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| 2014 Healthcare Preparedness Gap Analysis |
| Evaluation of Healthcare Preparedness Capabilities in North Carolina |
| Healthcare Preparedness Response and Recovery Program |

Metrolina Healthcare Preparedness Coalition

Submitted January 2014

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# INTRODUCTION

In January 2012, the U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response (HHS/ASPR) released the *Healthcare Preparedness Capabilities: National Guidance for Healthcare Preparedness* documentfor the awardees of the Hospital Preparedness Program (HPP). The eight HPP capabilities detailed within that document dovetail with the fifteen capabilities detailed in the *Public Health Preparedness Capabilities: National Standards for State and Local Planning* document.

The HPP capabilities are as follows:

1. Healthcare System Preparedness
2. Healthcare System Recovery
3. Emergency Operations Coordination
4. Fatality Management
5. Information Sharing
6. Medical Surge
7. Responder Safety and Health
8. Volunteer Management

This document details the identified gaps at the state level and Metrolina regional level, relative to the established Healthcare Preparedness Capabilities.

*Methodology*

A general guidance document of recommended resources to utilize during the process, as well as a document that separated each capability and function elements for ease of reference and submission, was provided to and utilized by the regional and OEMS planners. Two regions initiated the development of a Microsoft Excel-based tool of common questions, barriers, and scoring criteria that was further developed in collaboration with the OEMS and other regional planners to be utilized statewide. The intention was to develop a common tool to be utilized by each region in gathering information during face-to-face, virtual, and/or electronic means.

Based on the needs of each planner, a region-specific strategy was developed to facilitate the most accurate gathering of data and information. The received data was vetted by the regional planner and staff before being submitted to the OEMS planner for compilation into a statewide gap analysis document.

*Purpose*

This document is intended to guide the short and long-term strategic planning for the Healthcare Preparedness Response and Recovery Program at the state and regional levels, as well as to enhance collaboration and mitigate duplication of efforts with partner and stakeholder agencies. Utilizing a gap-based planning process will assist in ensuring the program and ultimately the State of North Carolina utilizes federal grant support in the most effective and suitable manner.

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# RESOURCES

For more detailed information regarding the Healthcare Preparedness Capabilities, please refer to *Annex A* of this document, which contains abridged descriptions of each of the eight capabilities.   
  
Follow the links below for the full published versions of the federal capabilities guidance documents:

1. [*Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness*](https://www.phe.gov/preparedness/planning/hpp/reports/documents/capabilities.pdf)
2. [*Public Health Preparedness Capabilities: National Standards for State and Local Planning*](http://www.cdc.gov/phpr/capabilities/dslr_capabilities_july.pdf)
3. [*Department of Homeland Security Core Capabilities Crosswalk*](http://www.fema.gov/pdf/prepared/crosswalk.pdf)

The following documents were utilized in the development of this report:

1. North Carolina Division of Emergency Management THIRA and State Preparedness Report
2. North Carolina Public Health Preparedness System Capabilities Assessment Gap and Strategies Report
3. UNC Gillings School of Global Public Health, Health Policy and Management, North Carolina Office of Emergency Medical Services Agency Assessment 2012-2013
4. HHS/ASPR/HSEB Healthcare Coalition Questionnaire October 2013
5. Metrolina Healthcare Preparedness Coalition gap analysis data and stakeholder feedback

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# EXECUTIVE SUMMARY

To be added upon completion of analysis.

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# CAPABILITY 1: Healthcare System Preparedness

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| Healthcare system preparedness is the ability of a community’s healthcare system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, community and faith-based partners, state, local, and territorial governments to do the following:   * Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community * Provide timely monitoring and management of resources * Coordinate the allocation of emergency medical care resources * Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders   Healthcare system preparedness is achieved through a continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.  *Note: For the purposes of this document, the State — unless otherwise noted — refers to the organization and its partners that represent the interests of healthcare preparedness or hospital preparedness for healthcare organizations within the State.* |

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| Function 1: Develop, refine, or sustain Healthcare Coalition |
| P1. Healthcare Coalition regional boundaries |
| P2. Healthcare Coalition primary members |
| P3. Healthcare Coalition essential partner memberships |
| P4. Additional Healthcare Coalition partnerships/memberships |
| P5. Healthcare Coalition organization and structure |
| P6. Multi-agency coordination during response |

