility requirements
- Facility (Service) – The infrastructure/service being recovered are owned and maintained by the applicant organization and were operational prior to the disaster
- Work – The work performed or to be performed will return the infrastructure/service to pre-disaster condition and is/was directly due to the disaster and is/was in a declared disaster area
- Cost – The costs are directly tied to the approved work minus any credits (e.g., insurance payments, salvage income, etc.).

Other issues affecting access to these funds that should be considered by healthcare organizations and Healthcare Coalitions assisting them through the process include:

- There is no common application for disaster recovery funds. If a healthcare organization is eligible for support through more than one program, separate applications must be made
- Application for eligibility can be applied for anytime pre- or post-disaster. Application pre-disaster is recommended
- There may be time limits for application by eligible organizations for funds. Applications for most FEMA funds must be submitted within 30 days of the FEMA disaster declaration date
- Cost estimation is viewed as the responsibility of the healthcare organization requesting the funds. There are no state programs that assist with this process due to conflict-of-interest concerns. It is recommended that healthcare organizations, without the expertise to make these estimations internally, contract for this service

Process and Roles:

Preparedness Phase (Pre-Disaster):

- Healthcare organizations apply for eligibility for long-term recovery assistance with appropriate state-level recovery agencies/sections (refer to **State/Federal Disaster Recovery Assistance** above)
- Local Emergency Management agencies and HCCs encourage healthcare organizations to apply for eligibility and may provide assistance with the application process upon request
    - HCCs contacted for assistance should ensure that healthcare organizations have coordinated with their local Emergency Management agency
- Applications are reviewed by the state-level recovery agencies/sections to confirm or deny eligibility. NCEM maintains fifteen (15) Public Assistance Teams statewide for receiving and evaluating PA applications for eligibility (**see NCEM PA Team Contacts at:** https://www.ncdps.gov/PAContactMap)

Recovery Phase (Post-Disaster (assumes that the healthcare facility has established eligibility)):

- Healthcare organizations notify their local Emergency Management agency and HCC of their need for long-term recovery assistance and collect information necessary to support their request to the

appropriate state-level recovery agency/section (refer to **Access Requirements and Considerations** above). If recovery assistance is awarded, healthcare organizations maintain accurate documentation of use of funds and performs the approved work.

- Local Emergency Management agencies encourage healthcare organizations to apply for assistance and provide assistance with this application process, if necessary (e.g., documentation of need, communication with appropriate state-level long-term recovery agencies/sections, etc.)
- HCCs ensure that healthcare organizations have coordinated with their local Emergency Management agency as well as any appropriate state regulatory agencies. In coordination with the local Emergency Management agency and healthcare organization, HCCs may assist with any aspect of this application process
- NCOEMS coordinates, as necessary, with NCEM, DHSR, and other relevant healthcare partner/regulatory agencies at the state-level in support of efforts to assist healthcare organizations through the process of obtaining recovery assistance.

Advocacy

Processes addressing advocacy for the complete recovery of healthcare infrastructure and services to pre-disaster conditions begin during the Preparedness phase and extend through the phases of Response and Recovery. Through these phases NCOEMS and its affiliated HCCs work together and with the SERT and healthcare organizations, as appropriate, to promote actions that mitigate the impact of disasters, ensure that unmet needs resulting from disasters are addressed, and assist with the resolution of recovery delays as necessary.

Process and Roles

Preparedness Phase (Pre-Disaster):

The assessment of vulnerabilities to the operations of healthcare organizations and development of capabilities and plans to address them are the most important factors in minimizing the negative impacts during disasters. In particular, the assessment of critical infrastructure necessary to support healthcare operations (e.g., Energy, Water, Access, etc.) and the development of plans, contracts, memoranda of agreements, etc. designed to protect and sustain critical infrastructure on which healthcare organizations are dependent are key to minimizing or negating the need for recovery operations during the response and recovery phases.

During this phase, Healthcare Coalitions support these efforts by:

- Working through their Coalitions to advocate for healthcare organization-level assessments of vulnerabilities that may negatively impact the delivery of healthcare services during disasters and for the development of capabilities and plans to address and minimize the vulnerabilities identified
- Coordinating assessment and planning efforts of healthcare organizations with similar/supporting efforts made by local Emergency Management agencies as necessary and appropriate to avoid unnecessary duplication of effort and improve overall visibility of capabilities and plans being developed

Additionally, HCCs may encourage healthcare organizations to utilize various critical infrastructure protection services available through the NCEM Infrastructure Section. These services include the conduct of facility-level Infrastructure Vulnerability Assessments (IVAs). Completed IVAs provide healthcare organizations with a written report identifying critical infrastructure strengths and vulnerabilities, recommended development of plans, capabilities, and other options for addressing identified vulnerabilities, and a listing of agencies/organizations that may assist with addressing the vulnerabilities identified. These services may be accessed through the Healthcare Coalition or directly by the facility to the NCEM Infrastructure Section by contacting **919-825-2500** and asking for a member of the Critical Infrastructure/Homeland Security Team.

Response Phase (Disaster):

During this phase, the ESF8 Lead, will work closely with the Emergency Services Group Supervisor (ESG Supervisor) and participate in a series of briefings and meetings coordinated and facilitated by the SERT Leader and NCEM Section staff. These interactions provide the opportunity for the needs of healthcare organizations, statewide, to be elevated to the awareness of SERT leadership, ESF organizations (e.g., Human Services, Public Works, Energy, etc.), and Sections (e.g., Logistics, Infrastructure, Recovery, etc.), so that they can be evaluated and prioritized for resolution within the SERT Incident Action Plan (IAP). These interactions also provide the opportunity for coordination of support to resolve issues resulting from the loss of critical infrastructure and for continuity in the delivery of recovery support from the Response phase into the Recovery phase. In general, the process includes the following activities:

- Healthcare services needs that are unmet are reported to the Emergency Services Group Supervisor (ESG Supervisor) by the ESF8 Lead, or their designee, based on situation reports, assessments, and resource requests submitted from HCCs and/or on-scene assessment teams. See **Assistance – Initial**, above.
- ESG Supervisor provides awareness of unmet needs to SERT leadership and assists the ESF8 Lead in identifying and beginning coordination with SERT ESFs and Sections that may be able to provide support to meet the assessed needs
- ESF8 Lead, or their designee, and/or the ESG Supervisor, participate in SERT briefings, Leadership meetings, and Tactics meetings, as necessary, to further inform and guide the development of the SERT IAP and other supporting plans of action (initial and long-term) to address unmet needs.
    - Loss of Critical Infrastructure: The ESF8 Lead, or their designee coordinate with the NCEM Infrastructure Section, and appropriate ESF organizations, on the identification of available resources (Federal, State, Private Industry, etc.) and plans of action necessary to restore critical infrastructure affecting the operation of healthcare organizations and delivery of healthcare services
    - Prioritization of Critical Infrastructure: The prioritization of critical infrastructure recovery is situational, based on the unique set of problems presented by each disaster. Lost critical infrastructure with immediate negative impacts on lives and life safety hold the highest priority in North Carolina. For this reason, the recovery of critical infrastructure necessary to restore lost healthcare services is always a high priority for the SERT regardless of the situation. The ESF8 Lead, or their designee, work within the processes established by the SERT Leader and Infrastructure staff to prioritize the recovery of critical infrastructure affecting the delivery of healthcare services
    - Transition from Response to Recovery: The ESF8 Lead, or their designee coordinate with the NCEM Infrastructure and Recovery Sections, as necessary, to ensure the continuity of action plans for the restoration of healthcare services as the SERT Leader transfers responsibility for continuing operations from Response organizations (ESFs) to the NCEM Recovery Section and Recovery Support Function (RSF) organizations under the **North Carolina Disaster Recovery Framework**
    - ESF8 Lead, or their designee, ensure that plans and information regarding the recovery of lost health care services are shared with HCCs (e.g., Coordination calls) and with NCDHHS leadership as necessary and requested

Recovery Phase (Post Disaster):

During this phase, the HCCs will work closely with affected healthcare organizations within their region and with the ESF8 Lead to assess and report the progress of recovery efforts, provide appropriate assistance (**see, Assistance – Long Term, above**), and participate in the resolution of delays in the recovery process as

appropriate. HCCs will also continue to advocate for the reassessment of vulnerabilities and the refinement of plans and capabilities as affected healthcare organizations attain their recovery goals. The ESF8 Lead, or their designee, will maintain awareness of ongoing healthcare recovery processes and progress and maintain a dialog with SERT Recovery, Infrastructure, RSF, and other involved organizations in support of the HCCs and the recovery efforts of healthcare organizations across the state.

Figure 1.0: NCOEMS Recovery Support High-Level Process

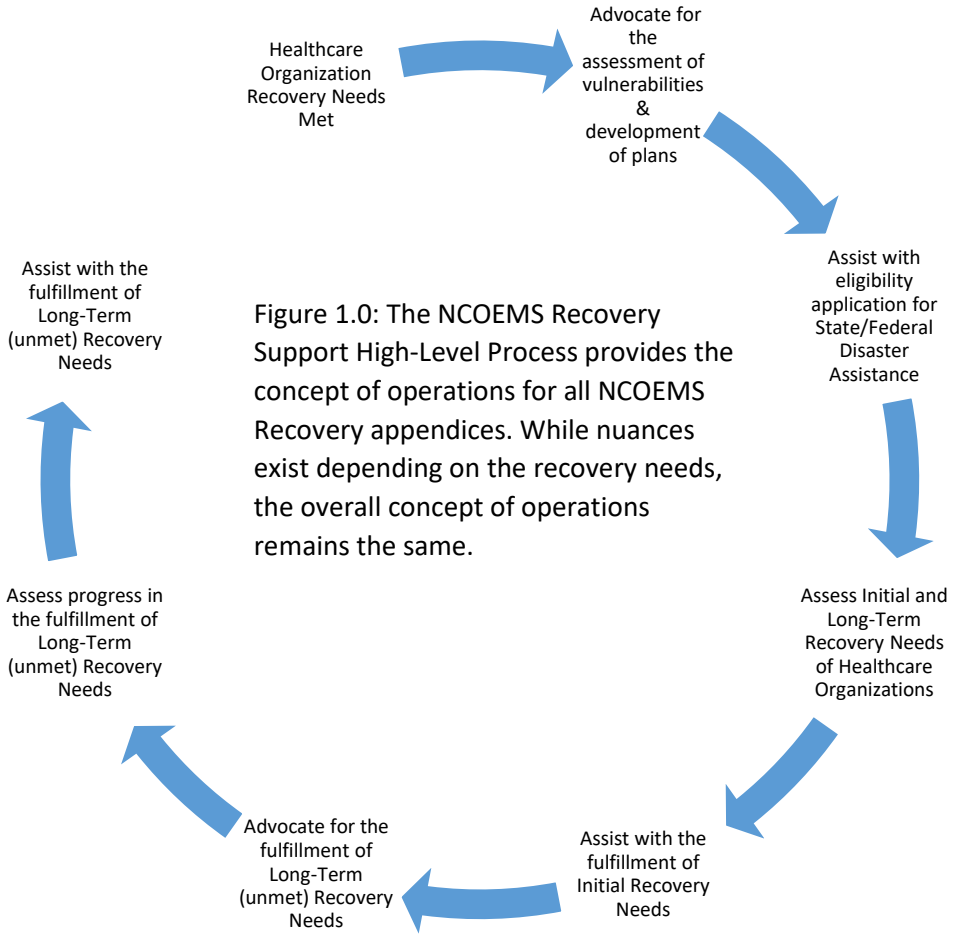

Figure 1.0: The NCOEMS Recovery Support High-Level Process provides the concept of operations for all NCOEMS Recovery appendices. While nuances exist depending on the recovery needs, the overall concept of operations remains the same.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX C:

MEDICAL SURGE

OCTOBER 2023

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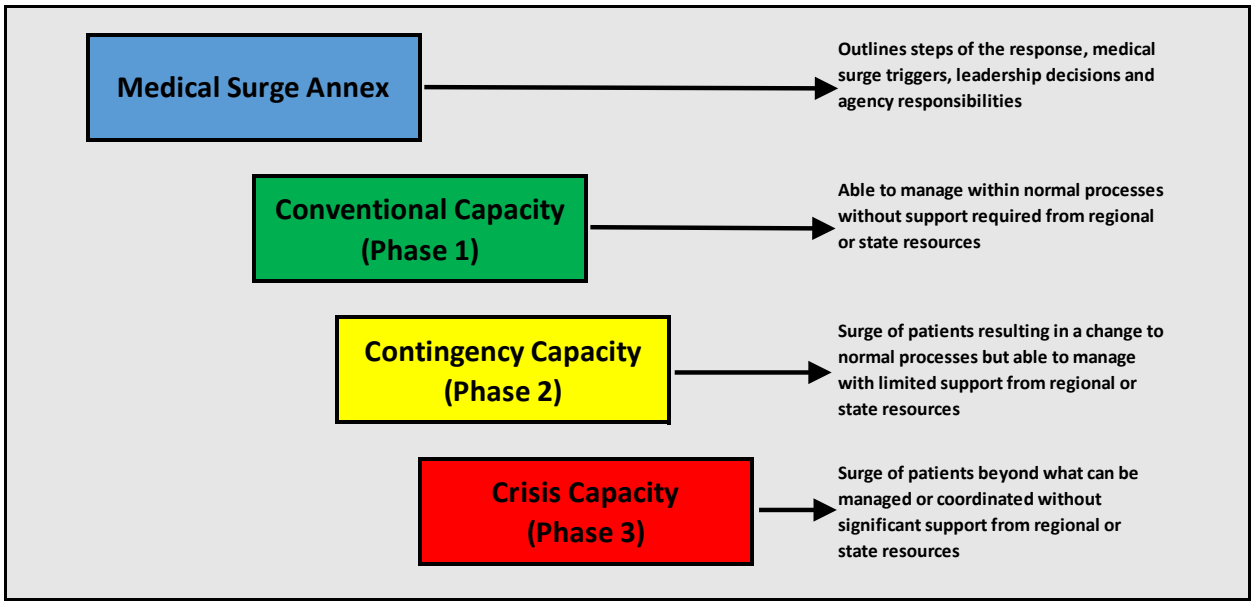
Overview

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.

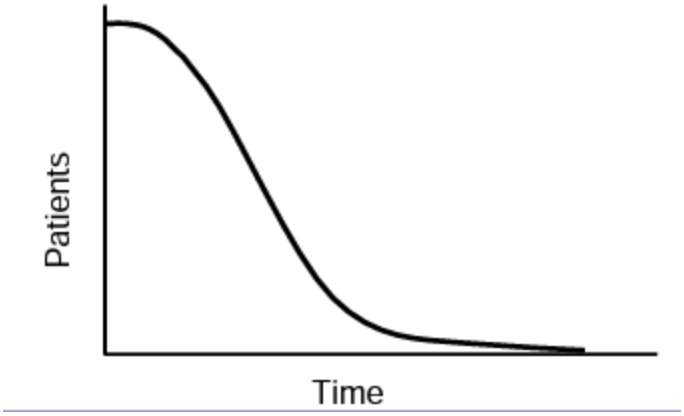
- Early recognition and a coordinated response to a medical surge incident is key to ensuring the healthcare system capacity does not become overwhelmed.

Medical Surge Incidents

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

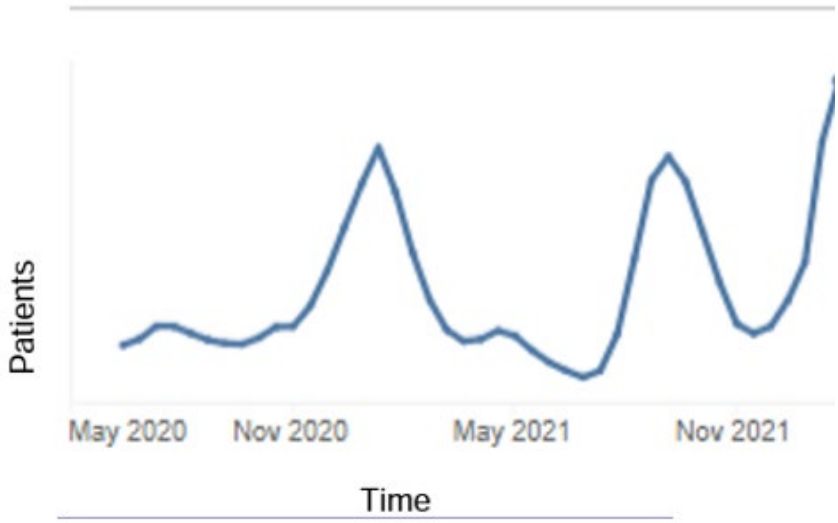
Immediate Impact

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

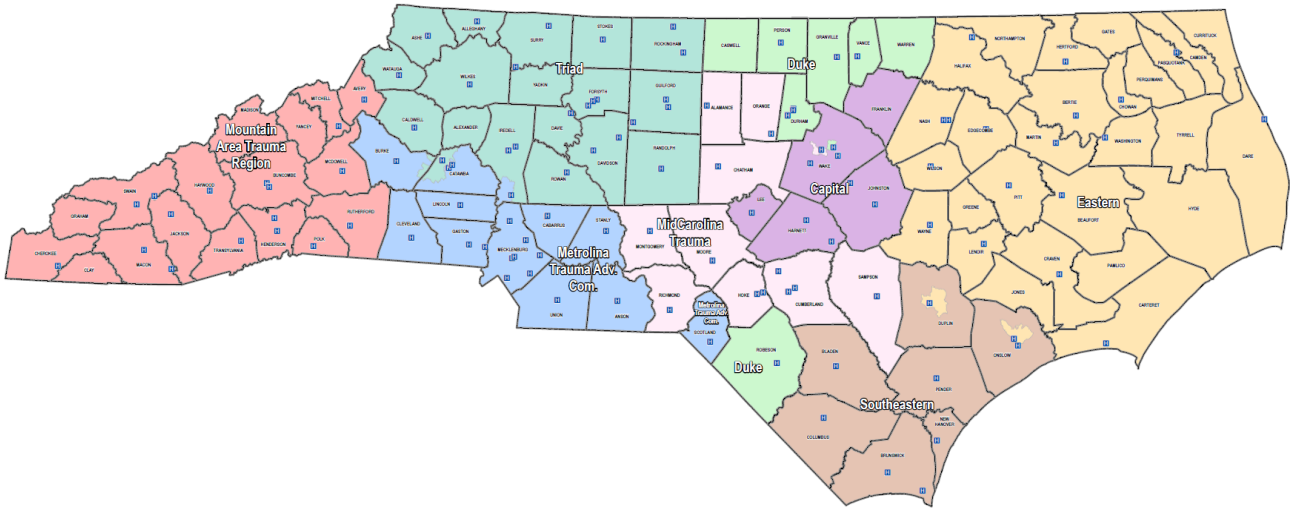
A medical surge incident that results in a sustained impact (highly infectious disease outbreak, high consequence pathogens outbreak etc.) have a gradual increase in number of patients impacting the healthcare system and can rise to a potentially catastrophic number with potentially multiple surges over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

Table of Contents

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

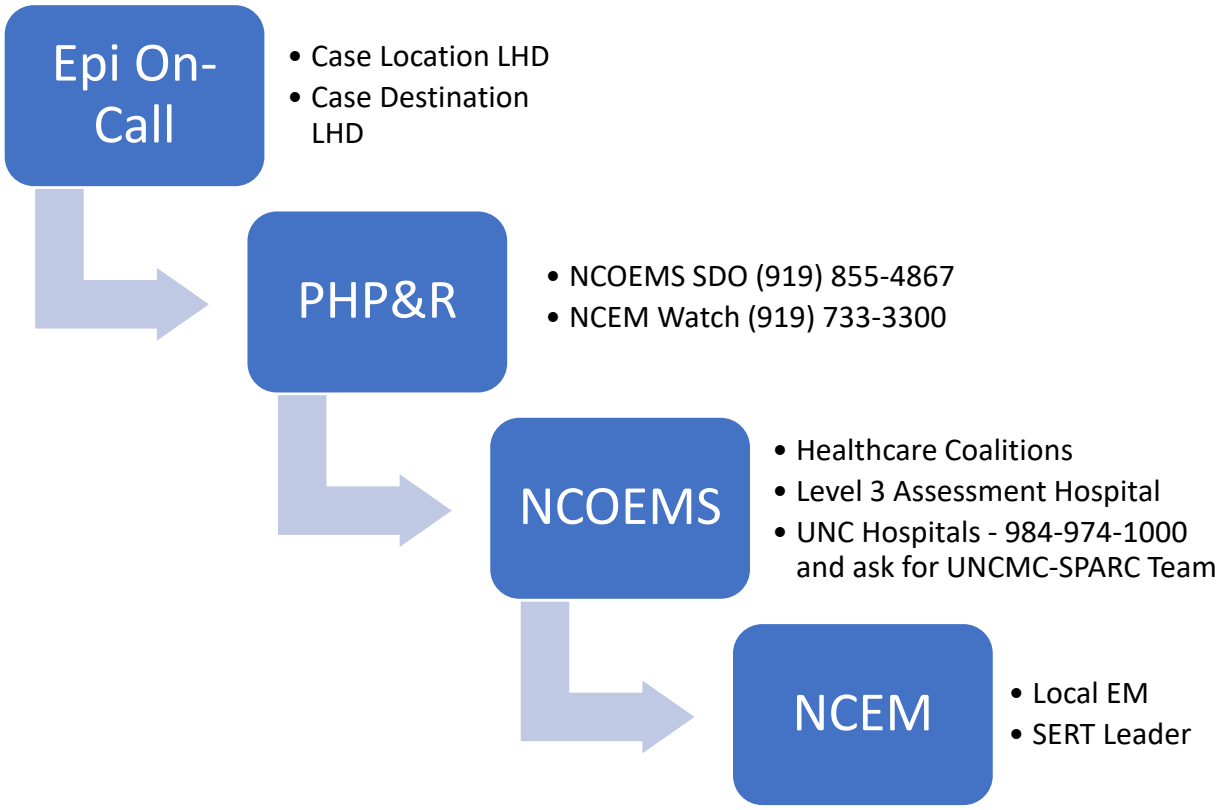
A key component of the assessment phase is a coordination call between the agencies involved in the risk assessment. These agencies include but are not limited to: Notifier/Monitor, EPI On- Call, State Epidemiologist, or designee, CDB Representative, the SLPH, and PHP&R Representative. EPI On-Call staff 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

Inform

- EPI On-Call Notified of Returning Traveler or Suspected Patient

Risk Assessment

- Assessment Phase Coordination Call: Notifier/Monitor, EPI On-Call, State Epi, CDB Rep, SLPH Rep & PHP&R Rep.

Determination

- Outcome of call should determine need for response phase or if continued monitoring will occur.

