NCOEMS EMERGENCY OPERATIONS PLAN (NCOEMS – EOP)

ANNEX D

PATIENT MOVEMENT CONCEPT OF OPERATIONS

MAY 2024

Table of Contents

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**.

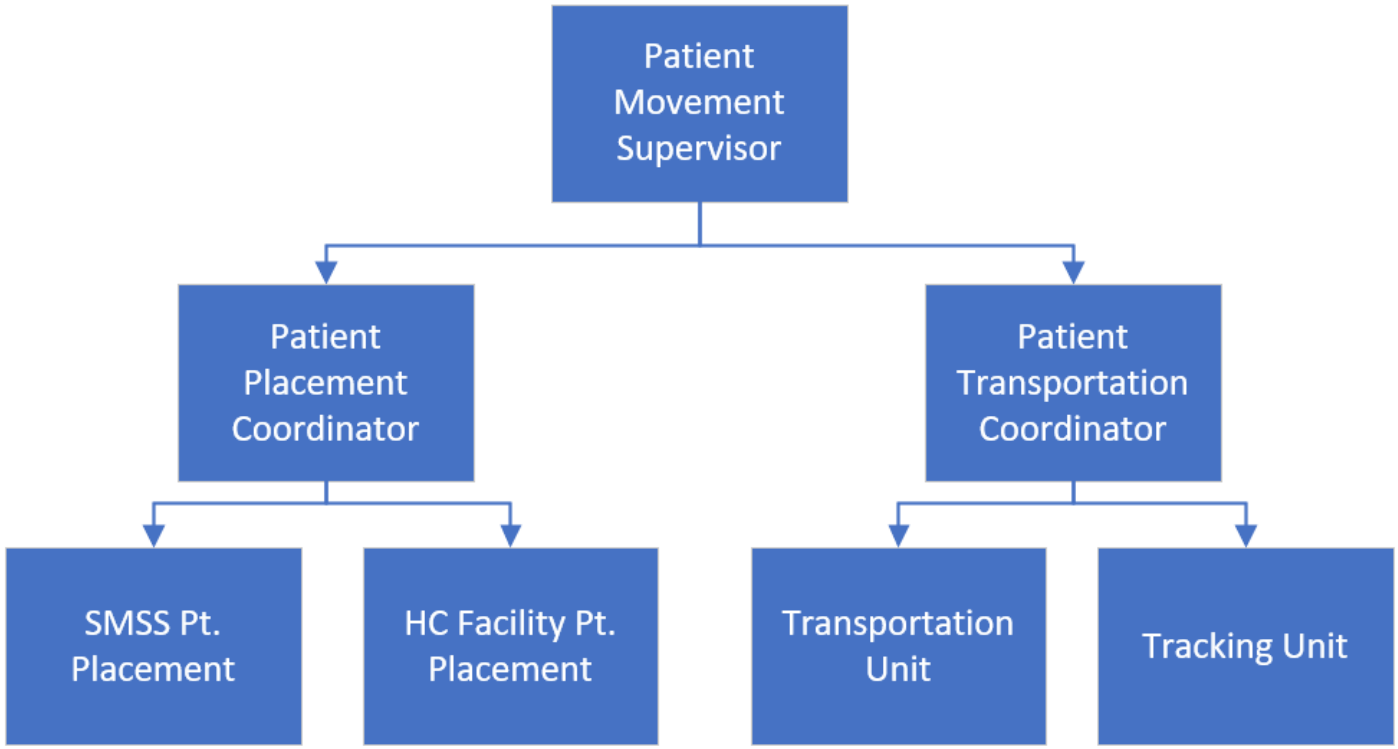
Tracking Unit:

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

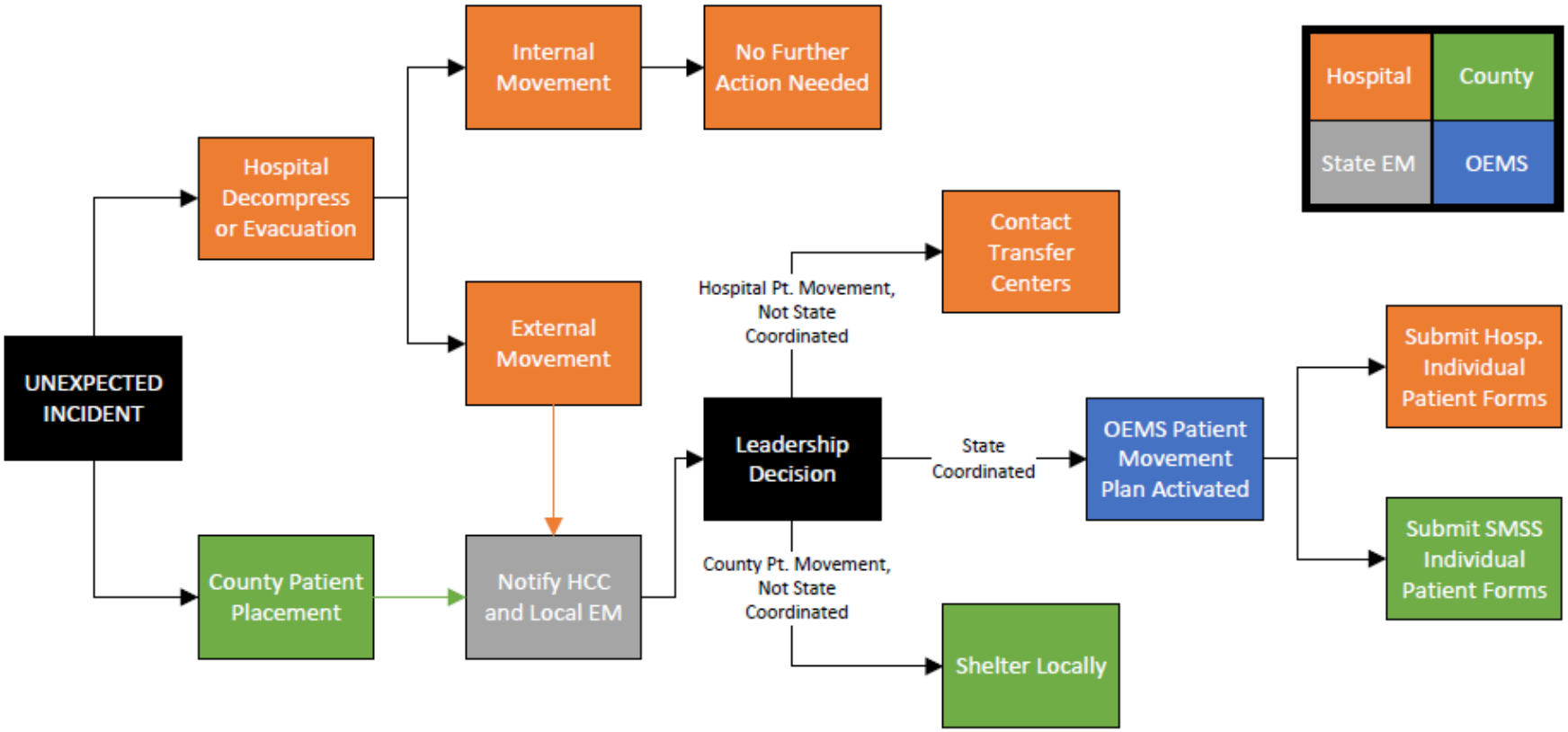


Figure 1.3: Patient Movement Flow Chart – Anticipated Incident