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| State Status/Gaps: |
| 1. Continuity of Preparedness: Current healthcare preparedness regions are not aligned with other regional concepts in the state, such as emergency management, Emergency Medical Services, or public health regional constructs. The trauma regions change based on business/patient referral patterns. The current regional constructs have the following problems: jurisdictions may not be grouped with day-to-partners, regions may contain split jurisdictions, or jurisdictions may be attached to a region in another part of the state.  2. Partnerships (Focus): The primary members of healthcare preparedness—Emergency Medical Services, public health, emergency management, and hospitals—are represented in region and state partnerships. Due to trauma-focused regions and personnel, partnerships need to continue to be developed and strengthened, specifically with public health and emergency management.  3. Partnerships (Coordination): Additional members and partners are needed from the following organizations that are not represented to ensure healthcare preparedness is being addressed fully: agriculture, Community Health Centers, long-term care, home health, hospice, mental/behavioral health, intellectual and developmental disabilities, substance abuse, Volunteer Organizations Active in Disaster, law enforcement, Community Based Organizations, Faith Based Organizations.  4. Program Structure—State: North Carolina Office of Emergency Medical Services program structure does not facilitate clear roles and responsibilities or ease of communication for partner agencies.  5. Program Structure—Regions: Region bylaws and relationships to the Regional Advisory Committees, trauma program, and hospital emergency management varies from region to region. Minimal standards have not been established by state program leadership.  6. Program Response Continuity: The State Emergency Operations Plan addresses state and regional Emergency Support Function 8 representation and coordination at the respective levels. North Carolina Office of Emergency Medical Services staff that represent Emergency Support Function 8 in regional coordinating centers have varying knowledge of Healthcare Preparedness, Response, and Recovery assets, resources, and plans. |

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| State Strategies: |
| 1. A contracted strategic planner is working with the Emergency Medical Services Advisory Council Hospital Preparedness Program Task Force to research and develop an effective healthcare coalition concept for North Carolina that addresses both sustainability and enables healthcare preparedness and response capability to be supported and developed at the local and organizational level.  2. Outreach through more regular planning meetings with North Carolina Hospital Association, North Carolina Emergency Management, North Carolina Division of Public Health, and North Carolina Department of Agriculture and Consumer Services. Implement a tiered approach with region personnel to develop stronger relationships with organizations listed in #3 above through work with functional advocacy associations, regulatory bodies, and conferences/meetings. Expand North Carolina Office of Emergency Medical Services representation with fusion centers/ISAAC.  3. As a part of strategic planning for healthcare preparedness and response, contracted planner will make recommendations for program infrastructure and staff roles and responsibilities.  4. Region bylaws and location will be addressed as a part of the healthcare coalition concept development.  5. Healthcare Preparedness, Response, and Recovery staff will conduct training with Office of Emergency Medical Services regional and main office staff to increase knowledge and awareness of Emergency Support Function 8 assets, resources, plans, and actions during activations. In conjunction with North Carolina Emergency Management, the Emergency Support Function 8 Support Cell plan should be reviewed, updated, and utilized, as well as Standard Operating Guidelines should be developed for Regional Coordination Center and State Emergency Operations Center representation. |

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| **Regional Status/Gaps:** |
| 1. The current regional structure is one of multiple regional structures in the state and does not correlate to any of the other concepts. The structure does not account for business relationships that may split counties and healthcare agencies or always allow for effective planning and training with neighboring jurisdictions.  2. Participation of agencies outside of established primary members varies. Responsibility of managing MOU/MOAs with agencies is unclear.  3. There is insufficient communication regarding the status, completion and improvement of regional and state activities and projects.  4. Sustainability planning is ongoing. There is a lack of perceived transparency from the region and state that is affecting engagement.  5. Roles and responsibilities of region personnel and state ESF-8 lead agency are unclear. |

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| **Regional Strategies:** |
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| Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster |
| P1. Healthcare system situational assessments |
| P2. Healthcare System disaster planning |

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| State Status/Gaps: |
| 1. Regional inventory assessments and risk assessments were conducted in previous grant year, with varying degrees of completeness. Gap analysis project is in process to assist in developing strategic direction for the program statewide.  2. Assessments and analysis projects, as well as all-hazards planning, have not been completed in collaboration and coordination with emergency management and public health; specifically, medical surge, communications, Continuity of Operations Planning, fatality management, Coastal Evacuation Sheltering Standard Operating Guidelines, Emergency Operations Plan Emergency Support Function 8 Annex, and State Medical Assistance Team deployable packages and protocols. |

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| State Strategies: |
| 1. Through working groups, collaborate with North Carolina Emergency Management, North Carolina Hospital Association, Department of Health and Human Services agencies on addressing the specific planning gaps listed above. |

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| **Regional Status/Gaps:** |
| 1. Due to lack of available information or established guidance or standards, planning has not adequately taken into account issues related to fatality management and special needs of at-risk populations.  2. Knowledge of available assistance, resources and personnel varies across the region. As mentioned previously, roles and responsibilities are unclear. |