Response Phase

- If moving to response, follow DPH Notification Scheme

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

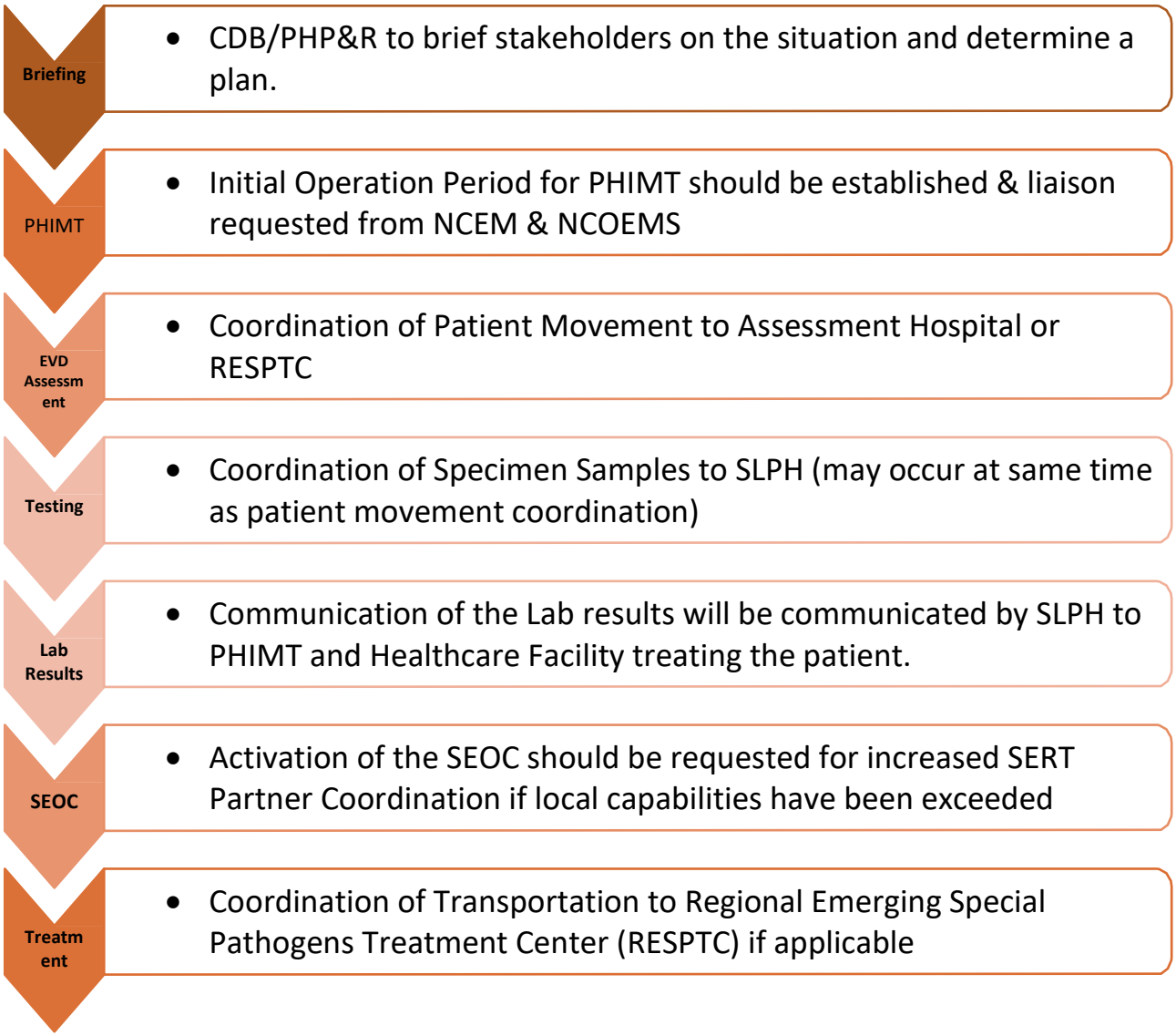
HCID patients within North Carolina will mostly likely be transferred from a Level 3 or Level 4 facility to the UNC Hospitals unless there are other reasons barring that placement (e.g., previous agreement with a different RESPTC, UNC Hospital is unable to accept patient(s) due to capability limitations, 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.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX D

PATIENT MOVEMENT CONCEPT OF OPERATIONS

MAY 2024

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Purpose

The purpose of the North Carolina Patient Movement Annex is to establish a concept of operations (ConOps) for patient movement that incorporates lessons learned from real events. This annex is comprised of regional and statewide patient movement guidelines to include patient identification, patient placement, patient transportation, patient tracking, patient repatriation, and the overall operational coordination by NCOEMS and Healthcare Coalitions (HCC). Additionally, the ConOps outlines the expected roles and responsibilities of other state and local emergency response organizations to ensure maximum effectiveness and efficiency. This annex addresses the ability to triage and place patients into appropriate receiving healthcare facilities (e.g., alternate care sites and medical support shelters) and develops a structure for the coordination for the transportation of patients to their destinations during a statewide emergency activation.

Situation and Assumptions

During emergencies and disasters, circumstances can occur where state support is required to move patients. Primarily this is due to local assets and/or healthcare facilities being overwhelmed and therefore unable to provide their usual level of service. In this situation, it is anticipated that state or federal assistance to manage patient movement, including the evacuation of existing healthcare facilities, will be required. The following assumptions were made during the development of this plan:

- This annex is intended for use in conjunction with the NCOEMS Emergency Operations Plan.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for Disaster Medical Services and is responsible for the maintenance, planning, coordination, and execution of the Patient Movement Annex.
- All county partners, healthcare systems and facilities should maintain their own primary and backup patient movement/evacuation plans and only request support from the state when they become overwhelmed and need additional resources or support.
- Patient movement operations are slow moving and access to resources may be delayed. Ample notice and early warning are necessary to provide time to support patient movement operations.
- The concept of operations outlined in this plan can be used for all types of state supported patient movement scenarios regardless of the examples provided in this plan.
- A patient's health generally does not improve with relocation. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or in-route delays due to weather, accidents, or secondary events after the originating event/incident.
- Ideally, patients should be stabilized prior to being transported. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources, and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process, all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- All evacuations are subject to weather conditions and safety considerations.
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities and the responsibility for costs resulting from patient movement are primarily the obligation of the sending entity.

Concept of Operations

Activation

The ESF8 Lead has the authority to activate this plan in consultation with North Carolina Emergency Management. This decision is informed by information shared by local and regional partners when there is an immediate or anticipated need to move patients beyond what the local resources can manage.

This plan may be activated prior to or during any event where there is an anticipated need for state coordinated support to move patients. Different guidelines for the movement of patients exist depending on the originating location and/or destination of the patients (refer to specific appendices for specific guidelines).

Notification

Upon activation of this plan, the ESF8 Lead, or designee is responsible to ensure notification to all State Medical Response System partners and North Carolina Department of Health & Human Services (NC DHHS) leadership. This notification will include links to submit all required planning documents, individual patient movement request forms, and the instructions on how to start the process. Additionally, instructions for how to do a bulk upload of patients and the necessary template will be sent in this same notification.

If the evacuation is expected to impact other states and/or state transportation resources are anticipated to be overwhelmed, the HHS Region IV Unified Planning Coalition (UPC) and Administration of Strategic of Preparedness and Response Regional Emergency Coordinators (RECs) should be notified in anticipation of Emergency Management Assistance Compact and/or Federal resource requests.

Patient Movement Concepts

The need for patient movement can be 'anticipated' or 'unexpected', as described below:

Anticipated – greater than 48 hours to expected impact, allowing time to deliberately plan, identify, triage and link patients with appropriate facilities, including but not limited to:

- Hurricanes
- Highly Infectious Disease/Pandemic
- Significant snow or ice storms
- Storm Surges and Flooding

Unexpected - the risk to life safety with immediate needs to relocate patients to an alternate facility, including but not limited to:

- Power loss in the absence of a functioning generator
- Tornado with direct impact
- Other compromised infrastructure with significant impacts anticipated within 24 hours or less.

Hospital Evacuation Patient Movement: Hospital evacuations should be considered a last resort when all other response options, such as sheltering-in-place, lateral/vertical movement within the facility, and providing additional resource or staff support, are exhausted or deemed insufficient. Hospitals are required to have their own primary and secondary plans for facility evacuation in case of an emergency or disaster. Sending facilities should be prepared to send staff, equipment and supplies with the patients when considering an emergency evacuation. During certain medical surge events an alternate care site (e.g., field hospital or medical support shelter) may be opened to help manage the surge of patients within the healthcare system. During this type of incident, it is anticipated that the alternate care site will be treated like any other hospital for the purposes of patient movement. **Refer to Appendix D1: Hospital Patient Movement Guidelines** for more details on how this type of patient movement will be coordinated.

State Medical Support Shelter Patient Movement: During major emergencies or disasters, State Medical Support Shelters (SMSS) may be activated to accommodate individuals that are evacuating and require specialized healthcare attention due to a disruption in their community healthcare support. Patient movement in this circumstance usually involves individuals coming from their homes to a SMSS or returning to their homes from a SMSS. **Refer to Appendix D2: State Medical Support Shelter Patient Movement Guidelines** for more details on how this type of patient movement will be coordinated.

Federal Coordinating Centers: As part of the National Disaster Medical System (NDMS) Federal Coordinating Centers (FCC) and Patient Reception Sites may be activated to provide medical care from another state or a federal medical response when the medical care capability in that area has been overwhelmed. FCC activation is a coordinated response between NCEM, NC DHHS, Veterans Affairs Medical Center (VAMC) and ASPR. Patient movement required during a Federal Coordinating Center (FCC) activation will follow a similar framework as a hospital evacuation, but additional nuances can be found in the **Appendix D3: FCC Patient Movement Guidelines**.

Transportation: A key part of patient movement is the coordination and oversight of transporting patients safely and efficiently from origin to destination. The ability to maximize the use of available resources and coordinate potentially scarce assets is key to successful patient movement. Refer to **Appendix D4: Patient Movement Transportation Guidelines** for more details on how the patient transportation process will be coordinated.

Patient Movement Roles

Patient Movement Supervisor:

Upon decision to activate the patient movement annex, the ESF8 lead, or designee will assign an NCOEMS staff member to the role of Patient Movement Supervisor as part of the NCOEMS support cell. The Patient Movement Supervisor has oversight and responsibility for all ESF8 operations that involve patient movement activities that include Patient Identification, Placement, Transportation and Tracking (e.g., healthcare facility evacuations, medical support shelter, FCC operations etc.) and can request to add or detract personnel to support the operations as the needs change. This position reports to the Support Cell Coordinator and is responsible for providing all patient movement information for Support Cell Situation Reports when requested by the ESF8 Lead. If this is the only position that is activated, then this individual must ensure all responsibilities outlined in this annex are completed. A Job Action Sheet for this position can be found in **Appendix 6: Organization and Assignment of Responsibilities** of the Base Plan.

Patient Placement Coordinator:

The patient placement coordinator is responsible for supporting the Patient Movement Supervisor and Healthcare Facility Patient Placement Unit (if active). This position is expected to be aware of the total number of patients that need placement, location of patients needing placement, type of patients needing placement and the total number of patients that have been placed. A Job Action Sheet for this position can be found in **Appendix 6: Organization and Assignment of Responsibilities** of the Base Plan.

Healthcare Facility Patient Placement Unit:

This unit, if activated, is responsible to lead the Statewide Patient Coordination Team and support the Patient Coordination Center Lead when patient movement involves placement into healthcare facilities (e.g., during hospital evacuations) and to receive the individual patient placement forms. For more details, see **Appendix D1: Hospital Patient Movement Guideline.**

Medical Support Shelter Patient Placement Unit: This unit is responsible for reviewing, vetting, and approving individual patient placement requests for Medical Support Shelters. For more details, see **Appendix D2: State Medical Support Shelter Patient Movement.**

Patient Transportation Coordinator:

The Patient Transportation Coordinator is responsible for supporting the Patient Movement Supervisor and overseeing all patient movement transportation assets (e.g., Ambulance Strike Teams, Ambulance Buses, Transport resources etc.). This position is responsible for advising ESF8 leadership on the type and quantity of

patient movement assets that need to be activated, providing details on number of assets currently deployed and maintaining awareness of assets available for deployment. Additional details on responsibilities are outlined in **Appendix D4: Patient Transportation Guideline** and in the Job Action Sheet for this position in **Appendix 6: Organization and Assignment of Responsibilities** of the Base Plan.

Transportation Unit:

This unit is responsible for reviewing, vetting and approving patient transportation requests for all patients that need to be moved as part of the ESF8 coordinated patient movement annex. This unit is also responsible for actual deployment of transportation assets and coordinating closely with the tracking unit. Additional details on responsibilities are outlined in **Appendix D4: Patient Transportation Guideline**.

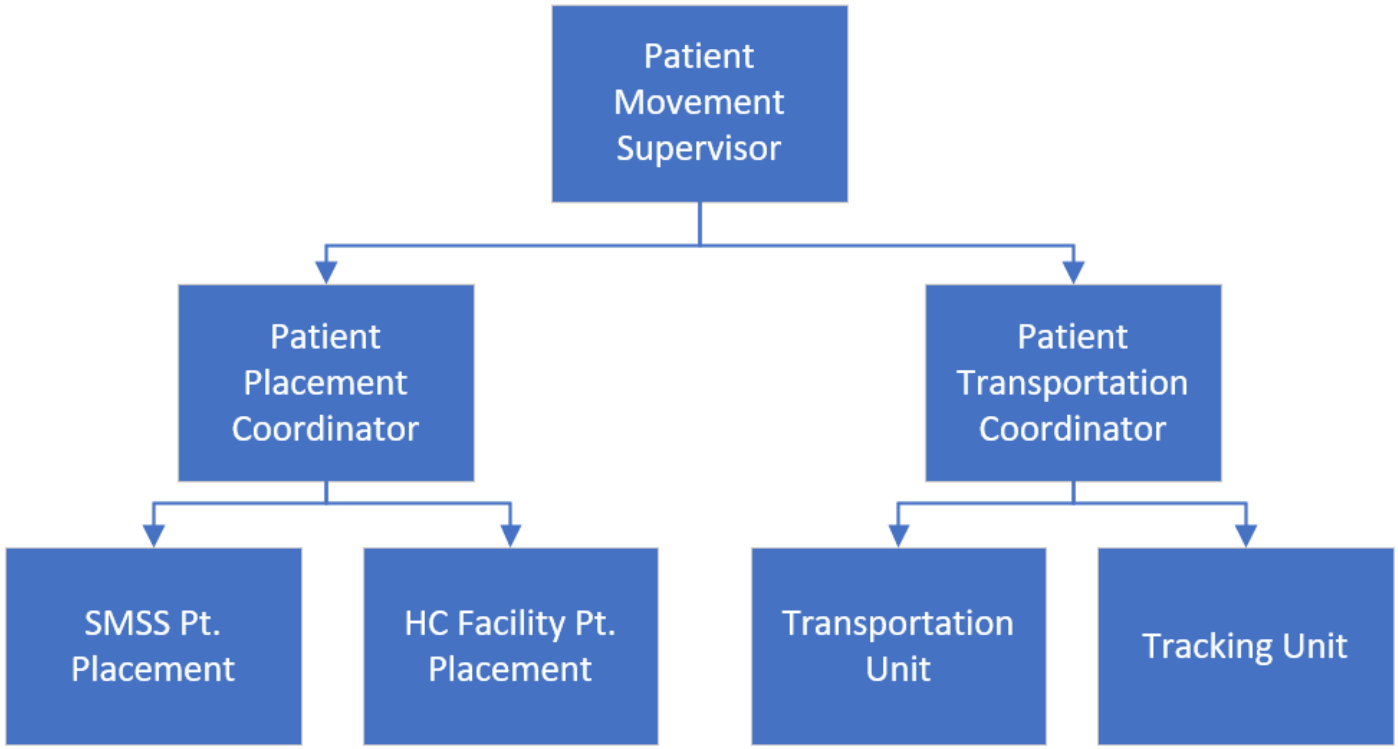
Tracking Unit:

This unit is responsible for ensuring that all patient movement activities are tracked from initial request for movement until final destination. Additional details on responsibilities are outlined in **Appendix D4: Patient Transportation Guideline**.

Medical Provider:

NCOEMS will ensure that at least one of the positions supporting the patient movement operations is a medical provider (Paramedic, Advanced Practice Provider, or Physician) to field any questions from non-clinical support roles regarding patient acceptance and placement. If the assigned medical provider is unable to determine patient placement, then the ESF8 lead should be consulted for further direction and engagement with the clinical advisor.

Figure 1.1: Patient Movement Organization Chart



Patient Movement Responsibilities

Patient Identification: Patient identification is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.) as they have the information necessary to ensure safe decisions are made on the movement of the patient(s). The NCOEMS has an established process to request additional state support for patient movement. This process starts by submitting the required planning form(s), which will aid in identifying the potential number of patients needing to be moved, potential number of transportation assets required, and placement capability needed to support the overall mission. Additionally, individual patient placement request forms will be required once the patients are ready to be moved to provide details on the patient, their medical condition, demographics, and other pertinent details as outlined in each specific patient movement appendix. This information will be shared during HCC coordination calls and links to the patient placement request forms will be emailed to stakeholders upon activation. These forms will also be accessible on the HPP website (https://hpp.nc.gov/) under the Resources tab.

Patient Placement: Patient placement is the responsibility of the NCOEMS staff member assigned to the role of Patient Placement Coordinator in coordination with the receiving facilities (e.g., hospital, medical support shelter, etc.). The main goal of the patient placement process is to ensure that individuals are moved to the most appropriate receiving location based on the information available about their medical situation. Depending on the size of the activation a Healthcare Facility Placement Unit and/or a Medical Support Shelter Placement Unit may be assigned under the Patient Placement Coordinator to complete these responsibilities. Specific details on the patient placement options are available within each specific patient movement appendix.

Patient Transportation: Patient transportation is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.). During large-scale events, transportation resources may be limited, and sending entities may need to request state support for the coordination of additional assets to fulfill the mission. Once the patient movement plan has been activated, the coordination of the state patient transportation assets is the responsibility of the NCOEMS to activate, deploy and track to ensure maximum efficiency and effectiveness in completing the patient movement mission. To accomplish this task, NCOEMS Support Cell Coordinator will assign a Patient Transportation Coordinator to oversee all patient transportation activities. All transportation coordination and assets assigned to patient movement will be assigned under this position to maintain consistency across multiple operational sites. Additional details on the patient transportation plan are available in **Appendix D4: Patient Transportation Guideline**.

Patient Tracking: Patient tracking is the responsibility of the NCOEMS and involves ensuring that all patients being moved as part of this annex are tracked from their originating location to their final destination. Accurate patient tracking is incredibly important as a patient's final destination is likely not known when they originally enter the patient movement process. Ensuring that all patients are tracked from when they originally entered the process to their final destination and the timeline for this process should be a top priority through the patient movement process. Depending on the size of the activation a Tracking Unit may be assigned under the Patient Transportation Coordinator to complete these responsibilities. A patient tracking system will range from pen and paper to technology-based tracking systems (such as ReadyOp). Additional details on patient tracking are available within **Appendix D4: Patient Transportation Guideline**.

Patient Repatriation: The repatriation of patients is the process of moving patients displaced by disasters back to their homes or to other locations (healthcare facilities, temporary housing, etc.) after the initial danger caused by the disaster has passed. The management of this process is the responsibility of the agency or facility originally responsible for moving the patient from their home or other location, referred to in this plan as Original Sending Entities. These typically include hospitals/healthcare facilities, and county, state, or federal

agencies. Like transportation support for patient movement, Original Sending Entities may request transportation support from NCOEMS to assist them in meeting their repatriation responsibilities. However, assistance from NCOEMS for patient repatriation is limited in the following ways:

- A State of Emergency must be in effect.
- Patients can only be transported with state supported assets for one trip within the state of North Carolina (e.g., from Medical Support Shelter to their home).
- Patients can only be transported **from** state-supported medical shelters, medical facilities (e.g. SMSS and MDH) and healthcare facilities **to** home, other healthcare facilities, or other appropriate locations (e.g. local shelters, temporary housing, etc.).

When transportation support for repatriation is requested, it is expected that Original Sending Entities will:

- Communicate to NCOEMS their intentions to repatriate patients as soon as appropriate conditions exist to do so.
- Provide information to NCOEMS staff confirming that the location patients will be repatriated to is safe and appropriate to meet the medical needs of the patient.
- Provide information to NCOEMS necessary for the coordination and tracking of the repatriation process.

When transportation support for repatriation is received, it is expected that NCOEMS staff assigned to the ESF8 unit appropriate to the situation (ESF8 Desk, SMSS IMT, MDH IMT) will assist Original Sending Entities with the coordination of transportation of their patients within the limitations discussed in this plan and the guidelines provided in **Appendix D4: Patient Transportation Guideline**.

Operational coordination: The responsibility for the operational coordination for all State Medical Response System patient movement activities is the responsibility of the NCOEMS. This includes the decision to activate the plan, notification of the partners and leadership entities, assigning staff to appropriate roles and overseeing each step and process for the movement of patients from originating location to destination.

Deactivation: The decision to deactivate the state coordinated patient movement process is up to the ESF8 lead in discussions with NCEM along with state and local entities. There may be a period during a major event, such as a hurricane, when the patient movement process will need to be temporarily deactivated for safety purposes and then reactivated once it has been deemed safe to do so. The deactivation decision, including temporary deactivation decisions, should be shared with the same parties that were notified at the start of the patient movement process and shared widely so all partners are aware. Key decision points to utilize when considering deactivation is primarily based on the point in the activation when the majority of patients have been repatriated and/or the ability to place and/or transport patients through normal processes has returned.

Figure 1.2: Patient Movement Flow Chart – Unexpected Incident

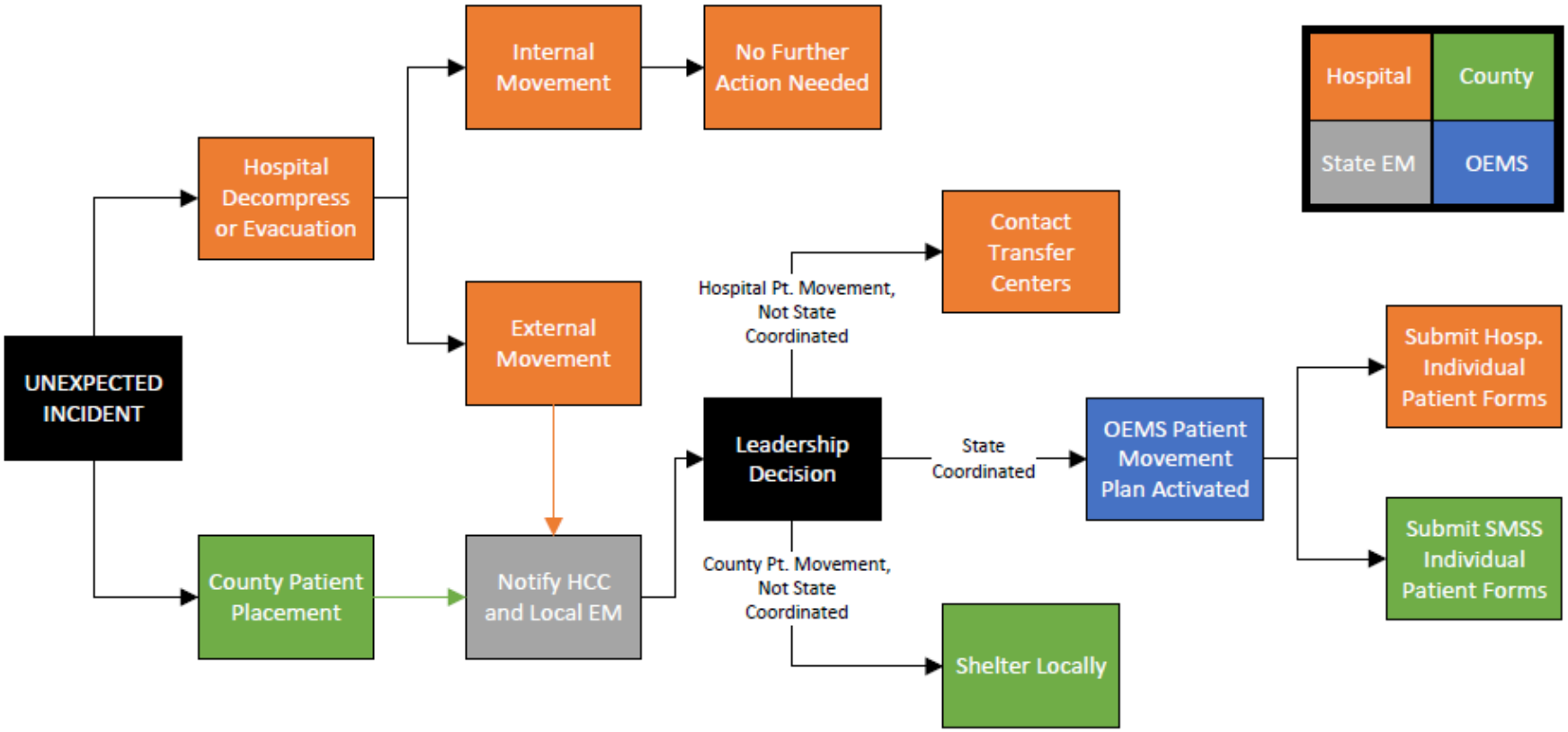
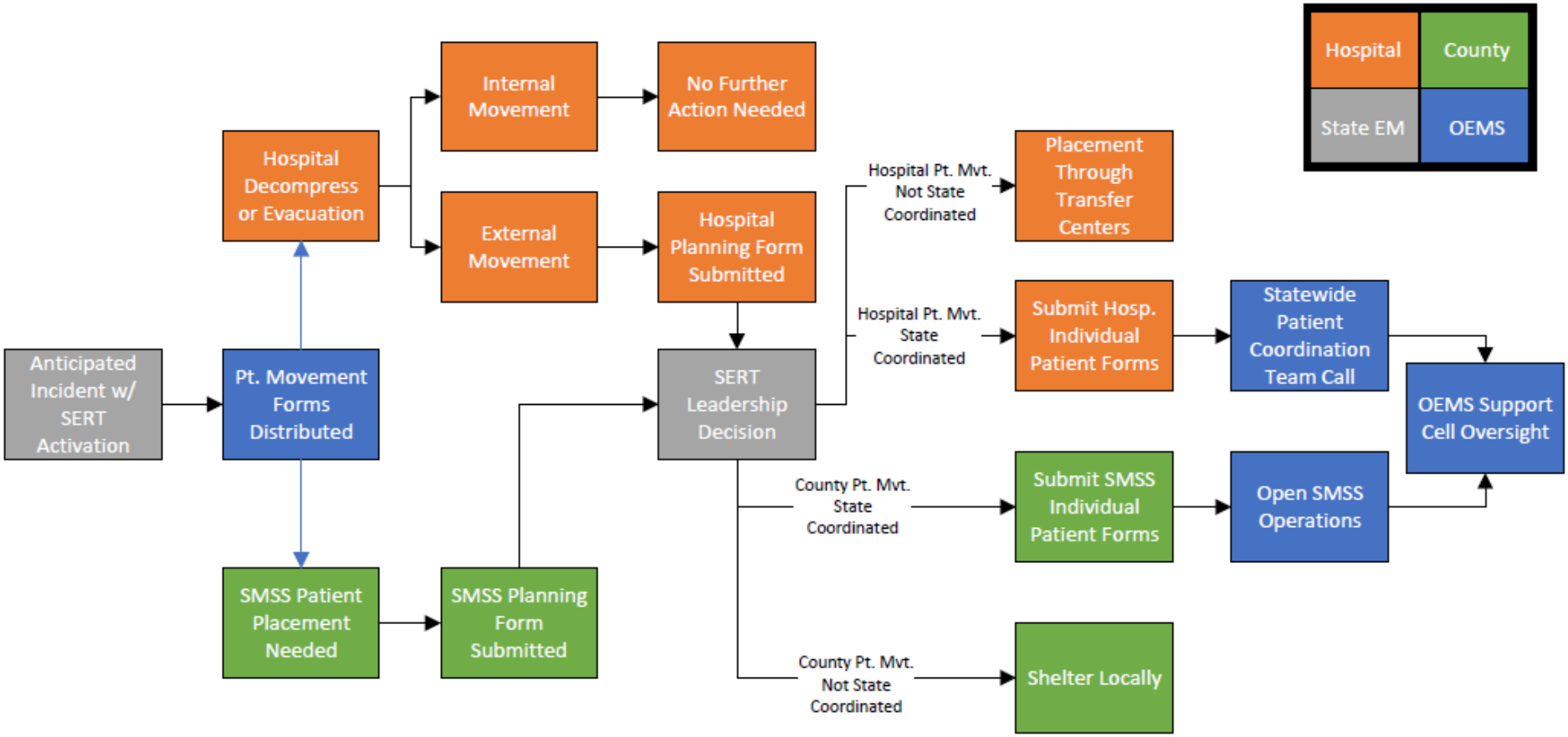


Figure 1.3: Patient Movement Flow Chart – Anticipated Incident



NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX D1:

HOSPITAL PATIENT MOVEMENT GUIDELINES

MARCH 2023

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Purpose

The purpose of the North Carolina Hospital Patient Movement Guideline is to establish a standardized framework for the movement of patients into a hospital. This guideline identifies activation triggers and outlines procedures for triaging and placing patients in appropriate receiving facilities. This framework applies during instances when local assets require state or federal assistance to manage patient movement, including evacuation of existing healthcare facilities.