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| **Regional Strategies:** |
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| Function 3: Identify and prioritize essential healthcare assets and services |
| P1. Identify and prioritize essential healthcare assets and services |
| P2. Priority healthcare assets and essential services planning |
| E1. Equipment to assist healthcare organizations with the provision of critical services |

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| State Status/Gaps: |
| 1. The State Medical Asset Resource Tracking Tool allows reporting on essential medical services and healthcare system assets for hospitals. The operational use of the system during an event is variable. In most hospitals, the appropriate personnel are not responsible for State Medical Asset Resource Tracking Tool updates and lack adequate training. The system does not allow for real-time reporting and allocation of beds and patients.  2. Bed status and patient allocation planning has not been completed and there is not a standardized process in place for hospitals to coordinate, per established North Carolina Emergency Management Emergency Operations Plan and Emergency Support Function 8 lead agency, patient movement.  3. Resource management planning and exercises are increasing in occurrence at a state level. There is a lack of standardization in planning between healthcare organizations and local emergency management.  4. Mobile Pharmacy Units are currently not fully incorporated into State Medical Response System plans and operations.  5. State Medical Response System assets and resources have not been fully communicated and do not accurately inform emergency management processes at a state, regional, and local level.  6. It is unknown if Community Health Centers, Long Term Care Facilities, and other critical medical service providers have adequate redundant power supplies or available hook ups.  7. Fatality management assets and resources exist, but have not been integrated as a healthcare (augmentation to hospital morgue surge/family assistance operations) or death care (augmentation to county/state Medical Examiner decedent identification and processing operations) asset in fatality management plans at all levels. |

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| State Strategies: |
| 1. State Medical Asset Resource Tracking Tool FAQ sheets have been developed and will be released. Targeted trainings across the state will be coordinated with North Carolina Office of Emergency Medical Services and the healthcare preparedness regional staff. A multi-disciplinary working group will be developed to evaluate State Medical Asset Resource Tracking Tool, possible changes, or additional systems that would meet the needs more effectively.  2. In coordination with North Carolina Hospital Association and North Carolina Emergency Management, develop a plan for bed allocation and patient movement during a surge event.  3. In coordination with state partners, healthcare region staff, and advocacy groups and associations, roll out long-term care emergency planning template resource and address associated planning needs.  4. Support region and local planning workshops, formally and informally, between healthcare, local emergency management, and public health.  5. Mobile Pharmacy Units gaps need to be evaluated, efficacy of units assessed, and incorporated into state level operational plans.  6. Response resource listings need to be updated and incorporated into state emergency management plans and processes.  7. State and coalitions need to include death care partners and begin dialog about how the current fatality management assets and resources may best be used or modified to meet or augment fatality management responsibilities of hospitals/MEs on the county/regional level. This may help inform/reopen needed discussions between North Carolina Emergency Management/Department of Public Health/Office of Chief Medical Examiner/North Carolina Office of Emergency Medical Services (Department of Public Health/Office of Chief Medical Examiner should lead) to review/refine any fatality management mission and decide how to support/modify the asset so it can be integrated into appropriate healthcare/death care operations. |

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| **Regional Status/Gaps:** |
| 1. While a resource inventory was initiated in FY12-13, it is not completed. There is not accurate information collected for regional and statewide resources that is readily available to partners and stakeholders.  2. Healthcare organizations have not completed deconfliction planning, as it relates to vendors for resupply.  3. Plans have been developed to manage decompression of patients, but have not been tested. Additionally, resource allocation and bed management across jurisdiction boundaries has not been tested.  4. The 96 hour time frame utilized in healthcare organization planning has not been tested.  5. As SMRS operational components expire or begin to reach end of life cycle, the tasked mission or purpose of the components needs to be evaluated for efficacy and sustainability. |

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| **Regional Strategies:** |
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| Function 4: Determine gaps in healthcare preparedness and identify resources for mitigation of these gaps |
| P1. Healthcare resource assessment |
| P2. Healthcare resource coordination |
| P3. Address healthcare information gaps |

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| State Status/Gaps: |
| 1. Resource inventory, risk assessment, and gap analysis are completed or in process. A targeted assessment and evaluation of resources has not been conducted.  2. There are multiple information sharing systems—WebEOC, State Medical Asset Resource Tracking Tool, Multi Hazard Thread Database, NCSparta, PreMIS, Health Alert Network, NCDETECT—that do not communicate with each other and without a standard plan and process for information sharing and/or reporting. |