The triggers for hospital patient movement may vary for each healthcare facility based upon classification, physical location, available resources, and other factors; therefore, the decision is made by the individual facility. This framework is not intended to overrule existing Healthcare Facility Emergency Operations Plans but is designed to provide guidance when statewide activation and resources are needed, and the anticipated needs exceed what the healthcare facility and affiliated healthcare coalition can coordinate and/or provide.

Scope

This framework covers the regional and statewide hospital patient movement guidelines to include patient identification, placement, and overall coordination by the NCOEMS, as well as the expected roles and responsibilities of other state and local emergency response organizations to meet its purpose. These guidelines were created to assist healthcare facilities plan and prepare for patient movement based upon impact to their facility from an event or incident; however, the basic framework can also be applied to a community-based event or incident when a local emergency manager requests assistance with patient movement resulting in patients being placed into a hospital or healthcare facility. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan, Annex D: Patient Movement, and Appendix D4 – Patient Transportation.

Definitions

- *1135 Waiver:* allows for federal waivers or modification of various requirements from section 1135 of the Social Security Act to include: Emergency Medical Treatment and Labor Act (EMTALA); screening, triage of patients at a location offsite from the hospital's campus; hospitals housing patients in units not otherwise appropriate under the Medicare Conditions of Participation; Preapproval Requirements; ability for healthcare facility(ies) to temporarily increase licensed bed capacity during a mass effect event to accommodate for a resulting influx in patients. A declaration of the Stafford Act or National Emergencies Act in addition to a public health emergency under Section 319 of the Public Health Services Act must precede state or healthcare facility request for an 1135 Waiver.
- *Decompression:* the identification and movement of admitted patients that are appropriate for discharge, downgrade, or lateral movement to another unit, to increase capacity to receive incoming patients. This is often a preparatory function of a receiving facility (as defined below).
- *De-risking:* the process by which a healthcare facility proactively relocates admitted patients in anticipation of an event that could trigger an emergent evacuation. This is often a preparatory function of a sending facility (as defined below).
- *Healthcare Facility Evacuation:* the emergent movement of admitted patients to an alternate internal or external location in response to a mass-effect event as a result of patient safety concerns.
- *Patient:* for the purpose of this framework, the term 'patient' will broadly include any person(s) who: are receiving in-patient medical care at a healthcare facility; are newly injured or ill due to an emergency incident/event or have existing medical conditions requiring the need to be moved to healthcare facility for treatment.
- *Patient Movement:* the physical relocation of a patient from one area to another to preserve their safety in anticipation of, or response to, a disaster or emergency situation where local resources have become overwhelmed and regional, state, or federal support for patient movement is required.

- *Patient Coordination Center Lead:* the incident/event-specific state-appointed healthcare facility that will help to facilitate planning and discussion amongst other pre-identified hospitals, healthcare facilities and Healthcare Coalitions (HCCs).
- *Receiving Facility* –a healthcare facility that may receive patients as part of a statewide patient movement plan activation. Note: There may be one or more receiving facilities based upon patient volume and acuity.
- *Sending Facility* – a healthcare facility that requests support to activate the statewide patient movement plan in anticipation of, or response to, a disaster that may/has impact(ed) patient care and hospital operations. Note: There may be one or more sending facilities based upon the magnitude of the impact.
- *Shelter-in-Place* – the process by which a healthcare organization hardens current infrastructure in order to provide safety and security measures for current inpatients in preparation of a potential mass effect event. This decision may be made as a result of a risk assessment which highlights that it is safer to remain in place than to relocate patients.
- *Statewide Patient Coordination Team* – a key point of contact and backup designee from each of the Transfer Center/Patient Flow Centers for the large healthcare systems in North Carolina to routinely meet and coordinate on the patient placement coordination within the state during disasters and emergency situations.
- *Transfer Center/Patient Flow Center* – the service unit within a healthcare organization that manages patient movement and flow during daily (normal) operations.
- *Triage* – the process of sorting and prioritizing patients' treatments based upon acuity.

Assumptions

- Decisions regarding when to move patients that are in a healthcare facility and who to move, are made within the hospital/healthcare system.
- A qualifying lead facility will have a transfer center and has been educated/trained to the state Patient Movement Annex and Hospital Patient Movement Guideline.
- Patients are often moved via ground and air ambulance through direct facility-to-facility transfer; however, competing transport resource requests may quickly overwhelm available resources during large incidents and should be avoided during statewide activation of the Patient Movement Guideline, except under the following circumstances:
    - Emergent patient transfers (STEMI, stroke, trauma, etc.). Standard procedures should ***not*** be bypassed during an activation of the Patient Movement Guideline to ensure safety of all patients.

Triggers

The need for patient movement can originate from external or internal sources as described below:

External – An event or incident, such as a hurricane, highly infectious disease/pandemic, fire, or hazardous plume that poses a risk to a healthcare facility that could compromise infrastructure, operations, or safety of patients/staff.

Internal – An event or incident such as an explosion, fire, hazardous material release or major utility failure involving only the healthcare facility.

Note: In all scenarios, prior to the movement of patients, healthcare decision makers have made the determination that the risk of sheltering in place outweighs the risk of moving the patients to an alternate location.

Activation Framework

There is a two-tiered approach to facilitating hospital patient movement:

- **Healthcare system** – utilization of flagship entity and affiliate sites to absorb patients without state support. Some agreements or standard partnerships between hospitals/healthcare systems may allow for the movement of low acuity and/or volumes of patients to respective facilities with no or minimal involvement from state coordinated patient movement.
- **Statewide activation** – requires collaboration between NCOEMS, the health system patient flow/transfer centers, and NCEM to facilitate movement, activate emergency contracts and implement mutual aid from other states, as necessary. If statewide activation occurs, ESF8 will assign a statewide Patient Movement Supervisor to oversee and coordinate all related operations. During an anticipated event it is expected that much of the decision to activate this guideline will be based on input from the Statewide Patient Coordination Team with the ultimate decision being made by ESF8 leadership.

Procedure

Initiation

Incident

- An incident impacts one or more healthcare facilities (or county if no healthcare facility involved), requiring some form of patient movement into a hospital.
- The healthcare facility Emergency Manager performs an assessment and makes a recommendation for patient movement based upon internal protocols.

Notification of Incident

- Upon the decision to request activation the Patient Movement Guideline:
    - Healthcare Emergency Management (EM) alerts County EM
        - County EM will notify their respective leaders & NCEM, as appropriate.
    - Healthcare EM alerts Healthcare Preparedness Coalition
        - Healthcare Preparedness Coordinator alerts NCOEMS ESF-8 Desk
            - NC HPP Shift Duty Officer 919.855.4687
    - Healthcare EM notifies other stakeholders as identified within their respective EOPs.
    - Patient Movement Planning Form should be completed by Healthcare Facility or designee (e.g., Healthcare Preparedness Coalition lead) to begin planning for potential patient movement resources. The link for the HIPAA Compliant ReadyOp Healthcare Facility Patient Movement Planning Form will be provided to stakeholders upon activation and also be accessible on the HPP website (https://hpp.nc.gov/) under the Resources tab.
        - Key Elements needed for ReadyOp Healthcare Facility Patient Movement Planning Form:
            - Associated Healthcare Preparedness Coalition
            - Healthcare Facility Information (County, Full Name of Healthcare Facility, Name of Individual Requesting, 24/7 Contact Info)
            - Anticipated Patient Transportation Request Details (e.g., number of stretcher bound Advanced Life Support and Basic Life Support patients needing transport, number of non-ambulatory patients that could be moved via wheelchair, any patients requiring air ambulance transport)
            - Anticipated Patient Placement Bed Types (e.g., Adult, Pediatric, NICU for Medical/Surgical, OB/LND, Psychiatric, Critical: ICU, Critical: CCU, NICU/PICU etc.)

Activation Decision

- Once the request is made to NCOEMS ESF8 Lead for patient movement support a series of steps occurs to determine need for activation. Based on urgency of need to activate statewide patient movement support, step two below is considered optional.
    - Request for support from healthcare facility or impacted county.
    - Optional: Discussion with the Statewide Patient Coordination Team to determine availability of resources for placement to support request
    - Situation Report to NCOEMS ESF8 Lead for decision to activate patient movement guideline.
    - Once approved NCOEMS ESF8 lead will assign Patient Movement Supervisor and Determine Patient Coordination Center Lead

Notification of Activation

- Patient Movement Guideline activation notification
    - Healthcare System – Notification may or may not occur depending upon the scale of the incident.
    - Statewide – NCOEMS activates communication trees (ReadyOp)

Identification of Patient Coordination Center Lead

- NCOEMS will work with unaffected lead hospitals from active members in the Statewide Patient Coordination Team to determine an appropriate Patient Coordination Center Lead based upon impact and availability.
- Notification of the Patient Coordination Center Lead will be provided in the initial activation communication.

Patient Movement Coordination Activation

- NCOEMS will send activation email to NCEM SERT Emergency Services, Healthcare Coalitions, all hospital EMs & all Statewide Patient Coordination Team Members – this notification will include the Patient Coordination Center Lead, brief details of the situation, and ReadyOp Forms for patient movement.
- An email notification will be distributed through the NCHA_EMC list serve to provide the information in the activation email from NCOEMS as a method of redundant communication.

Implementation

Patient Placement

- The Patient Coordination Center Lead will facilitate the patient placement process. All Statewide Patient Coordination Team members have a facility login for ReadyOp to view the requests for patient movement and to facilitate the placement of these patients. Additionally, a coordination conference call may be held to facilitate discussion, larger planning needs, and speed of process. NCOEMS will provide a Patient Placement Coordinator to record notes and provide overall support to these coordination calls. In large scale events a Healthcare Facility Patient Placement Unit may be activated to provide direct support to the Patient Placement Coordinator. This will likely occur when patient movement processes are supporting multiple mission types (e.g., SMSS Patient Movement and Hospital Patient Movement). This unit will answer to the Patient Placement Coordinator and is responsible to complete all Hospital Patient Movement responsibilities outlined for the Patient Placement Coordinator.
- Activation of the members of the Statewide Patient Coordination Team will be via their registered phone numbers/email addresses (as maintained in ReadyOp). Each team should have at a minimum of two contacts listed.
- Initial activation may be via email/phone call/text and should include an invitation to the initial conference call.

- Initial conference call agenda:
  - Roll Call (One spokesperson per entity/system)
  - Situation Update (pertinent information about reason/need for activation and expected timelines)
    - Anticipated patient volumes and acuities
  - Rules/expectations
    - Establish meeting cadence.
    - Discuss patient inclusion criteria.
    - Discuss need for physician presence in patient transfer center for acceptance of patients.
    - Determine timeline needed for patient placement.
  - Challenges/Issues
  - Updates to process
  - Next call

- Subsequent conference call agendas (if needed):
  - Roll Call (One spokesperson per entity/system)
  - Situation Update (pertinent information about current situation)
    - Current patient volumes and acuities
    - Patient
  - Patient Placement Update
    - Total number of patient placement needs identified.
    - Total number of patients placed.
    - Total number of patients pending placement
    - Total number of patient placements remaining
  - Challenges/Issues
  - Updates to process
  - Next call

- Patients requiring placement are identified by the sending facility or facilities based upon their entity's Emergency Operations Plan and are submitted via the HIPAA Compliant ReadyOp Hospital Individual Patient Placement Request Form provided in the activation email and accessible on the HPP website (https://hpp.nc.gov/) under the Resources tab.

  - The NCOEMS Patient Placement Coordinator or designee will receive via ReadyOp the Individual Patient Placement Request Form(s). After initial review they will be marked as "Received by NCOEMS Staff."
    - For bulk upload of patients, NCOEMS can provide an excel template and instructions for secure upload into ReadyOp to reduce the burden of multiple entries. These bulk uploads will create an individual entry in ReadyOp under the Individual Patient Placement Request Form to track these requests. Please note that all patients must be ready for placement at the time the form is uploaded.
  - Upon receipt of the hospital individual patient placement requests, each transfer center will review the patients in ReadyOp to identify the appropriate placement based on current resources, specialties, and bed availability.
  - The Patient Placement Coordinator or Healthcare Facility Patient Placement Unit (if activated) will monitor ReadyOp for patients that have not been placed and ensure these are brought up for discussion during the next scheduled Patient Placement coordination call (if applicable).

Sending Facility

The sending healthcare facilities should utilize the following checklist, built upon lessons learned from previous events, to help preplan and prepare for sending patients during regional/statewide patient movement event:

- ✓ Convene stakeholders (may include the Patient Logistics/Transfer Center, Nursing House Supervisors, Operational Executives, Emergency Management, Transportation, Medical Director, Care Management, etc.) to determine all patients that need to be moved.
  - De-risking should be completed 72-96 hours before an anticipated incident (e.g., hurricane)
  - Ensure completion of Healthcare Facility Patient Movement Planning Form to inform planning factors as soon as possible.
  - Patients that are submitted to NCOEMS ESF8 for placement are considered ready for placement and transfer (e.g., the patient, family & medical care team should be aware before submission to patient transfer center if applicable)
  - Patient placement location is dependent on the receiving healthcare facility and cannot be determined by sending facility if they are requesting support for statewide patient movement.
  - Evacuation decision should be no later than 72-96 hours before an anticipated incident (e.g., hurricane) to provide time for coordination and to ensure adequate transportation assets.
  - Use of Regional or Statewide Hospital Patient Movement support for decompression should only occur after activation of a facilities internal surge plan and active steps to manage surge internally has occurred (EOC activated, decreased surgical load etc.)
  - Ensure proper waivers and regulatory notifications have been made.
- ✓ Identify facility single point of contact for receiving information on the placement and acceptance of patients through the patient movement process.
- ✓ Identify a hospital patient transportation coordinator to communicate, direct and support incoming transportation assets.
- ✓ Ensure patient chart/documentation, belongings, and specialty equipment (when applicable) are ready to depart immediately upon arrival of transportation asset.

Receiving Facility

The receiving healthcare facilities should utilize this checklist, built on lessons learned from previous events, to help preplan and prepare for receiving patients during regional/statewide patient movement.

- ✓ Convene stakeholders (may include the patient logistics/transfer center, nursing house supervisors, operational executives, emergency management, transportation, medical director, care management, etc.)
- ✓ Identify facility single point of contact for receiving information and accepting patients.
- ✓ Obtain common operating picture and current state of hospital:
  - Evaluate capacity.
  - Evaluate staffing.
  - Evaluate critical supplies and equipment (and PPE)
- ✓ Identify patients that can be discharged, downgraded, or lateraled to increase receiving capacity:
  - Determine and activate patient movement, as necessary.
  - Patients can be discharged to State Medical Support Shelters if activated to help decompress facility to handle higher level of care patients.

- ✓ Engage affiliate sites, as appropriate.
- ✓ Participate in coordination call and/or regular review of ReadyOp patient list:
  - Review patient list compiled in ReadyOp and identify patients that may be an appropriate placement.
  - Ensure appropriate clinicians and decision makers are present/available to assist with patient acceptance.

Transportation and Tracking:

Patient Transportation Coordinator is responsible for the notification of patient placement only if state coordinated transportation is needed. Additional information on the transportation and tracking coordination for patient movement can be found in Appendix D4 – Patient Transportation Guideline.

Demobilization

- The deactivation of the statewide Hospital Patient Movement Guideline will be determined in consultation with NCOEMS ESF8 Lead, and the Statewide Patient Coordination Team based on the current requests for patient movement and the statewide availability of resources.

Patient Movement Considerations for Managing Medical Surge During Statewide Event/Impact

This patient movement guideline can be utilized to support the entire healthcare system during a large statewide event/impact due to catastrophic disaster or highly infectious disease outbreak response/pandemic to balance the medical surge and avoid overwhelming the entire healthcare system.

Key differences during this type of impact:

- Anticipate that majority/all healthcare facilities will be impacted by medical surge.
- State assigned roles may need to provide higher level of support to Patient Coordination Center Lead due to competing demands from medical surge on their facility.
- Primary goal of patient movement support will be to ensure patients are able to be cared for in most appropriate locations based on their conditions (e.g., ICU, Skilled Nursing Facilities, Alternate Care Sites etc.)
- The secondary goal of patient movement support will be to manage the medical surge needs of the entire healthcare system to optimize available space across each region and the entire state to balance the medical surge.
- Statewide collaboration, communication and cooperation will be key parts of the patient movement coordination during this type of impact to ensure the highest level of support across the entire state.
- Patient beds, appropriate staff and transportation assets will be extremely limited.
- Patients may need to be transferred from tertiary/specialty care facilities to support decompression and facilitate placement of higher acuity patients within those facilities.
- Additional facility types beyond just hospitals should be considered part of the patient movement coordination plan (e.g., Alternate Care Sites, Field Hospitals, Skilled Nursing Facilities as appropriate).
- Decision to activate hospital patient movement guideline will be based on request from Statewide Patient Coordination Team
- The timeframe for patient movement coordination may be extended due to length of the impact to healthcare system.

- Statewide patient movement coordination may be activated, and demobilized multiple times as needed throughout impact.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX D2:

SMSS PATIENT MOVEMENT GUIDELINE

SEPTEMBER 2023

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Purpose

The purpose of the State Medical Support Shelter (SMSS) Patient Movement Guideline is to establish a standardized framework for ESF8 SEOC and Support Cell staff to utilize upon activation of a SMSS. Staff must ensure that both the medical and transportation needs of patients are evaluated carefully when placing patients into a shelter.

Scope

This appendix covers specifics related to the movement of patients to/from the State Medical Support Shelters to include patient identification, patient placement, patient tracking, patient repatriation and overall coordination by North Carolina Office of Emergency Medical Services (NCOEMS) and Healthcare Coalitions (HCC). Additionally, it outlines the expected roles and responsibilities of other federal, state, and local organizations to ensure maximum efficiency and effectiveness during these operations. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan; Annex D: Patient Movement; and Appendix D4: Patient Transportation.

Guidelines

Patient Identification:

As outlined in the Patent Movement Annex, the identification of patients to be considered for placement within a State Medical Support Shelter is the responsibility of the sending entity (medical facility, county agency, state agency, or federal agency etc.). This is to ensure pertinent information to determine the appropriateness of placement is known prior to acceptance of the patient into an SMSS.
SMSS Patients can be received from various locations:

- **General Population Shelter** - Citizens arriving at a general population shelter may be triaged and found to be more appropriately served at a Medical Support Shelter. Request for placement into a SMSS from General Population Shelters should be initiated by the Healthcare Lead at the individual shelter and placed into the ReadyOp SMSS Individual Patient Placement Request Form. If telemedicine is in use at the general population shelter, then the patient may be referred directly by the physician supporting the shelter via telemedicine.
- **Healthcare Entity** – Hospitals, Long Term Care (LTC) Facilities, and other healthcare entities needing to de-risk, decompress, or evacuate, could potentially consider sending patients to a SMSS. Requests from Healthcare Entities requesting SMSS assistance should be routed through the healthcare emergency manager and placed into the ReadyOp SMSS Individual Patient Placement Request Form.
- **Home** – County entities (e.g., Social Services agencies, Emergency Management etc.) may identify individual residents in their communities who need to evacuate and require active monitoring/management. Requests for patients coming from home to be placed into the SMSS should be routed through local County Emergency Management and placed into the ReadyOp SMSS Individual Patient Placement Request Form.

The process for identifying patients appropriate for medical support shelters and those responsible for each step are outlined below.

Sending Entities

(local emergency management agencies, healthcare facilities, EMS agencies, social services agencies, independent living facilities, etc.) considering the placement of patients who have or will be disrupted by the situation should evaluate individuals seeking SMSS placement based on the **Medical Support Shelter Placement Guidance.** Entities are encouraged to have a plan ahead of an emergency on how they will identify and transport individuals that will need to be placed in a medical support shelter. County emergency managers or designees are encouraged to complete a SMSS Patient Movement Planning Form upon activation of this plan to allow NCOEMS to begin preparing to handle the necessary patients that may require placement. This form is an early planning document to help inform the need for size, number and location of medical support shelters,

potential transportation resources needed and staffing requirements. This should be completed at a minimum of 120 hours pre-land fall in the case of a potential hurricane.

1. *SMSS Patient Movement Planning Form* should be completed by the local county emergency manager, healthcare facility emergency manager or designee (e.g., county ESF8 lead or Healthcare Preparedness Coalition). A link to the form will be provided to stakeholders upon activation and is also accessible via the HPP website (https://hpp.nc.gov/) under the Resources tab.
    a. Key Elements needed for ReadyOp SMSS Patient Movement Planning Form:
        i. Name of Organization
        ii. Associated Healthcare Preparedness Coalition
        iii. County Contact Information (24/7 Contact Info)
        iv. Anticipated Patient Transportation Request Details (e.g., number of stretcher bound Advanced Life Support and Basic Life Support patients needing transport, number of non-ambulatory patients that could be moved via wheelchair, number of caretakers)

2. *Identified Patients* for placement in an SMSS, upon approval by the county emergency manager or designee, the SMSS Individual Patient Placement Request Form must be entered into the HIPAA Compliant ReadyOp platform. This form is an official request to have the patient accepted and placed in the medical support shelter and officially starts the process for patient placement. For counties that need to place multiple patients, there is a bulk upload Excel template on our website at https://hpp.nc.gov/internal-response-resources/smss-resources/ along with instructions for secure upload into ReadyOp utilizing a Bulk Patient Movement form. All patients must be ready for placement at the time the form is uploaded.
    a. Key Elements needed for ReadyOp SMSS Individual Patient Placement Request Form:
        i. Name of Organization (Name, County, Contact Person, Title, Phone Number)
        ii. Patient Details (Name, Address, Phone, Patient's Date of Birth, Veteran's Status, Weight (lbs.))
        iii. Patient Condition (Primary Diagnosis, Infectious Disease Status)
        iv. Any specialty patient considerations:
            1. Alzheimer's/Dementia, Dialysis, Feeding Tube, IV Medications, Oxygen Dependency, Tracheostomy/Stoma, Ventilator, Wound Vac, Other
        v. Transportation Details:
            1. Type of Transportation: Wheelchair Van - Driver Only (No Attendant), BLS - Basic EMTs (No Specialty Equipment), ALS - Paramedic (Limited Specialty Equipment), Specialty Care Transport - RN/Paramedic (Specialty Equipment), Other
        vi. Notes/Attachments
            1. Feel free to attach any additional information you may have, such as medical history, medications, allergies, concerns about the residence, etc.

Patient Placement:

NCOEMS will assign a Patient Placement Coordinator to oversee the placement of all patients into the SMSS. Depending on the size of the activation and patient movement needs there may be a specific Medical Support Shelter Unit assigned to oversee SMSS specific patient placement.

Receipt of SMSS Individual Patient Placement Request Forms

1. Monitor ReadyOp forms (Section 13 EOP), and email (OEMSSupportCell@dhhs.nc.gov) for individual patient placement request forms and bulk patient movement forms. Excel spreadsheets attached to bulk patient movement forms will need to be imported into ReadyOp to access the individual patient placement request forms inside them.
2. Mark all received patient placement request forms in ReadyOp as **"Pending"** to indicate that the form has been received. The requestor should receive confirmation that NCOEMS is working on the patient placement form within 30 minutes upon entry into ReadyOp.

Review of SMSS Individual Patient Placement Request Forms

1. Review each placement request form utilizing the SMSS Placement Guidance (**found in Appendix G2F: SMSS External Forms & Reference Documents**) to determine/verify that the individual(s) submitted for placement into an SMSS is appropriate. Mark incomplete requests as **"Additional Information Requested"** and follow-up with the requesting agency.
2. Consult with the assigned Medical Provider to resolve concerns or questions about the appropriateness for placement. This may require the reviewer/Medical Provider to contact the submitting organization.
3. Mark all individuals meeting the guidance for Skilled Medical Care placement as **"Accepted, Notification Pending"** within ReadyOp Patient Placement Status section and note which SMSS facility (if multiple SMSS are open) the patient has been placed into along with the date and time patient was placed.
4. Mark all individuals meeting the guidance for *Medical Support* placement (general population shelters) or *Acute Medical Emergency* (hospital) as **"Declined"** within ReadyOp Patient Placement Status section. Notes should be added to explain the reason for declination.
5. Complete an SMSS Patient Intake Report in ReadyOp for every patient accepted for SMSS placement.
    a. Mark Current Status as **"Accepted at Shelter"** and input the patient's DHHS Patient ID, Demographics, and Emergency Contact information.
6. Monitor the SMSS Placement Dashboard in ReadyOp (Section 13 EOP)
    a. Ensure that the Dashboard is updating properly based on the processing of patient placement requests.
    b. Communicate with the Patient Movement Supervisor to address any Patient Placement issues/concerns.

Resolution of SMSS Individual Patient Placement Request Forms (State Coordinated Transport)

Upon notification from the Patient Placement Coordinator that state coordinated transportation is needed (requests marked **"Accepted, Notification Pending"** in ReadyOp), the Patient Transportation Coordinator will review the request and contact the submitting organization to:

1. Notify them that their patient(s) have been accepted for SMSS placement.
2. Verify their need for state-coordinated transport.
3. Collect any additional information necessary for the creation of a transportation mission (e.g., type of transport needed, time, place, point-of-contact, etc.).

Once the need for state coordinated transport and mission details have been verified, the Patient Transportation Coordinator will work to:

1. Assign available and appropriate transportation resources (dedicated or non-dedicated) to the mission.
2. Communicate mission details to the assigned resource.
3. Complete the State Coordinated Transportation Tracking Information portion of the SMSS Individual Patient Placement Request Form.
4. Send confirmation of patient placement status to the submitting organization. The confirmation should include the SMSS location, SMSS IMT contact information, Point-of-Contact, contact information, and estimated time of arrival (ETA) of state coordinated transportation resources to the established patient pick-up point.

Refer to **Appendix D4: Patient Transportation Guideline** for more details.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX D3:

FEDERAL COORDINATING CENTER PATIENT MOVEMENT GUIDELINE

MARCH 2023

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Purpose

The purpose of the North Carolina Federal Coordinating Center Patient Movement Guideline is to establish a standardized framework for patient movement that incorporates lessons learned from real events when the movement of patients is initiated by the activation of a Federal Coordinating Center (FCC). This guideline identifies activation triggers, outlines procedures for triaging and placing patients in appropriate receiving facilities. These guidelines are intended for use in conjunction with the NCOEMS Emergency Operations Plan, Annex D: Patient Movement, Appendix D1 – Hospital Patient Movement Guideline and Appendix D4 – Patient Transportation.

Assumptions

- FCC Activation decision will be a joint decision between NCEM and NCOEMS with engagement from the Statewide Patient Coordination Team.
- A qualifying lead facility will have a transfer center and has been educated/trained to the state Patient Movement Annex and Hospital Patient Movement Guideline.
- A patient's health generally does not improve with relocation. Patient movement may expose patients to additional risks associated with exacerbation of their medical condition, transportation accidents, or in-route delays due to weather, accidents, or secondary events after the originating event/incident.
- Ideally, patients should be stabilized prior to being moved. The capability to effectively stabilize all patients prior to transport may vary based upon medical capabilities, available resources, and impending threats to the patient(s) (e.g., emergency evacuations).
- During the patient movement process, all efforts are directed toward maintaining continuity of patient care across the entire continuum of care.
- All evacuations/patient movements are subject to weather conditions and safety considerations.

Triggers

- The triggers for FCC patient movement begin with an alert of the FCC site which is part of a joint decision between NCEM and NCOEMS. The Statewide Patient Coordination Team will be notified of a potential activation for their concurrence that an activation can be supported. It is anticipated that greater than 48 hours before the initial arrival of patients will allow time to deliberately plan, identify, triage and link patients with appropriate facilities.

Activation Framework

Statewide activation – requires collaboration between NCOEMS, Statewide Patient Coordination Teams, and NCEM to facilitate movement, and activate emergency contracts. If statewide activation occurs, ESF8 will assign a statewide Patient Movement Supervisor to oversee and coordinate all related operations. It is expected that much of the decision to activate this guideline will be based on input from the Statewide Patient Coordination Team with the ultimate decision being made by ESF8 leadership and NCEM.

Procedure

Initiation

Event/Impact

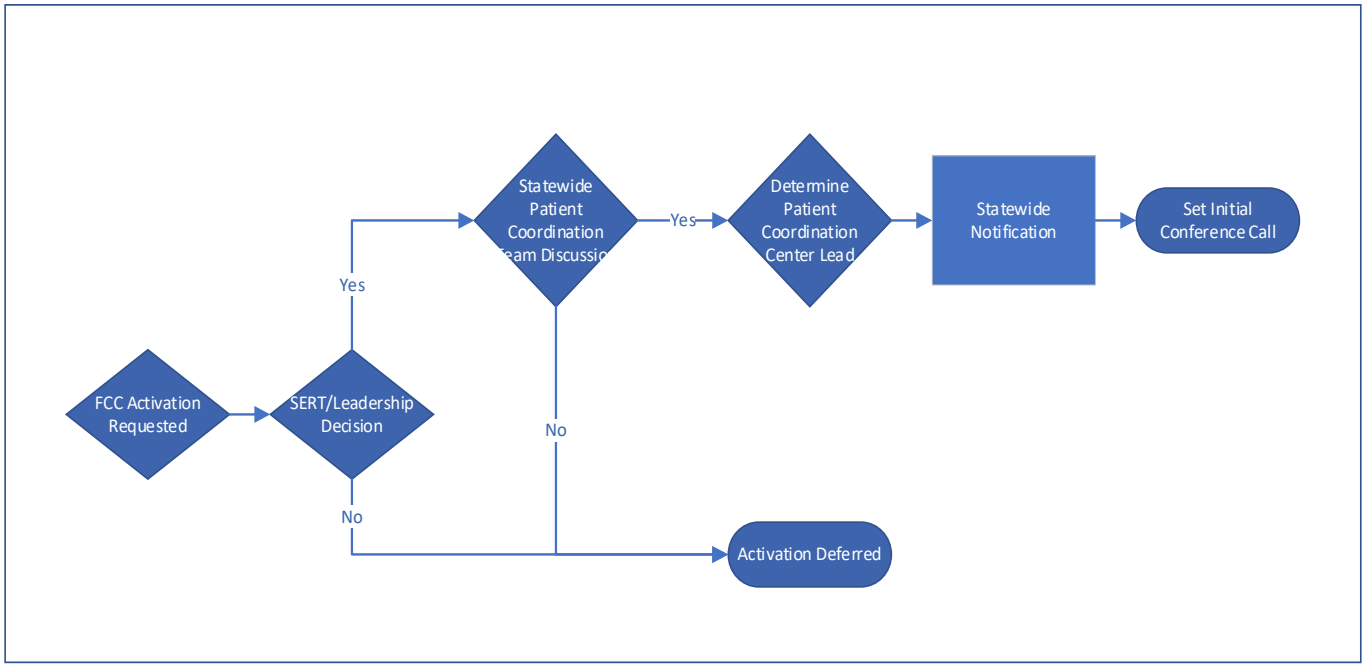
- An incident or event impacts an area outside of North Carolina necessitating the need for patients to be evacuated from that state or territory.
- The Veterans Affairs Area Emergency Manager (VA AEM) requests activation of a North Carolina Federal Coordination Center to the NC ESF8 Shift Duty Officer or ESF8 Lead.
    - Note: North Carolina has two FCCs, one in Salisbury, NC and one in Durham, NC. Both FCCs rely on the Piedmont Triad International Airport. Only one FCC can be activated at a given time.

- ESF8 Lead confers with NCEM Leadership and DHHS Leadership about the FCC Activation request. If concurrence to consider the FCC Activation is reached the Statewide Patient Coordination Team is notified for their input and concurrence.
- Once concurrence is reached the VA AEM is made aware that the FCC can activate.
- Final decision to activate and receive patients will come from the VA AEM once the decision to use that FCC has been determined through their chain of command.

Notification of Activation

- Upon the decision to activate the FCC Patient Movement Guideline:
    - Notification will be made to the North Carolina Healthcare system via the Healthcare Coalitions and the North Carolina Healthcare Emergency Management Council (NCHEMC) list-serv for redundant communications that one of the NC FCCs has been activated.
    - Patient Movement Planning Form should be completed through receipt of information from the VA AEM to begin planning for potential patient movement resources. This information will be shared with the statewide patient coordination team as soon as received.

Chart 2: Approval Flowchart of FCC Activation Guideline by NCOEMS



Implementation

- Patient Bed Reporting – it is anticipated that NC will be asked to provide the VA AEM and ASPR REC with the number of available beds by specific type (e.g., Adult, Pediatric, ICU, Med/Surgery, Psychiatry etc.). Currently bed reporting is completed via the APPRISS critical resource tracker and the Med-Surge Data Team can pull those bed numbers quickly to provide to VA AEM. NC does not track all the identified bed types so it will be limited to Acute Care (not including ICU) and ICU level beds for all ages.
- Receiving Patients - Patients will be sent from the sending facilities to one of the NC FCCs after a decision is made on placement by USTRANSCOM (the DoD patient evacuation agency responsible via the U.S. Air Force's Air Mobility Command team).
- Patient Placement Needs – USTRANSCOM should provide the patient manifest through the VA AEM and/or the ASPR REC. This will allow the patient coordination process to begin.

Patient Placement

- Patient movement to an FCC is determined by USTRANSCOM and provided to the receiving state's ESF8 lead by way of a patient manifest. This manifest should provide details on each patient's condition prior to their arrival and should include the number of patients, patient diagnosis, specialized equipment, types of beds needed, etc.
- The NCOEMS Patient Placement Coordinator or designee will review the patient information and distribute appropriately. Depending on timing these can be uploaded into ReadyOp and the Hospital Patient Movement Guideline followed. If there isn't time to facilitate this process, then the below information will be utilized to help distribute the information and coordination calls will be utilized to facilitate the discussion, placement and movement of these patients.
- The Individual Patient Information is provided to the Patient Coordination Center Lead
    - The Patient Coordination Center Lead will provide the initial and subsequent patient placement requests captured via HIPAA Compliant ReadyOp or via excel spreadsheet as tracked by NCOEMS Patient Placement Coordinator.
- Upon receipt of the patient placement requests, each hospital/health system will review the list to identify the appropriate placement of potential patients based off of current resources, specialties, and bed availability
- ReadyOp or excel spreadsheet will be updated during the coordination calls in real time by NCOEMS Patient Placement Coordinator.

Patient Reception Site

- A patient reception site will be set up at the FCC location for the receipt, triage, emergency treatment, and transport of patients.
- Depending on the number of patients being received, available transportation assets and expected length of the FCC activation a State Medical Support Shelter may be setup to support the FCC Operations. This decision is a joint decision between the ESF8 Lead and the Patient Movement Supervisor in consultation with NCEM.
- The patient reception site will have an Incident Management Team setup to coordinate and oversee operations onsite.
    - The patient movement roles identified in the Patient Movement Annex should be under the operations section with responsibility for the oversight of the roles outlined in that annex.

Patient Tracking

- Patient Tracking will be utilized to monitor and track patients in real-time – patient tracking is the responsibility of the Patient Transportation Coordinator or designee. In large scale events a Patient Tracking Unit may be activated to handle this responsibility. **Refer to Appendix D4: Patient Transportation Guideline for more details on patient tracking.**

Receiving Facility

The receiving healthcare facilities should utilize this checklist, built on lessons learned from previous events, to help preplan and prepare for receiving patients during regional/statewide patient movement

- ✓ Convene stakeholders (may include the patient logistics/transfer center, nursing house supervisors, operational executives, emergency management, transportation, medical director, care management, etc.)
- ✓ Identify facility single point of contact for receiving information and accepting patients
- ✓ Obtain common operating picture and current state of hospital
    - Evaluate capacity
    - Evaluate staffing
    - Evaluate critical supplies and equipment (and PPE)

- ✓ Identify patients that can be discharged, downgraded, or lateraled to increase receiving capacity
  - Determine and activate patient movement, as necessary
  - Patients can be discharged to State Medical Support Shelters if activated to help decompress facility to handle higher level of care patients.
- ✓ Engage affiliate sites, as appropriate
- ✓ Participate in coordination call
  - Review patient list compiled by the state and identify patients that may be an appropriate placement
  - Ensure appropriate clinicians and decision makers are present/available to assist with patient acceptance

Transportation: For the FCC activation there will be a transportation coordinator assigned as part of the Patient Reception Site Incident Management Team. This individual will work the transportation coordinators of the receiving facilities to ensure good communication and coordination for transportation. **Additional information on the transportation coordination for patient movement can be found in Appendix D4 – Patient Transportation Guideline.**

Demobilization

- The deactivation of the FCC Patient Movement Guideline will be determined in consultation with NCOEMS ESF8 Lead, and the Statewide Patient Coordination Team, ASPR RECs and VA Area Emergency Manager based on the current requests for patient movement and the statewide availability of resources.
  -

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX D4:

PATIENT TRANSPORTATION GUIDELINE

MAY 2024

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Purpose

The purpose of the Patient Transportation Guideline is to set forth a standard framework for state coordinated transportation for patients during an incident that overwhelms local resources. Additionally, it will allow maximum efficiency for the movement of patients during an emergency or disaster by having a central point of coordination for all patient transportation.

Assumptions

- EMS Resources referred to in this framework often involve private and public assets that will require reimbursement or payment for services rendered.
- All patient transportation is subject to weather conditions and safety considerations.
- In the absence of a Presidential declaration of a major disaster or emergency, there is no federal reimbursement available for costs associated with state or local patient movement activities and the responsibility for costs resulting from patient movement are primarily the obligation of the sending healthcare facility.

Guidelines

The sending entity is ultimately responsible for providing transportation from the patient's origin to their destination (healthcare facility, medical support shelter etc.). However, it is anticipated that during a large-scale incident there will not be enough local transportation assets to complete patient movement activities without state coordinated transportation support. Early notification when transportation support is anticipated is critical to ensuring enough assets can be coordinated.

Patient Transportation Coordinator:

The NCOEMS Support Cell will assign a Patient Transportation Coordinator to oversee all EMS resources assigned to the OEMS Support Cell. All patient transportation requiring state support from healthcare facilities and/or counties during the activation of patient movement should be coordinated through the Patient Transportation Coordinator or designee. A Job Action Sheet for this position can be found in **Appendix 6: Organization and Assignment of Responsibilities** of the Base Plan. Depending on the size of the activation a Patient Transportation Unit will be assigned under the Patient Transportation Coordinator to complete roles and responsibilities outlined below.

- Roles and Responsibilities for the Patient Transportation Coordinator include:
    - Monitors ReadyOp for Overall Transportation Needs
        - Monitor need for and availability of transportation resources for state coordinated patient movement activities.
        - Communicate with the Patient Movement Supervisor to address any Patient Transportation issues/concerns.
    - Monitors Vetted Individual Patient Movement Request Forms in ReadyOp
        - Verifies the need for State Coordinated Transport with sending entities.
        - Collects information necessary for the creation of an EMS Resource Assignment (e.g., type of transport needed, time, place, point-of-contact, etc.)
        - Assigns available Transportation Resources asset from ReadyOp.
        - Updates the Transportation Method portion of Individual Patient Placement Request forms in ReadyOp.
    - Creates EMS Resource Assignment & Tracking Forms in ReadyOp to initiate transportation missions.
        - Sets tracking details and enters patient assignment and communication information from Individual Patient Placement Request.
        - Marks form as "Assignment Pending" indicating that the mission is ready for assignment and tracking by the Tracking Unit.

Statewide Communication Channel: NCOEMS ESF-8 desk will request a statewide communication channel for transportation assets to utilize for direct communications between the transportation coordinator and the sending/receiving facilities and all transportation assets.

Sending Facilities Transportation Coordinator: Sending facilities should identify a Patient Transportation Coordinator to serve as the main point of contact at the facility to support patient transportation assets with access, direction, and coordination on site. This individual should have access to the statewide communications channel.

Specialty Care Transport (SCT) should be utilized to the extent possible when patient movement involves two healthcare facilities unless it is anticipated that there will not be enough SCT resources to manage all the patient movements in a timely manner. Resource allocation decisions should be made based on the individual patient transfer request forms as determined by the patient transportation coordination team. Ideal hierarchy of available resources is outlined below:

- Sending facility Specialty Care Transport entities should be utilized first when available in an acceptable timeframe to complete patient transport to receiving facilities.
- Receiving facility Specialty Care Transport entities should be utilized second when available in an acceptable timeframe to complete patient transport from sending facilities.
- Any available Specialty Care Transport entity should be utilized third when available in an acceptable timeframe to complete patient transport between sending/receiving facilities.
- Non-Emergency Transportation entity should be utilized fourth when available in an acceptable timeframe to complete patient transport between sending/receiving facilities.
- 911 EMS System assets should only be utilized when no additional transportation resources are available in an acceptable timeframe to complete patient transport between sending/receiving facilities.

911 EMS System assets should be utilized when patient movement is from a non-healthcare facility (such as a scene or large-scale community incident). Ambulance Buses are also commonly utilized as an effective way to move patients during an emergency or disaster. This can include healthcare facility transport (as outlined above) and medical support shelter transportations.

Dedicated Transportation Assets When transportation assets have been obtained specifically for the incident, (Emergency Transportation Contracts, Local EMS Resources, Emergency Management Assistance Compact (EMAC), Federal Ambulance Contracts etc.) as commonly seen during an anticipated activation, these assets should be used first and foremost to decrease the impact on the daily operational assets. The available transportation asset(s) will be updated and monitored in ReadyOp Transportation Resources Status Board to ensure visibility of available assets throughout the activation.

Non-Dedicated Transportation Assets: Are assets that cannot agree to being utilized specifically for the incident (911 resources, Non-Emergency Transportation Units etc.) but are available to run one specific mission to help with patient movement. Non-dedicated transportation assets will require approval through WEBEOC as they have not been previously approved in most cases. This can be done by number of missions being requested or by transportation entity as one request in WEBEOC. The non-dedicated transportation asset(s) will be updated and monitored in ReadyOp Transportation Resources Status Board during each mission available.

Patient Tracking The patient tracking unit is responsible for ensuring that all patient movement activities are tracked. The primary location for this tracking is in the EMS Resource Assignment & Tracking form in ReadyOp. The patient tracking unit picks up the tracking process when the form shows “Assignment Pending.”

- The Tracking Unit is responsible for notifying the assigned EMS Resource via Radio/Phone that they have been assigned a mission and provide the details of the mission.
- The EMS Resource Assignment & Tracking form with associated URL is emailed to the assigned EMS Resource to provide written confirmation of mission assignment and for completion of status changes during mission assignment.
- The EMS Resource Assignment & Tracking form is updated under the Resource Status to "Assigned."
- Upon finishing the assignment, the EMS Resource should notify the patient tracking unit via phone/radio to confirm their status.
- Once mission is complete the tracking unit updates three forms:
    - Individual Patient Placement Form
        - Mark State Coordinated Transport Complete
    - Transportation Resources Form
        - Update unit status (Available, Out of Service, Demob etc.)
    - EMS Resource Assignment and Tracking Form
        - Change Status to Completed
        - Archive Completed Entry

Anticipating Resources

It is important to anticipate when/if additional resources may be required for ongoing patient movement activities. This can be driven by the patient movement planning forms and/or awareness of patients in healthcare facilities or medical support shelters that will need repatriation. Identifying additional resources and receiving them in staging can take 24-72 hours depending on where the resources are coming from so the earlier this can be anticipated and requested the more successful the patient movement operation.

Repatriation

When patient repatriation transport support is requested from an original sending entity the following considerations should be considered.

Repatriation Resource Planning Factor: Estimates for the number of transportation resources needed to support repatriation operations from a location (e.g. SMSS, MDH, hospital, etc.) should be based on the percentage of patients at those facilities for which NCOEMS patient movement resources were used to transport them there. For example, NCOEMS patient movement resources were used to transport 20 of 100 patients sheltered at an SMSS, or 20%. The number of patients that may need repatriation can be estimated to be 20% of the patient census.

Transportation Support for Repatriation Operations: Repatriation requests requiring state-assisted transport from a county, healthcare facility, or ESF8 operational area (SMSS/MDH) will be routed to and managed by the NCOEMS ESF8 unit most appropriate to the situation.

- ESF8 Desk: All healthcare facility repatriation missions. If the number of missions exceeds bandwidth of the desk, then the support cell can be activated to support.
- SMSS IMT: Repatriation missions involving SMSS patients.
- MDH IMT: Repatriation missions involving MDH patients.

Regardless of the type of request for repatriation, the management of these requests by the responsible NCOEMS ESF8 unit will closely follow established patient movement processes but include the update of repatriation-specific sections of patient movement forms in ReadyOp to effectively manage the process from request to mission close-out.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX F:

SITUATIONAL AWARENESS & INFORMATION SHARING

OCTOBER 2023

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Purpose

The purpose of the Situational Awareness and Information Sharing annex is to provide a framework for how the North Carolina Office of Emergency Medical Services (NCOEMS) maintains situational awareness and coordinates information sharing with partners in a timely manner across the Healthcare System in North Carolina. Maintaining day to day situational awareness regarding potential threats that may impact the healthcare system, threats that have impacted the healthcare system, and ensuring this information is shared appropriately is a key component to the mission and goals for NCOEMS role as Disaster Medical Services. This annex provides a standard process and mechanism for gathering, analyzing, and ultimately sharing critical situational awareness to healthcare partners during an incident or event.

Assumptions

- This annex is intended for use in conjunction with the NCOEMS Emergency Operations Plan.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for ESF8, Disaster Medical Services, and is responsible for providing situational awareness and sharing information across the healthcare system on a day-to-day basis.
- Detailed information may not be available immediately following an incident resulting in the need to prioritize the most critical pieces of information early on and gather more in-depth details as the incident progresses.
- Healthcare Organizations are autonomous entities and choose what information to share with NCOEMS.
- Transparency and proactive communication are essential for accurate situational awareness and maintaining trust with partners is key to ensuring good situational awareness.

Concept of Operations

Activation

- The NCOEMS Shift Duty Officer SOG, EOP Appendix 1 from Emergency Operations Plan, outlines a 24/7 process for maintaining situational awareness and sharing information across the healthcare system every day. It also outlines the process for activation of the NCOEMS Emergency Operations Plan (EOP). Upon activation of the EOP, the Situational Awareness & Information Sharing Annex will simultaneously be activated as a core component of the coordination, collaboration and communication required to respond to any emergency or disaster that may impact the healthcare system.

Notification

- Initial notification of the activation of the NCOEMS EOP to healthcare partners is considered situational awareness and information sharing therefore no additional notifications shall be required.