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| State Strategies: |
| 1. Strategic planning summits will focus on gap-based planning and lay the foundation for in-depth assessments and evaluations of specific areas, such as resources. Future iterations of gap analysis and capability assessments will be coordinated with strategic partners at a state level to address duplication, as well as have a more structured approach to evaluation.  2. Evaluation of information systems, specifically State Medical Asset Resource Tracking Tool, will be completed. WebEOC training will be offered in coordination with partners and healthcare region staff to ensure hospital personnel access and availability. Fusion for WebEOC should be supported.  3. An information sharing plan for day-to-day operations and communications plan for events will be developed in collaboration with North Carolina Emergency Management, North Carolina Division of Public Health, North Carolina Hospital Association, and healthcare preparedness regional staff. Plans should include descriptions of the various disaster management/information sharing programs available and detail their functional use at various stages of activation. Similar to the recently developed forms for hospital/Emergency Medical Services use of State Medical Asset Resource Tracking Tool and the Data Management Roles, a document will be developed for the Support Cell plan. |

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| **Regional Status/Gaps:** |
| 1. The resource inventory previously initiated did address all disaster resources and the listing is incomplete. The State EM resource inventory and HPP program regional assets are available. There are no consolidated listings from EMS or hospitals. The current inventories that are available are overwhelming in size so it may be difficult to communicate the types of resources available to partners.  3. Deconfliction planning for resources and vendors has not been completed.  4. Stakeholders and partners are unclear on the process of requesting medical support or resources. Roles and responsibilities at the local, region, and state level is needed.  5. The number of ancillary healthcare organizations or facilities engaged in coordinated and collaborative planning is extremely low.  6. Due to staff turnover in healthcare organizations primarily, frequent VIPER training is needed to ensure functionality of system.  7. A region information sharing plan has been developed, but is under review and has not been disseminated.  8. Due to lack of regular usage and recent roll out, WebEOC capabilities within the hospitals are very low. |

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| **Regional Strategies:** |
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| Function 5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond |
| P1. Healthcare organization—National Incident Management System (NIMS) training |
| S1. Training to address healthcare gaps and corrective actions |

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| State Status/Gaps: |
| 1. Hospital National Incident Management System compliance is at approximately 70% statewide.  2. No standardized healthcare emergency management training course or certification is available.  3. Position/function-specific training not easily accessible or available to healthcare personnel.  4. Office of Emergency Medical Services Training Specialist position is currently vacant and duties are being shared by current staff. Additionally, training plan development and approval process is unclear to partners and stakeholders.  5. Multiple entities and organizations coordinate training programs with overlap, redundancies, and lack of coordination.  6. Operational components of program do not have established missions or associated training programs. |

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| State Strategies: |
| 1. National Incident Management System courses will continue to be offered statewide. Improve communication of emergency management ICS courses to healthcare partners and stakeholders. Ensure personnel are trained on Training and Exercise Management System, that system is regularly updated, and courses disseminated.  2. North Carolina Office of Emergency Medical Services will train Office of Emergency Medical Services regional staff on hospital National Incident Management System compliance in order to follow up on gaps and issues.  3. Coordinate with other Region IV states in development of a healthcare emergency management course.  4. Ensure operational components—State Medical Assistance Team II and III, Ambulance Strike Team—have established training programs accessible and available.  5. Develop process with existing action teams or develop work groups to develop coordinated education, training, and exercise plans.  6. Based on healthcare coalition development and strategic planning recommendations, repost training staff position or allocate duties to existing staff. Publish process for training plan development and course approval process.  7. Train North Carolina Office of Emergency Medical Services staff on the Support Cell plan and establish annual exercise.  8. Train and exercise the Coastal Evacuation Sheltering Standard Operating Guidelines, Emergency Support Function 8a annex to the State Emergency Operations Plan. Evaluate the efficacy of the Medical Coordination Team concept and applicable plan.  9. Gaps identified through the 2014 gap analysis process, and subsequent evaluations, will be included in the long-range strategic plan and training plan. |

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| **Regional Status/Gaps:** |
| 1. Current incident management courses are not geared to healthcare. The length of course is problematic due to financial and travel restrictions.  2. Based on the region hazards, vulnerabilities, and lessons learned from exercise and due to staff turnover, limited usage of skills, and expansion of systems, the need for NIMS training, specifically HICS, is high. |

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| **Regional Strategies:** |
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| Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation |
| P1. Exercise plans |
| P2. Exercise implementation and coordination |
| P3. Evaluation and improvement plans |
| P4. Best practice and lessons learned sharing |
| S1. Exercise and evaluation training |