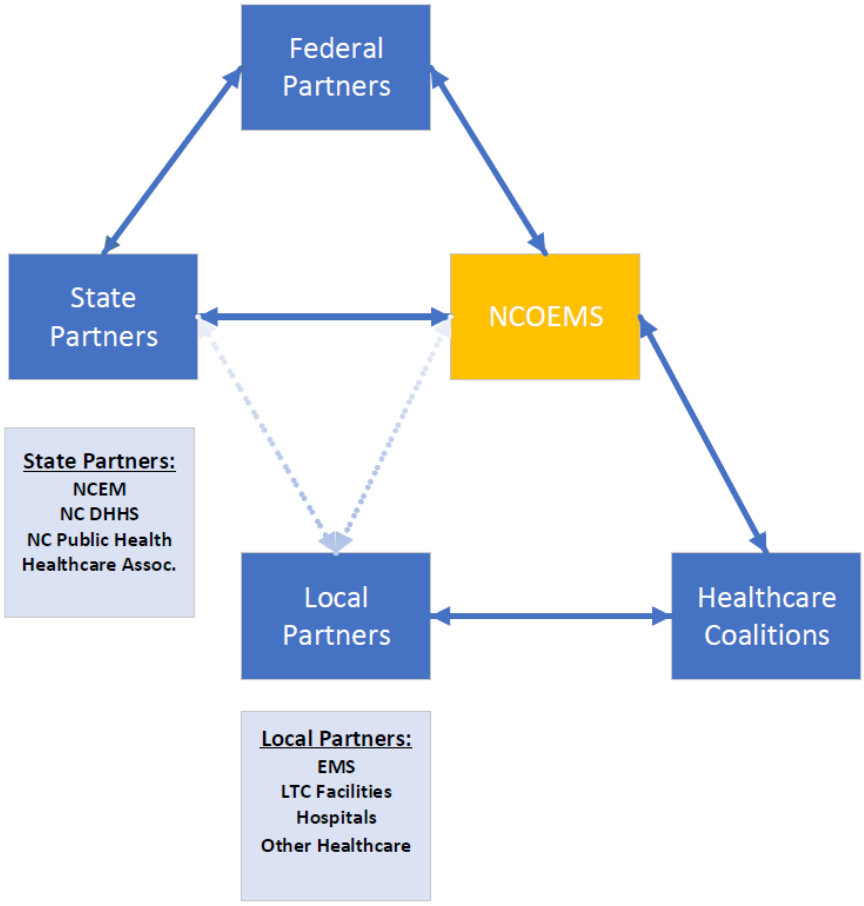
Situational Awareness

Purpose: Situational awareness is defined as maintaining knowledge of what is going on around you or your agency. In the context of this annex, specifically if impacts have occurred or are anticipated to occur to the healthcare system, the primary purpose of sharing the information is to provide an early warning. Providing initial and ongoing situational awareness can allow federal, state, regional and local healthcare partners to initiate preparedness and response actions, such as identifying potential resources, activating staff, turning on emergency contracts, and making decisions on patient evacuations etc. For the most effective situational awareness a low threshold for sharing information should be utilized by all healthcare entities and local, regional, state, and federal partners (see triggers outlined below).

Process: The process for maintaining situational awareness is based on bidirectional communication between federal, state, regional and local partners. Communications regarding real or potential impacts to the healthcare system should flow from local partners (county emergency management and/or healthcare partners), to Regional Healthcare Preparedness Coalitions (HCCs), to NCOEMS, to other state partners (NCEM, NCDHHS, Healthcare Associations etc.), and to federal partners (ASPR Regional Emergency Coordinators) as applicable. Other state and federal entities (NCEM, NCDPH, Healthcare Associations, ASPR RECs etc.) have their own established communication channels so many times the communications may flow laterally or top-down (see Figure 1.1 Situational Awareness Communications Diagram). NCOEMS has the responsibility to maintain and provide situational awareness to the North Carolina Healthcare System (e.g., EMS Agencies, Long-Term Care Facilities, Hospitals, Dialysis Centers etc.) through the Regional Healthcare Preparedness Coalitions which is a key facet of the bidirectional communication.

Process Exceptions: In some circumstances, NCOEMS will make the decision to communicate directly to the local partners. This is most commonly due to a need for expediency, privacy concerns and/or the regional HCC staff being overwhelmed. Additionally, the local healthcare partner emergency managers and/or emergency preparedness coordinators may contact NCOEMS directly. These two exceptions should be considered rare occasions and not the primary method of communication. The final exception in this process, which is more common, is when a local partner (e.g., county emergency manager, local public health department etc.) will contact a state level partner (e.g., NCEM, NC DPH etc.) directly to notify them of the situation and these state level partners will notify NCOEMS. All efforts will be made to ensure the HCC staff are aware of the communications when possible. Process exceptions are outlined in Figure 1.1 by the dotted lines showing these occasional alternate pathways of communication.

Figure 1.1 Situational Awareness Communications Diagram:



Information Sharing

Purpose: Information Sharing is a key component of ensuring that situational awareness is maintained by the many partners and stakeholders to the North Carolina Healthcare System. Information sharing is defined as the ability to share healthcare system related status updates and essential elements of information to maintain a common operating picture and pertinent healthcare system data.

Process: The process for information sharing relies on bidirectional communication between federal, state, regional and local partners. This may be in the form of situation reports, data collection and reporting, coordination calls and individual discussion between partners.

Secure Info: Information regarding potential or real impacts to the healthcare system should be considered secure messages in most circumstances. NCOEMS will utilize one of the following methods to ensure the messages are handled appropriately:

- *For Official Use Only* (FOUO): This marking on a document or email shows that the information is unclassified but considered controlled information. This marking can be used when sensitive information is being shared to indicate that it cannot be shared beyond those on initial distribution unless specifically authorized in the notification. Additionally, this information should not be posted or shared publicly.
- *Homeland Security Traffic-Light Protocol* (TLP): This protocol helps ensure sensitive information is not inappropriately shared and will be utilized to ensure messages that should have limited distribution have a standard system for identification. Information shared should have the TLP labels, outlined below, in subject lines and the body of notifications.
    - TLP: RED: Should be utilized when information cannot be effectively acted upon by additional parties, and could lead to impacts on a party's privacy, reputation, or operations if misused. Recipients may not share TLP: RED information with any parties outside of the specific exchange, meeting, or conversation in which it is originally disclosed.
    - TLP: AMBER – Should be utilized when information requires support to be effectively acted upon, but carries risk to privacy, reputation, or operations if shared outside of the organizations involved. Recipients may only share TLP: AMBER information with members of their own organization, and only as widely as necessary to act on that information.
    - TLP: GREEN – Should be utilized when information is useful for the awareness of all participating organizations as well as with peers within the broader community or sector. Recipients may share TLP: GREEN information with peers and partner organizations within their sector or community, but not via publicly accessible channels.
- *Encryption:* Information that could potentially contain sensitive information (such as Protected Health Information or PHI) must be sent via a HIPAA compliant platform or via encrypted email (as last resort) to ensure that the information is properly handled.
- *Specific Groups:* Information that is allowed to be distributed but is intended for a specific subset of partners (e.g., Hospital Emergency Managers) should have the group specifically identified in the notification to provide awareness to the Healthcare Preparedness Coalitions who the intended audience is for distribution. If the information is not marked with FOUO or TLP specifically then the HCCs can choose what audience to distribute the message but at a minimum the identified audience should receive the email as soon as possible.
- *HIPAA Compliant Information Sharing platforms*: NCOEMS maintains several HIPAA complaint platforms for use during an emergency. The below list outlines the systems used by NCOEMS and denotes whether they are considered HIPAA compliant or not.

- NCSPARTA – WEBEOC: Not HIPAA compliant
- NCTERMS: Not HIPAA compliant
- OWNCLOUD: HIPAA compliant
- READYOP: HIPAA complaint

Methods: NCOEMS maintains a variety of methods for sharing information with healthcare partners for the purpose of maintaining situational awareness during an event. Each of the below sections describes different tools used to share pertinent information.

- *Website:* NCOEMS maintains two different websites with pertinent information and updates: http://hpp.nc.gov and http://oems.nc.gov
- *Coordination Calls:* NCOEMS utilizes a variety of coordination calls to ensure the bidirectional sharing of information can occur during an activation. Typically, the calls will be based on the operational period (e.g., 24 hours operational period will have one coordination call per day). The frequency of calls is the decision of the NCOEMS ESF8 Lead & NCOEMS Operations Manager. Coordination call types may include the following:
  - NCOEMS Staff
  - NCOEMS & Operational Sites
  - NCOEMS & NC Regional Healthcare Coalitions
  - NCOEMS & Statewide Patient Coordination Team
  - NC Regional Healthcare Coalitions & Healthcare Coalition Partners
  - NCOEMS and NC Healthcare Associations/Partners/Stakeholders
  - Region IV Unified Planning Coalition
- *Email Groups & List-Servs:* NCOEMS maintains a variety of email groups and list-servs to help ensure continuity of operations during an activation. These email addresses and list-servs hit a group of people to ensure the information is shared even when certain staff are off-duty. Primarily outgoing information is sent via ReadyOp but there are email groups and list-servs that can be utilized to share information with staff and partners:
  - dhsr.ncoems.sdo@dhhs.nc.gov – this email group goes to all NC HPP Shift Duty Officers (SDOs) – anyone can send a message to this group email.
  - dhsr.ems.esf8@dhhs.nc.gov – this email group goes to all NCOEMS deployable staff – anyone can send a message to this group email.
  - hppsystemssupport@dhhs.nc.gov – this email group goes to the HPP Systems Support Team and can be used for system support requests (e.g., ReadyOp, WEBEOC, iCAMs etc.) – anyone can send a message to this group email.
  - dhsr.oems.regional.hpp@lists.ncmail.net – this list-serv goes to all Regional Healthcare Preparedness Coalition Staff and Leadership. All NC HPP SDOs have the ability to send messages via this list-serv.
  - OEMSSEOC@dhhs.nc.gov – this email group is used for any staff working at the State Emergency Operations Center during an activation.
  - oemssupportcell@dhhs.nc.gov– this email group is used for any staff working in the OEMS Support Cell during an activation – anyone can send a message to this group email.
  - oemspatientmovement@dhhs.nc.gov– this email group is used for any staff working as part of the OEMS Patient Movement team during an activation – anyone can send a message to this group email.
  - oemsstaffingsupport@dhhs.nc.gov– this email group is used for any staff working as part of the OEMS Staffing Support team during an activation – anyone can send a message to this group email.

Situation Reports

Written situation reports are crucial to providing key stakeholders and partners with information about the incident/event that has resulted in the EOP activation. The frequency of the situation report is the decision of the NCOEMS ESF8 Lead & NCOEMS Operations Manager but is typically once per operational period. The use of a situation report during an activation is to provide standard formatting to use when reporting information to stakeholders, partners, and leadership entities.

Guidelines

The below information is considered a guideline to completion and dissemination of situation reports during an activation of the NCOEMS EOP. The ESF8 Lead has ultimate oversight of the situation report to include the frequency, content, and distribution list. This may change depending on the cause of the EOP activation.

Collection of information:

A situation report is required for all operational areas (e.g., Support Cell, MDH, SMSS etc.). The SEOC ESF8 Desk Manager has the responsibility of collecting the information from operational areas, and pertinent partners (e.g., HCCs) to compile the full situation report and present it to the ESF8 lead or designee for approval.

ReadyOp is the primary system used to collect the information necessary for the completion of the situation report.
The following items are considered the minimum information to gather for a situation report:

1. Name of person completing the form
2. Operational Period Date & Time
3. Number of Staff Activated
4. Overall Status (e.g., No Change, Improving, Worsening)
5. Mission Assigned
6. Total number of patients impacted by mission (e.g., number of patients moved, number of patients sheltered, number of patients treated etc.)
7. Current Operations Summary
8. Critical Issues / Needs

Distribution of Information:

Once the situation report has been complied and approved it should be shared with the following groups:

1. NCOEMS Staff
2. Regional Healthcare Preparedness Coalition Staff
3. NCEM Operations Section (via the Emergency Services Lead)
4. Primary Stakeholders and Partners (as identified in the ReadyOp Partner Contacts Group)

Essential Elements of Information

Essential Elements of Information (EEIs) are a standard set of data elements that are collected pre-incident and post-incident to provide information on healthcare partner's state of readiness, resource availability, known gaps, and impacts to their infrastructure, services, patient load, and staff. There are several core purposes to the collection of EEIs:

1. Provide information before an incident on the elements that will be expected from partners to allow systems, processes, and preparedness activities to be set up to ensure the information can be provided.
2. Minimize collecting and reporting burden from various state and federal agencies that frequently request information on status from healthcare facilities and agencies.
3. Provide transparent data to drive decision making (ESF8 monitoring, potential resource needs, potential operational posture etc.)
4. Improve bi-directional information sharing.

NCOEMS will maintain an active link to the Pre-Incident and Post-Incident Essential Elements of Information on the website (https://hpp.nc.gov/internal-response-resources/essential-elements-of-information/). This information is available through a static link on that site for use by any of the Healthcare Coalition staff to share with partners.

It is recommended that annually each hospital in North Carolina provide an updated Pre-Incident EEI form as a preparedness activity. This can be done during exercises, blue sky days, or at the request of their Healthcare Coalition. Post-Incident EEI forms may be completed by any hospital in North Carolina following an emergency or disaster incident. Typically, Post-Incident EEIs will be required of hospitals that are in an impact area (e.g., a specific region, set number of counties, only one county etc.) and the request for those EEIs will be sent from the ESF8 Lead or designee.

If a federal disaster declaration has occurred, it is anticipated that ASPR Regional Emergency Coordinators will request the pre and post incident EEI forms for the identified area as part of their routine reporting requirements. When this situation occurs, an email notification will go out from the ESF8 lead or designee, indicating that the EEIs are required, providing the website link where the forms can be completed, and providing a set time each day that the forms are required. It is anticipated that 12pm each day will be the deadline for reporting to align with the ASPR requirements.

Information collected through the Essential Elements of Information forms is intended for use only by disaster response staff involved in the incident at the local, regional, state, and federal level. Inappropriate use or distribution of this information could result in a decrease in number and/or a lack of transparency when completing the data collection request.

Typically, EEI requirements involve a survey to healthcare facilities to determine the following:

1. Census
2. Number of Beds (different types depending on facility type i.e., inpatient vs. outpatient)
3. Patient Treatment Status
4. Structural Damage
5. Evacuation Type
6. Evacuation Status
7. Reentry Status
8. Power Status
9. Generator Fuel Status
10. Generator Fuel Type
11. HVAC Status
12. Water Supply Status
13. Dialysis Status (if applicable)
14. Sewer Status
15. Immediate Needs

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX G:

HEALTHCARE SERVICES IN SHELTERS

AUGUST 2023

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Introduction

North Carolina has experienced multiple natural disasters that resulted in the need for local and state government to provide shelter for residents and guests who evacuated or were displaced from their homes. Many of these individuals have requirements that necessitate unscheduled or continuous healthcare services to assist them in maintaining their usual level of health and avoid hospitalization.

Disaster incidents stress the existing healthcare delivery system due to several factors: an increasing number of patients receiving advanced medical care at home; an expanding number of individuals with chronic medical conditions; and minimal hospital surge capacity during normal conditions. Based on these identified risks, this plan outlines the methods for providing displaced individuals access to healthcare services in state-operated shelters to ensure the safety of all sheltered individuals while attempting to minimize the surge on the healthcare system.

Purpose

The purpose of the North Carolina Office of Emergency Medical Services (NCOEMS) Healthcare Services in Shelters plan is to provide the framework for healthcare services in state-run shelters. This framework outlines the NCOEMS method to ensure individuals seeking shelter at state-run sites have access to the proper healthcare services and are supported in the appropriate setting for their individual healthcare needs to maintain their usual level of health.

Scope

NCOEMS will coordinate healthcare services for state-run shelters. Requests for county level support with healthcare services are considered on a case-by-case basis and are a secondary mission to state-operated shelters.

Situation

During emergencies and disasters, circumstances can occur where state support is required to shelter the public. Primarily this happens when large areas of a community containing homes and healthcare facilities are temporarily deemed unsafe and local populations are asked to evacuate and/or healthcare facilities become overwhelmed and are unable to provide their usual level of service. In these situations, it is anticipated that state assistance to establish and manage shelter operations will be requested.

Planning Assumptions

The following planning assumptions were made during the development of this annex:

- Sheltering is first and foremost a local responsibility.
- All coordination for state-operated sheltering will be accomplished through the State Emergency Response Team (SERT).
- State-Operated sheltering refers to state efforts to provide emergency shelters, feeding, water, disaster human services, medical services, and preliminary case management for shelter residents.
- North Carolina Office of Emergency Medical Services (NCOEMS) is the lead agency for Disaster Medical Services and is responsible for the maintenance, planning, coordination, and execution of the NCOEMS Shelter Medical Services Annex
- NCOEMS is responsible for providing medical services in state-operated shelters through the coordination of medical staffing and medical supplies.
- This annex will be used in conjunction with the NCOEMS Emergency Operations Plan
- The framework outlined in this plan can be used for all types of state-operated sheltering scenarios regardless of the examples provided in this plan.

- Healthcare services in state-operated shelters require ample notice and early warning to provide time to activate and coordinate staff and supplies.
- An individual's health may not improve within sheltering operations. Sheltering operations may expose individuals to additional risks associated with exposure to new environments, living near unfamiliar people, the exacerbation of existing medical conditions, or other stresses after the originating event/incident.

Concept of Operations

Activation

- The ESF8 Lead has the authority to activate this annex in consultation with North Carolina Emergency Management. This decision is informed by local and regional partners when there is an immediate or anticipated need to shelter individuals beyond what the local resources can manage.
- Activation is usually initiated by an official request for sheltering support to the SERT. However, this annex may be activated prior to or during any event where there is an anticipated need for state-operated support for sheltering.

Notification

- Upon activation of this annex, the ESF8 lead, or designee is responsible to ensure notification to all State Medical Response System partners and North Carolina Department of Health & Human Services (NC DHHS) leadership and other organizations essential to the ability to provide healthcare services during sheltering operations. In these situations, it is likely that the NCOEMS EOP has already been activated and much of the internal notification and coordination with State Medical Response System (SMRS) organizations has occurred.
- If the healthcare services within sheltering operations are expected to impact other states and/or are anticipated to be overwhelmed, the HHS Region IV Unified Planning Coalition (UPC) and Administration of Strategic Preparedness and Response Regional Emergency Coordinators (RECs) should be notified as well in anticipation of Emergency Management Assistance Compact and/or Federal resource requests.

NCOEMS Sheltering Support Concepts

State Sheltering Support: State sheltering should be considered a last resort when all other options, such as sheltering at homes, hotels, local shelters, or other facilities is no longer an option. Jurisdictions in need of sheltering support should encourage residents to bring whatever medical supplies (e.g., pharmaceuticals, durable medical equipment, oxygen, etc.) and support (e.g., caregivers) they usually rely on with them. Healthcare facilities in need of sheltering support should be prepared to send staff, equipment and supplies with the patients.

Healthcare Services in Shelters: A key component to sheltering operations is providing healthcare services to ensure that sheltered individuals can maintain their usual level of health and avoid hospitalization. Two different levels of service are provided in state-operated shelters to provide the most appropriate attention to sheltered individuals to meet this objective.

- Coordination of Healthcare Services: All state-operated shelters provide the coordination of healthcare services by delivering medical triage, physical health assessments, basic life support, assistance with administering a patient's medications, managing durable medical equipment, and managing consumable medical supplies. The utilization of telemedicine services, pharmaceutical coordination and dialysis coordination will be key components of these services. Any individual requesting to stay in a shelter providing this level of service, regardless of their medical situation, should be accommodated within

that site or provided support to receive the necessary care at an appropriate location. For more details refer to **Appendix G1 - Healthcare Coordination in State-Operated Shelters**

- Provision of Healthcare Services: In North Carolina a limited number of State Medical Support Shelters can be set up to provide shelter for individuals requiring specialized healthcare attention due to a disruption in their community healthcare support system. These locations can be expected to provide physician led medical care for non-acute/non-infectious patients from home requiring 24/7 skilled nursing care, (e.g., ventilator patients, tracheotomy requiring suctioning, extensive wound management, stable dysrhythmia monitoring/management, bedridden and total care etc.). All individuals being sheltered in a State Medical Support Shelter must be triaged and accepted into the location by NCOEMS. Individuals that are accepted into a State Medical Support Shelter must agree with the placement into that site. For more details refer to **Appendix G2 - State Medical Support Shelter Plan.docx**

Medical Screening for Sheltering: To determine the best level of care, an individual medical screening during the placement and/or intake process of individuals seeking shelter must be utilized to ensure the most appropriate care is provided. This screening should include an assessment for unmet medical needs, symptoms of an infectious disease, or acute medical need. Individuals that require a higher level of healthcare services than can be provided at that shelter location should be referred for placement into the most appropriate location for their healthcare need. For additional information refer to Tab G2F: SMSS Placement Guidance.

Shelter Management: The management of state-operated shelters will follow Incident Command System (ICS) guidelines for Incident Management Teams (IMTs). The ESF8 lead will assign an NCOEMS staff member to be part of the IMT. NCOEMS has the authority and direct oversight for all healthcare services provided in state-operated shelters and is responsible for providing the ESF8 lead situation reports specific to healthcare services.

Personnel: Detailed roles and responsibility information about each of the NCOEMS coordinated staff positions in state-operated shelters including job action sheets, are provided in the operational plans for each shelter type. The role of NCOEMS within the IMT will depend on the level of healthcare services provided.

- Coordination of Healthcare Services: For shelters providing coordination of healthcare services, NCOEMS will have the responsibility of Healthcare Services Operations and all staff assigned to that branch. These positions may be filled through the SMRS.
- Provision of Healthcare Services: For State Medical Support Shelters, NCOEMS has the responsibility for identifying all staff working in this type of shelter. At least one position on the IMT will be filled by NCOEMS staff, additional positions may be filled through the SMRS.

Establishment of Shelter Operations: State-operated shelters require extensive coordination and support from NCOEMS, NCEM, and other organizations. To safely establish shelters, requests should be made as early as possible prior to the impact of any anticipated incident (e.g., hurricane) and alternatively, may not be able to be acted upon until safe conditions have returned following unanticipated events (e.g., tornado). The time necessary to establish these shelters will vary depending on multiple factors but for planning purposes a time factor of 24 to 72 hours should be considered with 24 hours representing perfect situations where all necessary facilities, services, assets, personnel, and weather are available and 72 hours representing less than perfect situations where the readiness of one or more of these elements hinders progress.

Transportation: The responsibility for the transportation of individuals to state-operated shelters is primarily the responsibility of the individual seeking shelter or the sending entity (e.g., county, healthcare facility etc.). Medical transportation assets needed to move individuals to a State Medical Support Shelter can be requested as part of the SMSS placement process. Once individuals are sheltered, EMS resources should be available for healthcare needs requiring additional treatment at a healthcare facility or if they have health issues that require routine maintenance (e.g., dialysis treatment). Non-medical transportation resources should be sought and

utilized to transport individuals whose health condition allows it. For details regarding patient transportation, refer to NCOEMS Annex D Patient Movement and its appendices.

Repatriation and Demobilization of Shelter Operations: When state-operated shelters are ready to demobilize, repatriation is the responsibility of the original sending entity. Factors that are considered in the decision to demobilize include the precipitating danger has passed, local capacity is restored, or shelter operations need to cease. Sheltered individuals are usually released back to their homes (if deemed safe by local authorities). If sheltered individuals cannot return home, they should be repatriated to a locally run shelter, to temporary housing, or to a healthcare facility depending on each unique situation. Support with medical transportation assets to repatriate individuals is outlined in NCOEMS Annex D Patient Movement and its appendices.

APPENDIX G1: Healthcare Coordination in Shelters
August 2023

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Purpose

To outline the operations for Healthcare Coordination in state-operated shelters, (SOS) established by the State Emergency Response Team, for the purpose of ensuring the continuity of healthcare for sheltered individuals.

Scope

Provides the activation, notification, and responsibilities for healthcare coordination in shelters by the North Carolina Office of Emergency Medical Services, (NCOEMS). It should be used in conjunction with the NCEM State-Operated Sheltering Guide and the NCOEMS Emergency Operations Plan.

Situation

Activation of this plan is most likely to occur when the State Emergency Response Team (SERT) has determined the need for state-operated shelters to be opened. NCOEMS has the responsibility to provide healthcare coordination in these shelters.

Planning Assumptions

- The provision of healthcare services to sheltered populations is essential to maintain their usual level of health during circumstances which are stressful and conducive to the spread of illness. These services provide a continuity of care and maximize the possibility of good health outcomes for sheltered individuals

- The healthcare needs of sheltered populations will include individuals, with or without accompanying caretakers, that need some assistance to maintain their usual level of health including those that are:
    - Oxygen dependent
    - Self-ambulating, with or without Durable Medical Equipment (DME), including wheelchair
    - Deaf/Hard of hearing and blind/low vision, with or without assistive devices
    - Diabetes, insulin and diet-controlled
    - Hypertension-controlled with medication
    - Respiratory illness (such as COPD)
    - Morbidly obese
    - Pregnancy requiring bedrest
    - Dialysis patients

- The bulk of healthcare services required to maintain the usual level of health for sheltered populations will involve on-site basic life support and first aid. The coordination of other healthcare services such as pharmaceutical, telemedicine, dialysis services, and transportation to healthcare services outside the shelter will also be necessary to avoid a change in their usual level of health.

Concept of Operations

Activation

- The ESF8 Lead has the authority to activate this appendix in consultation with North Carolina Emergency Management. The decision is based on the activation of a general population state-operated shelter.

Notification

- Will follow the same responsibilities and processes outlined in the NCOEMS Healthcare Services in Shelter Annex.

Responsibilities:

- Provide an NCOEMS liaison to participate as a member of each SOS Incident Management Team (IMT) as a Healthcare Services Supervisors.

- Provide Healthcare Service Coordination within the SOS Healthcare Services Branch including, but not limited to:
    - On-Site Basic Life Support and First Aid
    - Telemedicine Coordination
    - Pharmaceutical Coordination
    - Dialysis Coordination
    - Medical Transportation
    - Medical Logistics

- Providing staffing for these services by whatever means practical to include agency personnel, county personnel who volunteer to deploy via NCOEMS and out-of-state personnel via EMAC to serve under the Healthcare Services Supervisor in the roles of Healthcare Services Coordinators and Healthcare Services Workers

- Ensuring that personnel identified to meet staffing requirements complete required training, licensing, or credentialing as prescribed by NCOEMS

- Tracking and reporting status of all resources assigned to healthcare support services as requested by the SERT

State-operated Shelter capacities:

The configuration of a SOS is flexible and tailored to accommodate up to 2000 individuals based on the available space and scope of incident. Staffing levels are based on three different tiers:

- Up to 500 sheltered individuals
- Between 501 - 1000 sheltered individuals
- Between 1001 - 2000 sheltered individuals

Staffing

NCOEMS has the responsibility to ensure appropriate levels of healthcare staff are at established state-operated shelters to properly coordinate healthcare services.

For the SOS Healthcare Branch, staffing will include the following positions as outlined in the North Carolina State-Operated Shelter Guide:

- Healthcare Services Supervisor
- Healthcare Services Coordinators
- Healthcare Service Workers

The number of individuals needed to fill these positions will be dictated by the operational situation and the size of shelter being established, however, the initial number of recommended healthcare services staff are based on the NCEM North Carolina Sheltering Guide, Appendix A.

For up to 500 sheltered individuals:

Position	**# Personnel Day**	**# Personnel Night**
Healthcare Services Supervisor	1	1
Healthcare Services Coordinator	3	1
Healthcare Services Worker	2	2

Between 501 – 1000 sheltered individuals:

Position	**# Personnel Day**	**# Personnel Night**
Healthcare Services Supervisor	1	1
Healthcare Services Coordinator	3	1
Healthcare Services Worker	8	6

Between 1001 – 2000 sheltered individuals:

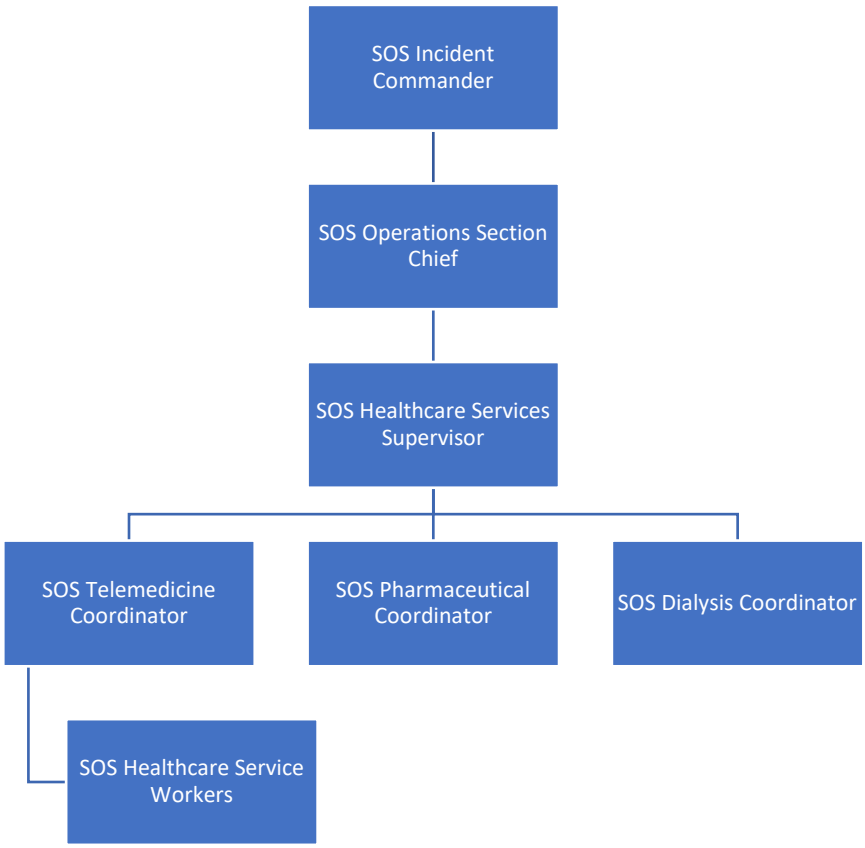
Position	**# Personnel Day**	**# Personnel Night**
Healthcare Services Supervisor	1	1
Healthcare Services Coordinator	3	1
Healthcare Service Workers	12	9

These requirements are detailed further under **SOS Medical Branch Job Qualification and Action Sheets**.

Personnel designated to fill these positions may serve in a variety of functional roles necessary to fulfill the responsibilities of the Healthcare Services Branch and will be primarily sourced from personnel affiliated with State Medical Response System (SMRS).

- Healthcare Services Supervisor
- Healthcare Services Coordinators
    - Telemedicine Coordination
        - Healthcare Service Workers
    - Pharmaceutical Coordination
    - Dialysis Coordination

Healthcare Services Branch Organizational Chart



Healthcare Services Coordination

Healthcare Services Supervisor – Responsible for overseeing all healthcare services coordination including assignments of staff and communication with Shelter Manager and larger Incident Management Team about supply needs and healthcare needs.

Telemedicine Coordinator – Coordinates the delivery of telemedicine services to sheltered individuals within the SOS. This may include assisting them with scheduling and use of the services available.

Healthcare Service Workers – Provide medical triage, physical health assessments, basic life support, assistance administering a patient's medications, assistance managing durable medical equipment, and assistance managing consumable medical supplies.

Pharmaceutical Coordinator - Assists sheltered individuals with coordination of pharmaceutical support outside the SOS. This may include assistance with the replacement and delivery of prescription medications.

Dialysis Coordinator - Assists sheltered individuals with coordination of dialysis services outside the SOS. This may include coordination with the ESRD Network 6 (https://www.esrdncc.org/en/network-6/) to support scheduling of appointments and transportation (medical or non-medical) to these services.

Medical Transportation **–** Provides transportation to local emergency departments and other healthcare facilities to sheltered individuals when medically necessary. Consists of, at minimum, one Basic Life Support ambulance.

Medical Logistics **–** Provides a limited inventory of medical supplies including durable medical equipment (DME) to Healthcare Services Branch staff for the purpose of meeting the needs of sheltered individuals. If the appropriate medical supplies are not available on-site, works with the Medical Lead and the SOS Logistics Section Chief to facilitate the ordering and delivery of needed medical supplies following established procedures.

Personal Medical Supplies (pharmaceuticals, devices, etc.) **–** Sheltered individuals for whom medications, devices, and supplies have been prescribed, may bring those items necessary for health maintenance with them to the shelter. These items will remain under the ownership and cognizance of the individual(s) to whom they belong.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

APPENDIX G2:

STATE MEDICAL SUPPORT SHELTER

AUGUST 2023

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Purpose

To provide direction for the establishment and operation of State Medical Support Shelters (SMSS) so the continuity of healthcare is maintained for individuals with medical conditions requiring active monitoring and management by a credentialed medical professional during emergencies and disasters.

Scope

This plan covers the selection, staffing, activation, operation, and management of SMSS by the North Carolina Office of Emergency Medical Services (NCOEMS) as well as the expected roles and responsibilities of other state, regional and local emergency response organizations. It should be used in conjunction with the NCOEMS Emergency Operations Plan and the NCOEMS Annex G Healthcare Services in Shelters.

Situation

Activation of this plan is most likely to occur when the State Emergency Response Team (SERT) has determined the need for a state medical support shelter to be opened due to an emergency or disaster impacting or expected to impact the daily health care delivery system. NCOEMS has the responsibility for the oversight and management of these shelters.

Planning Assumptions

- Each day the health care delivery system (e.g., home healthcare, clinics, hospice, medical offices, skilled nursing facilities, and hospitals) provides a comprehensive range of healthcare care to the residents and guests of North Carolina. However, during a disaster there can be a temporary loss of capacity or capability to provide needed healthcare services.
- Temporary loss of community healthcare supports (e.g., home healthcare, clinics, hospice, and medical offices) result in a medical surge on the already stressed healthcare delivery system (e.g., EMS, long-term care facilities and hospitals).
- In many cases individuals can maintain their usual level of health in a temporary residence (e.g., hotel, shelter, and relatives' home) with minimal healthcare support required. However, some individuals will require a specialized level of medical care to maintain their usual level of health and avoid hospitalization.
- Depending on the size and scope of disaster, the initial SMSS Incident Management Team (SMSS IMT) and SMSS personnel may not receive additional support (e.g., equipment, supplies, and personnel) for up to 72 hours.
- SMSS operations require local, regional, and state coordination for medical equipment, medical supplies, personnel, adequate facilities and may need up to 72 hours of preparation time prior to opening.
- SMSS staffing is dependent on volunteerism from the State Medical Response System (SMRS) or other state and federal healthcare providers.

Concept of Operations

Activation

The ESF8 Lead has the authority to activate this appendix in consultation with North Carolina Emergency Management. The decision is based on the identified need to provide care to individuals who:

- Have non-acute/non-infectious health conditions requiring a higher level of medical skill or resource than can be provided in a general population shelter;
- Have a reasonable expectation of requiring a higher level of medical care to maintain their usual level of health after evaluation by a medical professional (e.g., telehealth or EMS); or
- Have been discharged from an in-patient healthcare facility after receiving stabilizing medical care and a medical provider is requiring a higher level of medical skill or resource than can be provided in a general population shelter.

Processes for the activation and deployment of SMSS assets differ depending on whether the incident is an anticipated incident (e.g., hurricane) or an unanticipated incident (e.g., radiological release).

- For anticipated incidents, to meet the mission safely and effectively, the initial planning and placement of SMSS should be determined in anticipation of potentially affected areas and coordinated through the NCEM and NCOEMS in coordination with regional and local partners.
- For unanticipated incidents the process begins with a request from the State Emergency Response Team (SERT).

Notification

Will follow the same responsibilities and processes outlined in the NCOEMS Healthcare Services in Shelter Annex.

SMSS Capacities

The configuration of an SMSS is flexible and tailored to accommodate different numbers of patients depending on the size of the facility. Ideally an SMSS would be set up for a minimum of 50 patients and could go up to 200+ based on the space availability, staffing levels, equipment and supplies available. If there is an expectation that there will be less than 25 patients needed to shelter in an SMSS then alternative options should be considered (e.g., placement in long-term care facilities).

Placement Considerations

Placement considerations for the initial planning and placement of SMSS:

- The emergency (e.g., likely storm track and affected areas);
- Factors that support the key mission goals (e.g., safe proximity from affected area, infrastructure to support, and operational within the requested time); and
- Location of adequate available facilities (**Tab G2F: Facility Checklist**).

NCOEMS, with input from NCEM, will determine locations for SMSS placement. Coordination with NCEM-Operations should include confirmation through Human Services (ESF6) that separate general population sheltering operations are established to serve the placement location.

Staffing and Organization

NCOEMS has the responsibility to ensure appropriate levels of staff are at established State Medical Support Shelters to properly provide healthcare services. At a minimum, one NCOEMS staff member

will be part of the Incident Management Team. All other positions can be filled through the SERT or SMRS.

Staffing for an SMSS will include the following functional areas:

- SMSS Incident Management Team (IMT)
- SMSS Personnel (i.e., non-clinical and clinical staff); and
- SMSS Logistics (e.g., logistics staff, equipment, and supplies).

The number of individuals needed to fill these positions will be dictated by the operational situation and the size of shelter being established, however, the initial number of recommended staff are outlined below with additional details provided in **Tab G2A: SMSS Staffing Levels, Roles, and Responsibilities**

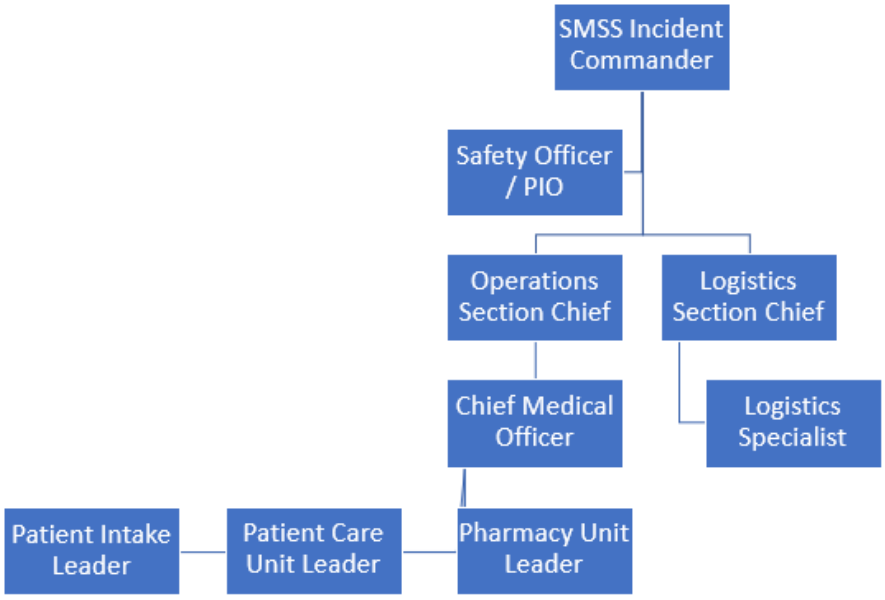
For 50 Sheltered Patients:

Position	# Personnel Day	# Personnel Night
Incident Commander	1	1
Operations Section Chief	1	0
Safety / Public Information Officer	1	1
Logistics Chief	1	1
Logistics Specialist	1	0
Case Worker	2	0
Total Administrative	**7**	**3**

Position	# Personnel	# Personnel
Chief Medical Officer	1	0
Advanced Practice Provider	1	1
Respiratory Therapist	1	1
Pharmacist	1	1
Registered Nurse	6	6
Paramedic	6	6
Medical Worker*	10	5
Total	**26**	**20**

* Medical Worker is defined as any level of healthcare provider to include Certified Nurse Aid, Certified Medical Assistant, Emergency Medical Technician or any higher level of certification or licensure.

Figure 1.1: SMSS Organization Chart for up to 50 patients:



External Partner Support: To determine what support is needed per SMSS location and mobilize those resources NCOEMS staff will:

- Contact identified SMSS host facility owners to activate existing Memorandum of Agreements (MOAs) and verify space and services available.
- Coordinate with local and state Emergency Management:
    - To identify the locations of "general population" sheltering operations established to serve the affected area(s). General shelters outside an affected county (state-supported) may satisfy this need; and
    - Secure law enforcement, fire safety, and other "wrap-around" logistical support that is not provided by the facility and cannot be provided otherwise.
- Coordinate with Division of Public Health (NCDPH) to verify and/or establish available support for environmental health and mortuary services.
- Coordinate with appropriate patient transport resources to verify and/or establish medical and non-medical patient transportation capability.
- Coordinate with local healthcare organizations (e.g., ESRD and Behavioral Health) to verify and/or establish access to patient care services.

Refer to **Tab G2B: SMSS Site Requirements and Support Services** and **Tab G2F: SMSS Services Checklist** for specific support service requirements.

Placement of Patients in SMSS: To ensure that healthcare capabilities are adequate to care for individuals directed to SMSS, potential patients' medical support needs must be evaluated prior to transport. The SMSS Patient Movement Guideline (**Appendix D2, Annex D: Patient Movement, NCOEMS EOP**) details the process of patient movement to SMSS locations. The process is summarized here:

- Organizations considering the placement of patients who have or will be disrupted are expected to evaluate individuals seeking SMSS placement based on Medical Support Shelter Placement Guidance, see **Tab G2F: SMSS Placement Guidance .**
- Organizations submit completed SMSS Individual Patient Placement Request Forms into ReadyOp for all patients that meet the guidance for SMSS placement.
- The assigned NCOEMS Patient Placement Coordinator monitors ReadyOp for patient placement request forms.
- Patient Placement Coordinator ensures the review of the forms to verify that SMSS placement is appropriate and updates the status of each request as one of the following:
    - Pending (review in progress)
    - Additional Information Requested (request incomplete)
    - Accepted, Notification Pending (request verified and SMSS facility is available)
    - Declined (request not verified)
- If additional information is requested or the patient has been declined it is the responsibility of the Patient Placement Coordinator or designee to reach out to the sending entity for disposition.
- For each patient accepted, the Patient Placement Coordinator creates an SMSS Patient Intake form in ReadyOp (completes at a minimum the first/last name and county of residence info) for the SMSS to which the patient is assigned (forms are shelter-specific).
- Request forms marked **Accepted; Notification Pending** are processed by the assigned Patient Transportation Coordinator. This involves notification to the sending entity that the patient has been accepted and determines mode of transportation to the SMSS.

SMSS Site Operations

Facility Pre-Operation Survey/Inspection**:** Upon arrival at the activated SMSS, the SMSS Incident Commander and the Host Facility Liaison will conduct a joint inspection of the areas of the facility that will be utilized for the SMSS operations. The purpose of the survey is to:

- Document the initial condition of the facility and facility equipment designated for SMSS use, and ensure they are ready or identify necessary corrections prior to use.
- Ensure that the facility can be properly secured against weather and unauthorized entry, and that areas that are not to be used for SMSS operations are secured and clearly identified as off limits.
- Identify and verify the locations in the facility where the various medical and logistical units and areas will be set up to ensure they are conducive to efficient patient flow.

Area/Unit Staffing, Check-In, and Set-Up**:** As staff assigned to the SMSS arrive on site, they are expected to check-in and report to the SMSS IMT to receive their work assignments. Initial check-in will involve completion of an SMRS Staff Registration Form, to record essential information, and an SMRS Check-In/Check-Out Log, to maintain accountability of all personnel on site. Both forms will be site specific

and will be maintained in ReadyOp by staff assigned to the Registration Desk. Following check-in, the SMSS IMT will identify staff to fill available medical and logistical areas and unit leader positions, work with area and unit leaders to fill available staff positions, and brief available staff on the chain of command and current situation.

The initial set-up of the SMSS is very labor-intensive and assistance from local fire and EMS agencies may not be available. For that reason, Healthcare Coalitions (HCC) tasked with providing the Logistics Team must ensure that adequate numbers of staff are activated and deployed for this purpose. Once set-up is completed, these team members may be demobilized unless they have also been tasked to work in the SMSS. Details covering staffing for set-up can be found in **Tab G2A: SMSS Staffing Levels, Roles, and Responsibilities.**

Once staffing is complete, all SMSS area and unit leaders and staff should begin setting up their various functional areas and medical units as planned to include proper exterior and interior signage. Standard SMSS functional areas and medical units are listed under SMSS Medical Operations below. To guide set up, SMSS unit and area leaders and staff should refer to:

- **Tab G2F: SMSS Patient Flow** for initial patient flow into the SMSS;
- **Tab G2C: SMSS Site Set-Up Considerations** for area-specific operation guidelines;
- **Tab G2F: SMSS External Forms & Reference Documents** for forms utilized throughout the SMSS; and
- **Tab G2G: SMSS Job Action Sheets** for the specific job duties of each position in the SMSS.

Arrival of Patients**:** Security personnel should direct all incoming potential patients to the Waiting Area. Assigned Patient Intake staff will look up each patient's SMSS Patient Intake Form in ReadyOp, use the form to complete patient registration, evaluate the patient's condition, and determine appropriate placement within the SMSS patient care area.

Buses should be directed to a designated SMSS Drop-off Area near the SMSS main entrance if possible. Individuals in private cars who need assistance should be allowed to unload at the Drop-off Area. Non-medical volunteers should be utilized, when possible, to assist with parking cars in designated areas.

SMSS Medical Operations

General**:** Medical operations in the SMSS encompass the following functional units and areas:

- Patient Intake (e.g., waiting, initial, triage and registration);
- Patient Care (e.g., patient care, emergent care, and isolation areas); and
- Pharmacy

Functional descriptions of these areas are provided in **Tab G2C: SMSS Site Set-Up Considerations** and specific staffing requirements are provided in **Tab G2A: SMSS Staffing Levels, Roles, and Responsibilities**.

Medical Direction**:** Once the SMSS becomes operational, it shall be the duty of the Chief Medical Officer (CMO) to provide medical direction for the shelter, maintain a shelter census, evaluate the

conditions of patients, and to recommend healthcare staffing level adjustments as appropriate. The CMO directs healthcare operations providing treatment orders and approving medical procedures.

Patient Intake Leader: The SMSS will have a patient intake leader who is responsible for the initial triage and assignment of patients into individual patient care units. Qualified medical personnel will serve this role but Paramedics with supervisory experience are recommended for the position.

Patient Care Unit Leader**:** Each SMSS unit will have a patient care unit leader who is responsible for the overall operation of their unit including suggesting staffing adjustments. Qualified medical personnel will serve this role but Registered Nurses (RN) with emergency department/intensive care unit and supervisory experience are recommended for the position.

Caregivers**:** Caregivers include RNs and Paramedics not in supervisory positions as well as CNAs, certified home health aides, home health aides, EMTs, personal care attendants, nursing aides. These individuals will be assigned an area to work in and may work under the supervision of an RN/Paramedic as appropriate.

Pharmacist/Pharmacy**:** The assigned Pharmacy Unit Leader and pharmacy technicians will be responsible for the proper storage, security, and distribution of pharmaceuticals in the SMSS. The SMSS pharmaceutical cache may be deployed through supporting hospitals and/or pharmacies (e.g., CVS, Wal-Mart, etc.) in the vicinity of the SMSS. At a minimum, a lockable room with a safe and a small refrigerator should be provided for the storage of narcotics and pharmaceuticals requiring controlled temperatures as necessary. Patients and/or their care givers should disclose all prescribed medications during the intake process. New medications may be ordered while at the SMSS.

Social Service/Discharge Planning**:** When an SMSS is activated, it is necessary to have a social worker or case manager on staff. This is to allow efficient referrals and placement of the patients. These individuals must understand the SMSS operations and disaster medicine.

On Call Specialists**:** There may be a need for onsite or on call specialist such as Hospice workers, Dietitian, Mental Health specialist, and others.

Patient Transportation: At a minimum, at least one fully staffed ambulance will be at the SMSS location and available 24/7 to support at the SMSS operations.

Levels of Care: The level of care provided at an SMSS should not exceed the level of staff skills and resources available. Medical providers that are assigned to an SMSS are operating under an emergency situation and should exercise reasonable care and judgment to assure patient safety. Any person who presents or develops the need for a level of care beyond that which can be provided at a medical shelter should be transported to an appropriate medical facility or the care/resource required should be requested from NCOEMS so that care can continue at the SMSS.

The following is a list of reasonable expectations for the levels of care being provided for at an SMSS. Individuals should agree with placement in an SMSS and should never be sent against their will even if their condition is outlined below.

1. Individuals who require active monitoring, management, or intervention by a medical professional to maintain their normal level of health.
    a. Patients from home requiring 24/7 skilled nursing care
    b. Hospice Patients from home
    c. Ventilator Patient
    d. Tracheotomy which requires suctioning
    e. Extensive Wound Management
    f. Stable Dysrhythmia monitoring/management
    g. Bedridden and total care required.
    h. Individuals who have been evaluated by a medical professional and deemed necessary for care at a medical support shelter to maintain their normal level of health.

Organization and Assignment of Responsibilities

The successful establishment, maintenance, and operation of SMSS requires close coordination and planning between NCOEMS, HPCs, NCEM, SMSS facility owners, local emergency management, local healthcare, and many other organizations. To facilitate these efforts, planned roles and responsibilities for these organizations have been identified and listed below and identified by phase in the emergency management process as applicable: Preparedness, Response, Recovery, and Mitigation.

Internal Support Organizations:

NCOEMS:

- Preparedness
    - Support the identification of facilities suitable for SMSS operations.
    - Establish Memorandum of Agreements (MOA) with facilities (SMSS Facilities) identified as suitable for SMSS operations.
    - Develop and maintain plans for SMSS operations.
    - Establish and maintain personnel to provide SMSS IMT support.
    - Coordinate with NCEM for the provision of logistical support necessary to establish and maintain SMSS operations.
    - Coordinate with the IPRO ESRD Network 6 for the provision of dialysis services for SMSS patients.
    - Coordinate with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) for the provision of behavioral health support for SMSS personnel and patients.
    - Support SMSS/SMSS IMT training for NCOEMS/HCC personnel through the Healthcare Coalitions.
- Response
    - Provide strategic and tactical oversight and support of SMSS operations through the:
        - Planned activation of SMSS appropriate to the situation;
        - Deployment of personnel to establish SMSS IMTs; and

        - Deployment of EMS resources for medical transportation.
    - Coordinate with local Emergency Management agencies through the SMSS IMT or SEOC ESF8 Desk concerning:
        - Location(s) of general population shelters;
        - Vetting of evacuees prior to transport to SMSS facilities to ensure available SMSS services are appropriate; and
        - Availability and provision of public transportation resources to assist with SMSS patient access to non-emergency health services.
    - Coordinate with partner agencies through the SMSS IMT or SEOC ESF8 Desk to provide necessary support services to the SMSS (e.g., fire/safety inspection, sanitary inspection (e.g., food, environmental, laundry), food service, waste management, and janitorial services).
    - Support and coordinate, as necessary, the resupply of medical and non-medical supplies to active SMSS operations
    - Coordinate with response partners to meet the immediate operational needs of activated SMSSs (e.g., NCEM for logistical support, IPRO ESRD Network 6 for dialysis services, DMHDDSAS for behavioral health services).
- Recovery
    - Conduct Hot Wash/After Action Reviews of SMSS operations with SMSS IMT to gather information on strengths, opportunities for improvement, and recommendations for future SMSS operations.
- Mitigation
    - Conduct or support activities addressing identified opportunities for improvement of SMSS operations (e.g., installation of transfer switches to ensure uninterrupted power supply, etc.)

External Support Organizations:

Healthcare Coalitions (HCC):

- Preparedness
    - Coordinate with local emergency management agencies within region to identify facilities suitable for SMSS operations, facilitate communication with local services (EMS, Fire, Police), and identify services that may be available to support the SMSS when opened.
    - Coordinate with local health and medical agencies (Public Health, hospitals) within region on the location(s) of facilities suitable for SMSS operations and identify services that may be available to support the SMSS when opened.
    - Establish and maintain personnel to support initial SMSS set-up, staff SMSS medical or logistics support teams, and support the SMSS IMT.
    - Participate in the development of the SMSS Operations Plan and ensure that personnel are familiar with it.
    - Establish and maintain SMSS Logistics Package, including pharmaceutical cache.
    - Establish plans for and provide resupply of medical and non-medical supplies to active SMSS operations through Lead Hospitals, Healthcare Coalitions, and NCOEMS
    - Provide SMSS and SMSS IMT training for NCOEMS and HCC personnel.
- Response

- Provide medical or logistics teams to support SMSS operations.
- Provide personnel to support initial SMSS set-up and SMSS IMT staffing.
- Provide initial SMSS Logistics Package, including pharmaceutical cache.
- Support and execute resupply of medical and non-medical supplies to active SMSS operations through Lead Hospitals, Healthcare Coalitions, and NCOEMS

- Recovery
  - Participate in Hot Wash/After Action Reviews of SMSS operations with SMSS IMT to gather information on strengths, opportunities for improvement, and recommendations for future SMSS operations.
- Mitigation
  - Conduct or support activities addressing identified opportunities for improvement of SMSS operations (e.g., improvement of patient tracking systems, upgrade of patient care equipment and supplies, etc.)

SMSS Facilities**:**

- Preparedness
  - Maintain close coordination with NCOEMS/HCC on the on-going maintenance, changes in structure or function, and operational readiness of facilities identified for SMSS operations.
  - Maintain designated shelter areas and services so they remain adequate in the area and function as planned:
    - Patient and medical treatment areas;
    - Utilities (e.g., electric, water, and sewer);
    - Common areas (e.g., restrooms, storage areas, and meeting rooms);
    - Other areas, if provided (e.g., sleeping areas, loading and dock areas, shower facilities, laundry facilities, and kitchen and dining areas);
- Response
  - Upon notification of activation, make notifications to facility support staff and initiate actions to prepare the facility for use as an SMSS as per the SMSS Site Operations Plan and MOA (e.g., inspect, remove, and/or relocate facility equipment and/or supplies).

NCEM:

- Preparedness
  - Participate in the development of the SMSS Operations Plan
  - Assist with the establishment and support of SMSS facilities through coordination with NCOEMS and local Emergency Management agencies.
- Response
  - Support the establishment and operation of identified SMSS facilities through the provision of logistical support that may include but not limited to:
    - Food services (e.g., K&W) and staff lodging and billeting;
    - Shower/bathroom facilities/trailers
    - Power generation/back-up (e.g., generators);
    - Medical and non-medical equipment and supplies (e.g., Hill-Rom);
    - Security services (e.g., ALE, DOI, and State Parks);
    - Environmental (e.g., janitorial) services;

- Laundry and linen services;
- Waste management services (e.g., trash and medical waste pickup)

Direction, Control, and Coordination

General**:** Activation of this plan will be the responsibility of NCOEMS. Once SMSS resources have been deployed the designated SMSS Incident Management Team (SMSS IMT) will provide the primary direction, control, and coordination function for established SMSS operations. NCOEMS staff, acting from the State EOC or NCOEMS Support Cell as part of the State Emergency Response Team (SERT), will provide strategic planning and support to those operations.

Chain of Command: A clearly defined chain of command is necessary to ensure continuity of operations. The chain of command should be based on the knowledge, skills, and abilities of individuals and the established disaster response structure. The planned chain of command for SMSS operations will follow the established ICS structure with an Incident Commander, Operations Chief, Planning Chief etc.

SMSS IMT**:** All members of the established SMSS IMT report through the chain of command up to the SMSS Incident Commander. In coordination with the SMSS Incident Commander (SMSS IC) SMSS IMT members will manage their assigned functional areas and, as necessary, will assist the SMSS IC with opening and closing of the SMSS, external reporting, personnel staffing decisions, the receipt, storage, and disbursement of equipment and supplies, and the establishment of site security.

Operational Schedule & Situation Reporting: All SMSS IMTs will follow the operational schedule provided below for operational activity and situation reporting. This schedule details personnel work shifts and times when briefings and conference calls will occur and when Situation Reports will be produced. The SMSS Planning Section Chief will manage the operational schedule.

SMSS Operational Activity/Reporting Schedule **Shift 1: 0700 – 1900 - Shift 2: 1900 – 0700**	
0700	SMSS Situation Report due in ReadyOp. Start Shift 1, end Shift 2.
1100	NCOEMS Conference Call with SERT ESF8 Desk Representative, NCOEMS regional staff, Healthcare Preparedness Coordinators, SMRS Incident Management Teams, and other essential ESF8 partners as the incident situation requires (optional).
1900	SMSS Situation Report due in ReadyOp. Start Shift 2, end Shift 1.

The SMSS IMT should participate in NCOEMS coordinating calls and submit situation reports to the SERT ESF8 Desk according to the established schedule. ReadyOp will be utilized for situation reporting when available and appropriate.

Patient Medical Records: All medical records of patients are considered confidential information and shall be safeguarded by the SMSS staff. SMSS staff will utilize shelter specific SMSS Patient Intake Forms (provided in ReadyOp) and other forms, as appropriate, to create and update patients' medical records as needed. Upon demobilization all patient records will be collected by the SMSS IMT and

provided to NCOEMS leadership for maintenance and storage. Refer to **Tab G2F: SMSS External Forms & Reference Documents**.

Security, Safety, and Management of Non-SMSS Personnel: It is the responsibility of the SMSS IMT through the Safety Officer and Security Unit Leader to ensure that the areas and units in and around SMSS operations are safe and secure. To meet these goals, **Tab G2D: SMSS Security Guidelines** **&** **Tab G2E: SMSS Safety Guidelines** have been developed to assist these individuals and the SMSS IMT with the development of SMSS site-specific security plans.

General Security Notifications

- Situations involving the potential for violence or other actions taken by staff, patients, or visitors which may be harmful to them, others, or disrupt SMSS operations should be reported to SMSS IMT and security personnel immediately. In turn, the SMSS IMT should make notification to the SERT ESF8 Desk as soon as possible. These actions will not be tolerated and may result in removal from the SMSS by security personnel. Under no circumstances should SMSS staff attempt to diffuse potential violent situations
- Other emergency situations (e.g., fire, flood, loss of power, loss of HVAC, etc.) or situations which escalate to an emergency (e.g., partial loss of power/HVAC) should be reported by the SMSS IMT to the SERT ESF8 Desk as soon as they are recognized.

Electronic Devices and Privacy: The use of cell phones, tablets, laptops, and personal gaming systems are permitted in an SMSS. However, when using devices, SMSS staff, patients, and visitors are expected to alert others before taking pictures and/or video in the event they do not want to be in the photo and/or video and not to post any pictures and/or videos that include other individuals without those individuals' written consent.

Weapons*:* Weapons are not allowed in SMSSs. Individuals with weapons will be asked by SMSS Security Officers to secure them in the individual's vehicle. If that is not an option, Security Officers may secure the weapons in their law enforcement vehicle.

Visitors: Access to the SMSS by visitors and the media is allowed but may be restricted or cancelled by the SMSS IMT or Chief Medical Officer if deemed to be detrimental to SMSS operations or the health outcomes of patients. Upon arrival all visitors must sign in at the SMSS Registration Desk to provide identification, explain the reason for their visit, and await an appropriate escort if necessary. Once visitors are approved for entry, Registration Desk staff will inform the SMSS IMT. Visitors will be given a visitor pass which allows them access to specific designated areas only. If visitors require escort, the SMSS IMT will assign staff for escort duty. During their visit, all visitors will be treated in a kind and courteous manner. However, actions taken by visitors which disrupt SMSS operations will not be tolerated and may result in removal. The visitor Waiting Area should not interfere with SMSS operations.

Types of Visitors:

- Family and Friends of Patients: Family and friends are allowed access to visit once the visit is approved by the patient and the CMO. Depending on the condition of the patient, the CMO may restrict or not allow patient visits. Once the visitors have been identified, Registration Desk staff will confirm approval through the CMO. Visits should be limited to avoid

disrupting ongoing SMSS medical operations while being respectful of all who may want to visit. For that reason, no more than 2 visitors will be allowed per visit and visits will be time-limited at the discretion of the CMO.

- Host Facility Personnel: These are individuals that may work in or otherwise utilize areas of the Host Facility that are not being utilized for SMSS operations. These individuals must check-in at the SMSS Registration Desk and should only be allowed into operational SMSS areas and units if it is related to their work or they must pass through to get to their part of the Host Facility. Registration Desk staff will assign an escort in coordination with the SMSS IMT.
- Volunteer Organizations: These are individuals representing organizations that may want to provide support to some aspect, medical or non-medical, of SMSS operations. They must be vetted and approved by staff at the SERT ESF8 Desk or Support Cell prior to arrival and should arrive in duty uniform, with appropriate and current identification. If not, they should not be allowed access until they have been approved. Once approved, Registration Desk staff will direct them to their assigned work area or unit as provided by the SMSS IMT. They should not require an escort.
- VIPS and Media: Visits by these individuals must be vetted and approved by staff at the SERT ESF8 Desk or Support Cell prior to arrival. They should present them with appropriate and current identification. If not, they should not be allowed access until they have been approved. Once approved, Registration Desk staff will assign an escort in coordination with the SMSS IMT. Visits should be limited to avoid disrupting ongoing SMSS medical operations while being respectful of all who may want to visit. For that reason, no more than 2 visitors will be allowed per visit and visits will be time-limited to no more than 30 minutes at a time.

Media**:** The management of media coverage at SMSS operations and interaction with SMSS staff will be coordinated through the NC DHHS Office of Communications in conjunction with the ESF8 Desk or NCOEMS Support Cell. The ESF8 Desk or NCOEMS Support Cell should coordinate and communicate media requests directly with the SMSS IMT. Media visits may be further restricted or cancelled at any time at the discretion of the SMSS Incident Commander and/or the Chief Medical Officer due to patient privacy and patient safety. All personnel present in a SMSS should sign the DHHS Media Release Form prior to allowing media to enter the operational area according to policy. If media presents directly to an SMSS site and has not coordinated through the ESF8 Desk or NCOEMS Support Cell and/or the NC DHHS Office of Communications, the SMSS IMT should immediately contact the ESF8 Desk or NCOEMS Support Cell for guidance and direction.

- Security personnel will escort media members to and from designated parking areas and notify the SMSS ICP that media are on campus. SMSS IMT staff will notify the SERT ESF8 Desk of the visit.
- Media members will be asked to sign in at the SMSS Information Area and wait for an escort in an area that does not interfere with the SMSS operations. If the weather or conditions permit, the media may be asked to wait outside.
- The privacy rights of the staff and patients in the SMSS are to be observed, and media personnel should only be allowed to access areas of the SMSS that do not interfere with anyone's rights or with the SMSS operations. If the media wish to interview patients or staff in the SMSS, the SMSS IMT may ask for volunteers, but no one is required to provide an interview.

- All media releases must be approved by SERT ESF8 Desk in conjunction with DHHS Communications prior to release.
- Media visit information will be included in the SMSS situation reports to the SERT ESF8 Desk.

Communications

SMSS Communications Plan (ICS-205): Upon establishing operations the SMSS IMT will submit any information necessary for the development and update of the ICS-205.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2A:

SMSS STAFFING LEVELS, ROLES, AND RESPONSIBILITIES

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General Guidelines:

Staff Preparedness: All activated staff should ensure their families and property are prepared prior to deployment. Appropriate pre-deployment preparedness activities include:

- Securing their home;
- Planning for family members/service animals during their activation;
- Locating the personal supplies that should be needed during the activation;
- Ensuring that any vehicles and/or equipment they should need are operational and that any supplies they may need during the event are on hand.
- Reviewing the SMSS Operations Plan so they are familiar with their roles and responsibilities.

Report for Duty: All assigned staff should report for duty, in duty uniform, with appropriate and current identification, and ready to work. Upon arrival at the SMSS, all staff will report to the Staff Registration Desk for check-in and assignment to their work area/unit.

Work Hours: SMSS staff members should not be scheduled to work for more than 12 consecutive hours in a 24-hour period.

Standards: Medical/health professionals should only perform those duties consistent with their level of expertise and only according to North Carolina professional licensure laws, regulations, and protocols.

Staffing Reports: The SMSS IMT must estimate the SMSS patient load and report the staffing requirements above their on-site capabilities to the SERT ESF8 Desk in accordance with the established operational schedule.

Staff Rotation: Persons who staff a shelter should be rotated every five to seven days on a regular basis. However, rotations should be staggered or phased to prevent the complete turnover of operational staff at one time**.** The Chief Medical Officer is responsible for developing and managing the staffing plan and should keep the Operations Section Chief informed of staffing plans, and unmet needs.

Staffing Levels:

Up to 50 patients:

Position	# Personnel Day	# Personnel Night
Incident Commander	1	1
Safety / Public Information Officer	1	1
Operations Section Chief	1	0
Logistics Chief	1	1
Logistics Specialist	1	0
Case Worker	2	0
Total Administrative Staffing	**7**	**3**

Position	# Personnel Day	# Personnel Night
Chief Medical Officer	1	0
Advanced Practice Provider	1	1
Respiratory Therapist	1	1
Pharmacist	1	1
Registered Nurse	6	6
Paramedic	6	6
Medical Worker*	10	5
Total Medical Staffing	**26**	**20**

* Medical Worker is defined as any level of healthcare provider to include Certified Nurse Aid, Certified Medical Assistant, Emergency Medical Technician or any higher level of certification or licensure.

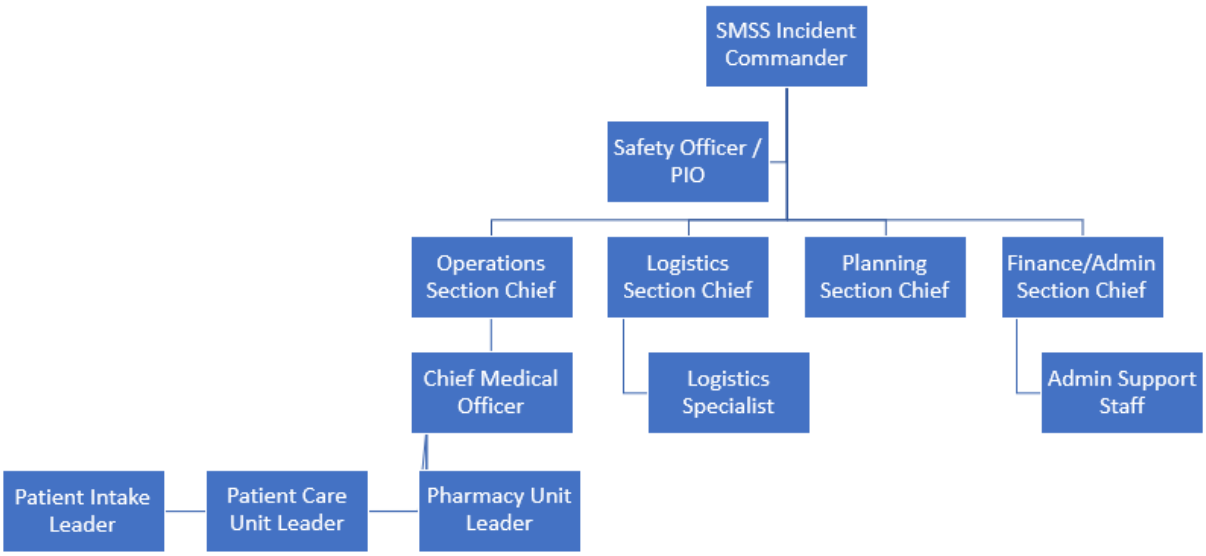
51+ patients: The medical staffing chart will be adjusted based on the need and number of patients assigned. Likely an increase in Medical Workers will be needed with each additional 25 patients added to a census.

Position	# Personnel	# Personnel
Incident Commander	1	1
Safety / Public Information Officer	1	1
Operations Section Chief	1	1
Logistics Chief	1	1
Planning Section Chief	1	0
Finance/Admin Section Chief	1	0
Communications Unit Leader	1	0
Logistics Chief	1	1
Logistics Specialist	1	1
Admin Support Worker	1	0
Case Worker	4	0
Total Administrative Staffing	**14**	**6**

Position	# Personnel Day	# Personnel Night
Chief Medical Officer	1	0
Advanced Practice Provider	1	1
Respiratory Therapist	1	1
Pharmacist	1	1
Registered Nurse	6	6
Paramedic	6	6
Medical Worker*	16	16
Total Medical Staffing	**32**	**31**

* Medical Worker is defined as any level of healthcare provider to include Certified Nurse Aid, Certified Medical Assistant, Emergency Medical Technician or any higher level of certification or licensure.

Figure 1.2: Organization Chart for 51+ Patients



For more detailed information covering specific job duties refer to **Tab G2G: SMSS Job Action Sheets.**

Initial Set-Up Staffing:

Planning options for addressing staffing for the initial set-up of SMSSs may vary depending on whether the facilities have been reviewed and "pre-diagramed" (set-up locations for equipment and supplies have been established through prior facility reviews or training events).

The preferred option, in both cases, is for the HCC assigned to the logistics mission to provide an SMSS Logistics Team consisting of **12-14 personnel** broken down as follows:

- **2 – Logistics personnel** (Logistics Lead and Logistics Specialist) who would work at the trailers. When initial set-up has been completed these individuals become part of the SMSS IMT
- **10-12 – Other personnel** (SMRS Staff) who would off-load and move stuff to the treatment areas, set up cots, etc. These personnel are expected to deploy within the same timeframe of the logistics personnel however, when initial set-up has been completed these individuals will likely be able to demobilize.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2B:

SMSS SITE REQUIREMENTS AND SUPPORT SERVICES

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Purpose

The following listing is meant to assist planners and understand the ideal physical requirements and services for successful SMSS operations and, subsequently, identify needs that should be considered in the development of any Memorandum of Agreement (MOA) with prospective host facilities.

Geography/Area Infrastructure:

- Outside flood plains
- Easy access to major transportation routes

Site Attributes/Configuration:

Requirements (must provide):

- Facility is ADA compliant (as close as possible)
- Patient area adequate to accommodate at least 50 patients at 70-100 sq. ft. per patient (3500 – 5000 sq. ft.)
- Areas adequate to conduct the following medical functions:
  - Patient Intake (for initial holding, triage, and registration)
  - Patient Care (for patient care, emergency care, isolation as necessary)
  - Pharmacy (for pharmaceutical storage and distribution)
- Electric power service with back-up power source (generator or transfer switch)
  - Adequate power distribution system (multiple, working electrical outlets in all areas)
- Water service (hot and cold running)
  - Adequate water distribution system (multiple, working sinks in all areas)
- Sewer service (with hookups for shower trailers if no showers in facility)
- Restrooms (1 toilet per 8 patients)
- Command and Control area (for overhead management of SMSS)
- Logistics area adequate for unloading and the secure (lockable) storage of supplies, equipment and meds needed for immediate operations)

Recommendations (may provide):

- Facility on single floor
- Separate rooms for:
  - Emergent Care (for patients needing emergency care/resuscitation)
  - Isolation (for those with infectious disease)
  - Mortuary (for deceased patients (hospice/DNR)
- Area or nearby facilities adequate to accommodate staff billeting (away from patients if possible)
- Logistics area adequate for unloading and storage of **all equipment and supplies from trailers.**
- Shower facilities (1 shower per 15 patients)
- Laundry facility (for staff only)
- Kitchen or food prep area for meals, including cold storage for food.
- Loading dock
- Internet connectivity (network)
- Phone service and SAT link

Site Support Services and Supplies:

Medical/Patient Support:

- EMS resources (critical to getting patients to/from dialysis, hospitals, discharges etc.)
- Public transportation support (in addition to EMS resources)
- Behavioral Health support (request through Human Services DMH representative in SEOC)
- Mortuary Services w/ plan (area to isolate body for pick-up or delivery to collection point)
- Discharge Planning support

Medical/Patient Supplies and Internal Logistics Support:

- M8 Trailer configured for staff billeting (if not provided in facility, can also augment Overhead Team/Command & Control function)
- Refer to SMSS Minimum Supply & Equipment List maintained by the SMRS Logistics Action Team

External Logistics Support:

- Forklift (must be onsite before or arrive with SMSS trailers)
- Food Services
- Site Food Cache (i.e., tuna fish in can, cans of vegetables, Ensure, etc. for patients in case food service is not delivered initially or supply breaks down during operations; 48-72hr supply)
- Security Services (24/7, ALE or Dept. of Insurance agents preferred)
- Laundry Services with contract for laundering patient clothes/bedding
- Environmental (janitorial) services
- Waste management services (including containers and removal of medical and regular waste)
- Fuel Services w/ delivery plan
- Consider capability for EMR / HIE, and/or Telemedicine.
- Consider large TVs/video screens that can be used for status boards etc.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2C:

SMSS SITE SET-UP CONSIDERATIONS

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Medical Areas

Patient Intake Area

Waiting Area

Functional Description:
Covered area adjacent to the SMSS drop-off/arrival area large enough to hold multiple patients (~30+ patients) and allow for them to undergo initial triage without interfering with the patient registration or other SMSS operational areas.

Tasks: See Initial Triage & Patient Registration

Initial Triage & Patient Registration

Functional Description:
Adjacent to or set-up in a portion of the Waiting Area. Activities are focused on the initial, rapid, sorting and registration of patients, identification of patients requiring higher levels of care, and the movement of patients to appropriate sections of the Patient Area. Activities include:

- Assisting with the unloading of patients at the SMSS patient drop off point.
- Collecting patients' basic registration information in the SMSS Patient Intake Form (ReadyOp)
- Evaluating patient initial information to determine the level of care required.
- Assigning patients to a bed in the Patient Area if they meet SMSS criteria for care or arranging transfer to appropriate healthcare or shelter facilities if they do not.

Patient Area

Functional Description:
Set-up dictated per facility, but typically consists of a single area for care and shelter located adjacent to the Patient Intake Area. Nursing stations serving this area should be centrally located with space for charting and tables for medical supplies and equipment. Activities are focused on providing basic care to patients arriving at the SMSS and include:

- Receiving patients from the Patient Intake Area and escorting them to their assigned bed
- Completing the patient's SMSS Patient Intake Form and making any necessary adjustments to care or placement
- Providing basic patient care as necessary and updating and maintaining patient records accordingly

Emergent Care/Isolation Area

Functional Description:
An area dedicated for the care of patients which are temporarily unstable and need emergency care or are affected with a disease or condition that warrants isolation from other patients. The area should be separated from the other areas. O2, suction, ECG, and BP monitoring in the area. Must have appropriate PPE and hand washing capability. Note: If the CMO makes the determination that the patient probably does have an infectious disease the patient will be transferred to a hospital. However, these patients should only be moved if stable.

Pharmacy

Functional Description:
A lockable room with a safe and a small refrigerator should be provided for the storage of narcotics and pharmaceuticals requiring controlled temperatures as necessary.

Non-Medical Areas

Command and Control Area

Functional Description: This area serves as the Incident Command Post for the SMSS and houses IMT staff and a briefing room that will accommodate at least twelve people for meetings. It must have internet connectivity, telephones, and electrical outlets.

Location and Space Requirements: Space is also required for tables and chairs. Preferably the ICP should be located near an outside entrance and a parking lot. Space requirements; 400-600 sq. ft.

Staff Registration Desk

Functional Description: Activities in this area focus on the registration of incoming/outgoing SMSS personnel, direction to their assigned work area, and management of personnel sign-in/sign-out. Staff assigned here provide the SMSS IMT Planning Section Chief with daily summaries of on-site staff.

- Badging: The deployed HCC responsible for logistics SMAT should provide badging equipment to accommodate personnel without appropriate/current identification badges. SMSS personnel should have/receive an SMRS ID Badge which covers the anticipated duration of the event plus ten (10) days before expiring.

Location and Space Requirements: This area should be placed close to the main entrance of the SMSS, or other entrance designated for the entry of personnel. Typically, it is co-located with Patient Registration in the Patient Intake Area. It must have space for a table and several chairs, easy access to electrical outlets, and a black/white board where updates, emergency/service information, and SMSS rules can be posted. Space requirements are approximately 150 sq. ft.

Logistics and Supply Area

Functional Description: This unit is designed to receive, sort, and dispense all disposable medical supplies to the SMSS upon receiving properly documented requests.

Location and Space Requirements: This unit must be located near an outside entrance and preferably a loading dock for delivery trucks. It must have worktables and space for storage shelves and boxes to store large quantities of medical supplies. Space requirements are approximately 400 sq. ft.

Food Service Area

Functional Description: Areas designated for the service and storage of food to SMSS personnel, patients, and supporting staff. These areas must be identified, prepared for use, and include

kitchen, serving, dining, and storage areas. Facilities should have standard kitchen commercial equipment or be connected to an outside entry for catering or a field kitchen. NCEM has contracts with food service vendors to provide food services for the SMSS personnel, patients, and supporting staff, including those with required special diets.

Location and Space Requirements: The kitchen and serving area should have a minimum of 800 sq. ft. The dining area should be capable of serving at least 70 at a time (half of minimum census for 50-bed SMSS (~140 total)) approximately 12 tables with 6 chairs each and 1,600 sq. ft. of space. Total inside space = 2, 400 sq. ft. Outside space must be available for a standard refrigerated trailer and/or parking for catering vans.

Staff Billeting Area

Location and Space Requirements: Ideal situation would be to provide staff hotels or separate buildings for billeting to ensure proper space to rest and relax away from the SMSS. If the staff billeting area is onsite, a quiet area of the SMSS, preferably away from the main traffic, should be considered. Access to bathrooms, showers and laundry trailers for staff use should be considered.

Communication Area

Functional Description: Activities in this area should focus on providing interoperable and redundant communications within the SMSS operation and with the SERT ESF8 Desk/Support Cell, Healthcare Coalitions, local Emergency Management, and other local and regional response partner organizations via phone, internet, radio, and satellite radio.

Location and Space Requirements: This area should be co-located with the SMSS Incident Command Post. The location must have connectivity to outside walls/windows for antenna connections, multiple electrical outlets, and IT connections. Space requirements: 200 sq. ft.

Security Area

Functional Description: Activities in this area should focus on the coordination of security services within the SMSS operation and in the area surrounding the SMSS location.
These services are critical to the safe operation of an SMSS and must be instituted when the SMRS is activated. Consider co-locating with the SMSS Incident Command Post.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2D

SMSS SECURITY GUIDELINES

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Purpose

To maintain a safe environment for medical shelter staff, patients, and visitors

General Security Requirements

1. Medical shelters are particularly vulnerable to security hazards and threats due to the circumstances of their establishment:
    a. Disrupted services/infrastructure due to ongoing or recent disaster.
    b. Large population of patients
    c. Presence of pharmaceuticals and other valuable equipment and supplies
2. Security must be established and maintained at State Medical Support Shelter (SMSS) facilities 24 hours a day and 7 days a week from the time SMSS Incident Management Teams (SMSS IMT) first arrive to establish the shelters until demobilization of the shelters are complete. The level of security required will depend on the emergency and location of the medical shelter site. For a checklist outlining the items for security consideration refer to the SMSS Site Security Assessment Form
3. Security includes, at a minimum:
    a. The physical presence of trained, sworn Law Enforcement officers (local, state, etc.) with jurisdiction to enforce the law, in adequate number to meet the purpose of this SOG (see Security Roles and Staffing Levels) and to perform or assist the SMSS IMT with achieving the following security priorities:
        i. Conducting an initial site security assessment and developing an operational security plan
        ii. Establishing control of access outside the SMSS including traffic control, external presence/patrols, and escort activities
        iii. Establishing control of access inside the SMSS including internal presence/patrols and enforcement of shelter rules and policies
        iv. Coordinating SMSS security activities, including requests for additional assistance, with local law enforcement
    b. The active support of the SMSS IMT and all SMSS staff for the development of the security plan and enforcement of SMSS rules and policies, especially as they related to security and safety

Security Roles and Staffing Levels:

1. SMSS IMT: Provides direction and coordination of plans, policies, and actions related to on-site security and safety through the SMSS Operations Section Chief and Safety Officer positions. Specific responsibilities of individuals assigned to these positions are covered in their Job Actions Sheets (see, **Tab G2G: SMSS Job Action Sheets**).

2. Law Enforcement
    a. Roles: Provides sworn law officers to fill Security Unit Leader and Security Officer positions within the SMSS Incident Command Structure.
        i. Security Unit Leaders are supervised by and report to the SMSS Operations Section Chief, coordinate their actions with the SMSS Safety Officer, and provide direction to all assigned Security Officers.

ii. Security Officers are supervised by, report to, and perform their duties based on direction from the Security Unit Leader.
iii. The specific responsibilities of law officers assigned to these positions are covered in their Job Actions Sheets (see, **Tab G2G: SMSS Job Action Sheets**).

b. Staffing Levels: The number of Security Unit Leaders and Security Officer positions adequate to meet the purpose of this Security Officer Guide will be determined prior to the deployment of SMSS resources by the ESF8 Lead, in coordination with the SMSS Incident Commander, ESF13 Lead (Law Enforcement), and the Emergency Services Group Supervisor or their designees. However, initially, at least four (4) law enforcement officers should be provided to meet SMSS security needs over each 24-hour period (2 – day, 2 – night).

Security Priorities and Best Practice Guidelines:

Site Security Assessment and Operational Security Plan Development:

Assessment completed by Security Unit Leader with input from the Operations Section Chief and Safety Officer following initial situation briefing and facility tour. Security Unit Leader and Safety Officer work together to develop site-specific plan. Assessment and plan should:

1. Identify hazards for mitigation and associated corrective actions.
2. Set initial area perimeters for work, living, and recreational activities, identify conditions for their modification, and include a simple diagram or map depicting them graphically for staff, patients, and visitors.
3. Address the establishment of exterior and interior security measures.
4. Support shelter rules established by the SMSS IMT regarding personal conduct, pharmaceutical storage, etc. and incorporate existing SMSS Safety Policies (Tab G2E) covering Fire, Use of Force, Missing Persons, and Evacuation
5. Address the coordination of SMSS security activities with local emergency management and law enforcement

Control of access outside the SMSS:

Directed by the SMSS IMT, in accordance with the results of the initial security assessment and maintained by the Security Unit Leader and assigned Security Officers upon their arrival to the SMSS.

1. Establish traffic control plans for vehicles and foot traffic.
    a. Provide escort for vehicles entering/exiting premises, if necessary
2. Establish primary entrance for patients, visitors, and staff and secondary entrance for equipment and supplies.
3. Secure exterior doors to areas in use that are not being used as entrances from outside entry, however:
    a. DO NOT KEEP OUTSIDE DOORS PROPPED OPEN
    b. DO NOT BLOCK EMERGENCY EXITS
4. Establish Patient Intake/Staff Registration desk(s) at the primary entrance. Include check-in/check-out procedures for patients, visitors, and staff, vehicles, and keys.
5. Post security personnel at the primary entrance 24/7 and establish schedule for external patrols.
6. Establish an evening check-in time (e.g., 2200 check-in to Branch Directors and report to SMSS IMT Section Chiefs no later than 2210)

7. Establish a plan for facility lock-down to restrict access into and out of the SMSS due to disturbances (e.g., demonstrations, civil disobedience, gang activity, etc.). Plan should include procedures for the rapid securing of exterior entrances and establishment of a single point of entry/exit.

Control of access inside the SMSS: Directed by the SMSS IMT and CMO/CNO, in accordance with the results of the initial security assessment. Maintained by the Security Unit Leader and assigned Security Officers upon their arrival to the SMSS (Note: Signage and posting of signage is the responsibility of the Logistics Section Chief.)

1. Secure sensitive (e.g., pharmacy) and unused areas and clearly identify them as off-limits by posting "Do Not Enter" signs and/or use of colored safety tape.
2. Post signage identifying service areas and defining acceptable conduct (Shelter Rules). Rules should be displayed prominently where they can be easily seen by patients, staff, and visitors.
3. Ensure that emergency evacuation routes are clearly identified.
4. Establish schedule for internal patrols by security personnel.
5. Enforce established controls and policies for media access and personnel as specified in the SMSS plan.

Coordination of SMSS security activities: Processes for requesting and obtaining assistance from local law enforcement will be based on agreements established between SEOC (ESF8 Desk, Public Safety (ESF13), and NCEM Emergency Services) and local Emergency Management representatives prior to SMSS deployment. Once deployed, SMSS IMT will manage these processes in accordance with agreements and utilize the Security Unit Leader and assigned Security Officers for direct coordination with local law enforcement.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2E:

SMSS SAFETY GUIDELINES

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Fire

PURPOSE: To provide guidelines in responding to fires and define responsibilities of the SMSS IMT and staff in the activation of this policy.

DESCRIPTION OF THE THREAT: Fires are extremely destructive and have the potential to spread and rapidly become a hazard to life and property. If a fire develops, smoke production is the first and greatest hazard to patients, staff, and visitors.

EQUIPMENT: Fire extinguishers

RESPONSIBILITY: SMSS Incident Commander and Incident Management Team are responsible for managing all mitigation, preparedness, and response activities related to fire/threat of fire in an SMSS (see SMSS IC/IMT sections under **RESPONSE** below).

MITIGATION/PREPAREDNESS:

- Fire safety issues will be included as part of the SMSS Site Security Assessment
- The Safety Officer will be responsible for the resolution of any fire hazard issues noted during the inspection and ensure that:
    - All fire extinguishers provided by the SMSS are properly placed.
    - Staff are aware of the locations of all available fire extinguishers and Fire Alarm Pull Boxes and how to utilize them.
    - SMSS staff are familiar with this policy especially as it pertains to response and Fire Safety Guidelines

Fire Safety Guidelines:

- **"FIRE"** will be the signal word for verbal notification of a fire in progress:
- **"Attention, Attention, FIRE and (location)"** will be used for notification over the radio of a fire in progress to all SMSS work areas. This notification may be made by any SMSS staff.
- **"Attention, Attention FIRE All Clear!"** will be used for notification over the radio that a fire in progress has been extinguished and it is safe to return to SMSS work areas. This notification may only be made by the SMSS Incident Commander or the Safety Officer
- Firefighting: SMSS staff should not fight a fire unless:
    - The fire can be fought effectively with portable extinguishers.
    - They have knowledge or training on using a portable fire extinguisher.
    - They can safely fight the fire in normal work clothing.
- Operating a Fire Extinguisher:
    - Pull the pin on the fire extinguisher.
    - Aim the fire extinguisher nozzle at the base of the fire.
    - Squeeze the handle trigger.
    - Sweep the extinguisher from side to side at the base of the fire.
- Checking Work Areas: If doors are closed, feel the door and the doorknob before entering. If either is hot, DO NOT open the door. If the door and the doorknob are cool, stand to the side of the door and open the door slowly.

Response:

SMSS Staff: Staff responsibilities will vary depending on whether they are working in an area affected by a fire or not. Responsibilities, in these situations, are as follows:

Directly Involved in a Fire:

1. Call out the fire signal **"FIRE!"**
    a. All other area staff will relay that call and ensure that their Unit Leaders are notified.
2. Notification
    a. Staff will activate the facility fire system by pulling down on the nearest fire alarm pull box. Staff should also ensure that 911 is activated to start a Fire Department response.
3. Extinguish the fire.
    a. If the fire is small enough to be put out by a fire extinguisher, appropriately trained staff may use a fire extinguisher, or other available fire suppression equipment to put out the fire immediately if they deem it safe.
    b. If the fire cannot be extinguished immediately, it is deemed too dangerous, personnel are not trained, or the fire is too large to be put out by a fire extinguisher,
        i. Evacuate any person(s) in immediate danger (if it can be done safely)
        ii. Contain the fire (close doors to patient rooms, offices, hallway closets, smoke doors, fire doors, windows, etc.)

Not Directly Involved in the Fire:

1. Proceed to your area of responsibility; if you do not have an assignment outside your unit, remain in your work area for instructions
2. Close doors to patient rooms, offices, hallway closets, smoke doors, fire doors, windows, etc.
3. Leave the lights on
4. Clear hallways of equipment, carts, etc. If equipment and carts cannot be removed from hallways, move them along the wall opposite any fire stairwells to create the widest possible space for movement of patients.
5. Request that all visitors report to a waiting area or remain in the patient's area until the "All Clear" is announced.
6. Remain in your area of responsibility until notified of all clear

SMSS Unit Leaders: In areas directly involved with a fire, Unit Leaders are responsible for the following, if deemed safe to do so, until relieved by fire department staff.

1. Ensuring the fire is reported to 911 and the SMSS ICP
2. Directing internal patient movement
3. Shut off medical gas valves in the Patient Care Area

SMSS IMT: When notified of a fire or potential fire event, the SMSS IC will take the following actions to maintain direction and control over SMSS operations and the health and safety of patients, staff, and visitors:

1. Ensure contact to 911, report the situation, and coordinate local fire department support.
2. Direct the Logistics Section Chief or Communication Specialist to broadcast notification of the fire (**"Attention, Attention, FIRE and (location)"**) over radio to all SMSS areas, if not already done.

a. If radio communications are down, direct the Logistics Section Chief and Finance/Admin. Section Chief to assign runners from available non-medical support staff to communicate with Unit Leaders in other SMSS areas.

3. Direct the Logistics Section Chief or Communication Specialist to broadcast notification of all clear (**"Attention, Attention FIRE All Clear!"**) over radio, to all SMSS areas once the fire has been extinguished.
4. Contact the SEOC ESF8 Desk to report the incident, provide status, and request any necessary support needs. This should be done one the situation has been mitigated or all persons evacuated.

Infection Control Plan

Health Screening and PPE Use

To prevent the spread of infectious disease, neither patients, staff, nor visitors will be allowed into the facility except in specific circumstances:

- All staff and visitors will be screened for symptoms of acute respiratory illness (e.g., fever, cough, difficulty breathing) before entering the facility.
- Recommendations on PPE procedures will be set by the Chief Medical Officer, to minimize the spread of infectious disease when applicable.
- Infection control measures should be congruent with those provided in the Infection Prevention Toolkit for Long-Term Care (LTC) facilities.

Workplace Violence

PURPOSE: To provide guidelines for maintaining the safety of staff, patients, visitors, and other members present in the SMSS. At times to ensure this safety the use of force may be required. In most cases this should be the responsibility of the Security Officers onsite. Force refers to the application of physical techniques, chemical agents, or weapons to a subject.

POLICY:

1. **Follow North Carolina State Law and Agency Associated Guidelines per agency training. If this does not exist, the below guidelines may be considered.**
2. Attempt verbal de-escalation techniques to calm situation.
3. Employ only the minimum level of force necessary to assume control of situations that threaten the security of SMSS while:
    a. Protecting the Security Officers
    b. Protecting staff and patients
    c. Protecting the subject from himself or herself
    d. Protecting others in the immediate area from danger
4. Limit the use of force to those instances when Security Officers reasonably believe that it is the most appropriate method to assure the safety of the environment and control the situation.
5. When faced with an incident that may require the use of force, Security Officers are expected to assess the situation, determine the level of force that will most effectively de-escalate the situation and bring it under control with the least risk of injury to the Security Officers and others, including the subject.

6. Security Officers must never escalate to a greater level of force without first exhausting all less severe alternatives or reasonably believing that any lesser degree of force would be ineffective.
7. Use of force against patients should be limited to defensive techniques. Chemical sprays should not be used inside SMSS patient care areas.

Reporting the Use of Force: Whenever a SMSS Security Officer uses any level of force the Security Unit Leader and SMSS IMT will be notified. An unusual event report and any agency specific reports should be completed. When a person is removed from the facility or escorted off the facility and no force is used, a statement that "no force was used" should be included in the appropriate report.

Missing Person

Scope: This procedure addresses missing patients admitted to the SMSS. A missing person at the SMSS is a serious event, requiring immediate response.

Situation: Each deployment is unique, requiring differing planning and response. This plan should be seen as a guideline and can be altered by the SMSS IMT as needed. Weather and SMSS deployment location are among the factors to be considered in planning efforts.

Concept of Operation: In the event of a missing person is discovered to be missing, the following actions will be taken:

1. Conduct initial search and notification.
    a. Restricting facility access.
    b. Gather information, and
    c. Expand/contract search resources as situation dictates.
2. Maintain search operations to conclusion.
    a. Provide situation updates until search concludes (e.g., every 30 min.)
    b. Report results of search to the SEOC ESF8 Desk

Initial Search and Notifications

Affected SMSS Area: The staff member discovering that a person is potentially missing will notify their Unit Leader and other area staff to immediately confirm that the person is not in the area. The Unit Leader will provide the SMSS IMT with the following information:

- Name
- Age
- Sex
- Skin and hair color
- Clothing type and color
- Time last seen.
- Photo, if available

Security Unit Leader or designee

- Report to the affected SMSS area to interview staff to collect information about what happened and,

- Dispatch on-shift Security Officers (Security Officer) to establish restricted access to the SMSS with one entry/exit into the facility and begin a perimeter search.
- Notify off-shift Security Officers of the potential need for their assistance and contact local law enforcement to assist if deemed necessary or if requested by the SMSS IC.
    - Abduction: If abduction is suspected, the Security Unit Leader will notify local law enforcement immediately

Search Operations Responsibilities

All SMSS Areas:

- Unit Leaders or designee will:
    - Coordinate with CMO to identify staff not critical to patient safety and make them available to participate in searches of surrounding areas.
    - Direct the search their unit areas.
    - Report the results of their area searches back through their chain of command.

SMSS IMT:

- SMSS Incident Commander or designee will:
    - Contact the SEOC ESF8 Desk to report the event, provide status, and request any necessary support needs.
    - Coordinate with SEOC ESF8 Desk on plans to inform missing individual's family if person is not found in one (1) hour from start of search.
    - At close of search, ensure completion of a SMSS Unusual Event Report is submitted to the SEOC ESF8 Desk

- Security Unit Leader or designee will:
    - Coordinate with local law enforcement for additional support as necessary.
    - Report to the affected SMSS area to interview staff, develop report, and report any additional information to the Operations Section Chief
    - If necessary, establish a command post and notify the Operations Section Chief of its location.
    - Report status of search every thirty (30) minutes to the Operations Section Chief
    - At close of search, work with Operations Section Chief to update the SMSS Unusual Event Report in ReadyOp

Facility Evacuation

Purpose and Scope: To provide basic guidelines for action if an operational SMSS facility has to conduct an external evacuation (planned or no-notice) or an internal evacuation (horizontal or vertical).

Planned Evacuations

Situation: Due to internal (e.g., expected loss of power) or external (e.g., expected rise of flood waters) circumstances the SMSS must be evacuated within a known but not immediate time period.

Decision to Evacuate: This decision will be made by ESF8 lead in coordination with NCEM. The potential negative impacts on patient health outcomes must be considered in any decision to evacuate. Depending on these impacts, it may be decided to shelter in place and provide additional assistance as needed to "ride out the storm" and continue operations as indicated.

Roles and Responsibilities: Once the decision to evacuate has been made the following actions must be taken:

ESF8 Operations Manager will:

1. Identify secondary locations that meet the established need and support SMSS standards for operation.
2. Request any additional resources (e.g., staff, material handling equipment, trucks, etc.) necessary to relocate the SMSS within the available time window.

SMSS IMT will:

1. Provide the ESF8 Operations Manager with the following minimum information:
    a. Number of ambulatory and non-ambulatory patients (to identify needed patient transportation units)
    b. Number of additional staff required.
    c. Material-handling equipment needs (forklifts, trucks, etc.)
    d. Staff transportation needs
    e. Estimated time it will take to prepare patients, staff, and equipment for evacuation.
2. Develop an evacuation IAP and brief all SMSS Unit Leaders
3. Direct the packing and loading of SMSS equipment and supplies.
4. Coordinate the staging of patient transportation units as close as possible to the SMSS if the designated patient drop-off/pick-up area is unsafe.

SMSS Patient Care Unit Leader will:

1. Ensure that the Patient Care area maintains a limited operational capability until all patients are transported from the SMSS facility.
2. Document what transportation unit transported each patient and what facility the patient is moved to. This document must be verified by the Operations Section Chief before the Charge Nurse leaves the SMSS facility.

No-Notice Evacuations

Situation: Due to internal (e.g., fire) or external (e.g., flash flood) circumstances the SMSS must be evacuated immediately.

Decision to Evacuate: This decision will be made by SMSS IC in coordination with the ESF8 Lead. The potential negative impacts on patient health outcomes must be considered in any decision to

evacuate. Depending on these impacts, it may be decided to shelter in place and provide additional assistance as needed to "ride out the storm" and continue operations as indicated.

Roles and Responsibilities: Same as for Planned Evacuations. Immediate life safety concerns are the priority, patients must be moved rapidly. Non-ambulatory patients may need to be moved in their beds or on litters with four-person carries. Semi-Ambulatory patients may be evacuated in wheelchairs if available.

Horizontal Evacuations

Situation: The extent of the hazard (e.g., fire, loss of power, etc.) is limited and does not affect the entire facility housing the SMSS. Evacuation of a portion of the SMSS may need to happen immediately or within a known time period.

Decision to Evacuate: Same as for No-Notice Evacuations.

Roles and Responsibilities: Same as for Planned Evacuations. Patients must be moved as quickly as possible to protected areas of the facility (e.g., areas beyond firewalls, areas with functioning HVAC, etc.).

Vertical Evacuations

Situation: Same as for Horizontal Evacuations.

Decision to Evacuate: Same as for No-Notice Evacuations.

Roles and Responsibilities: Same as for Planned Evacuations. For patients being moved from areas above the first floor, SMSS staff should utilize any vertical evacuation equipment available (e.g., stair-chairs, etc.). For larger, non-ambulatory patients, the use of four-person carries with the patients secured on a bed/litter using 9 ft. straps or sheets folded in 4–6-inch straps may be necessary.

NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

TAB G2F:

SMSS EXTERNAL FORMS AND REFERENCE DOCUMENTS

OCTOBER 2023

Process Workflows for SMSS Patient Intake
Process Workflows for SMSS Patient Movement Operations
SMSS Controlled Substances Accountability Record
SMSS Discharge Planning Checklist
SMSS Facility Checklist
SMSS General Supply Order Form
SMSS Minimum Supply & Equipment List
SMSS Patient Placement Guidance
SMSS Refusal of Care/AMA Form
SMSS Rules
SMSS Services Checklist
SMSS Site Security Assessment Form
SMSS Support Checklist