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| State Status/Gaps: |
| 1. The current exercise plan is developed annually, at a state-level and State Medical Assistance Team-focused, and without a multiyear perspective.  2. Action Reports and Improvement Plans are not submitted to a specific program or individual.  3. There is no single portal or repository for After Action Reports and Improvement Plans or lessons learned/best practices documents.  4. Homeland Security Exercise and Evaluation Program courses are not offered with enough frequency and there is no formal evaluation training. |

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| State Strategies: |
| 1. Coordinate with North Carolina Emergency Management and North Carolina Division of Public Health on a training and exercise workshops in order to develop a multiyear training and exercise plan.  2. Ensure that the exercise plan incorporates exercise needs identified by stakeholders and partners in this gap analysis and future analysis and evaluation processes, specifically local jurisdiction and healthcare organization needs.  3. Collaborate with North Carolina Emergency Management to communicate the availability of Homeland Security Exercise and Evaluation Program training for partners and stakeholders. Identify training specific to exercise evaluation. Develop train-the-trainer/instructor capability for future sustainment strategies.  4. In coordination with partners, evaluate LLIS-similar portal or website development. |

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| **Regional Status/Gaps:** |
| 1. A statewide training and exercise plan has not been disseminated.  2. Exercises have historically focused on SMRS operations and not needs of local jurisdiction or healthcare organization needs. Additionally, exercises have not historically been cross-jurisdiction or function.  3. The available personnel with exercise development, execution, and evaluation skills are limited.  4. Exercise requirements of ancillary healthcare organizations, such as CHCs, LTCs, etc., are unknown.  5. There is not a single portal for AAR/IPs to be shared and tracking for follow up or completion.  6. HSEEP is not utilized consistently across the region, due mostly to lack of formal training, education, and experience.  7. Sharing of information sharing systems with the trauma RAC has caused some confusion related to contacts, resource storage, and information dissemination.  8. The current HSEEP course is not geared to healthcare and, due to the course length, travel and financial restrictions, is prohibitive to healthcare organization staff attending. The frequency of available classes does not meet the current need. |

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| **Regional Strategies:** |
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| Function 7: Coordinate with planning for at-risk individuals and those with special medical needs |
| P1. Healthcare planning for at-risk individuals and functional needs |
| P2. Special medical needs planning |

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| State Status/Gaps: |
| 1. There is not a standardized definition for “at-risk”, “special medical needs”, and “functional needs” patients.  2. Mass care support trailers developed and placed across the state. State of contents and locations are unknown.  3. Operational State Medical Support Shelter plans have not been finalized and effectively disseminated.  4. Mental health/behavioral health/intellectual and developmental disabilities populations have not been included in planning activities. Existing plans do not address the needs of these populations.  5. Multiple Department of Health and Human Services divisions meet quarterly, however, minimal planning initiatives take place. |

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| State Strategies: |
| 1. In collaboration with partners and stakeholders, develop common definitions for above terms to be used in planning.  2. Trailer locations need to be audited, contents inventoried and back-filled, and training on usage in coordination with North Carolina Emergency Management and North Carolina Division of Public Health.  3. State Medical Support Shelter plans need to be evaluated or edited based on previous evaluations and disseminated to partners and stakeholders. Ensure state level exercises include State Medical Support Shelter locations.  4. Develop a planning action team or specific work groups to address specific planning needs.  5. Collaborate planning with Division of Mental Health, Developmental Disabilities, Substance Assistance Services (MHDDSAS) and related divisions and groups to address operational needs related to State Medical Support Shelter plans.  6. Collaborate planning with MHDDSAS and related divisions and groups and assist in the development of aids for home-based populations, detailing medication, care plans, providers, etc. for pre-hospital and hospital personnel reference.  7. Collaborate with North Carolina Division of Social Services and North Carolina Division of Public Health to incorporate planning initiatives for the at-risk population during quarterly meetings. |

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| **Regional Status/Gaps:** |
| 1. There is not a standardized definition of “at-risk”, “special medical needs”, and “function needs” that can be utilized for effective planning.  2. Special needs registries vary in implementation and usage.  3. The organizations that care for these populations are not consistently included in planning efforts at all levels.  4. The responsibility for at-risk populations planning varies across the region. This creates challenges with regional planning initiatives. |

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| **Regional Strategies:** |
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# CAPABILITY 2: Healthcare System Recovery

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| Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community. |

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| Function 1: Develop recovery processes for the healthcare delivery system |
| P1. Healthcare recovery planning |
| P2. Assessment of healthcare delivery recovery needs post disaster |
| P3. Healthcare organization recovery assistance and participation |

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| State Status/Gaps: |
| 1. Emergency Support Function 8 roles and responsibilities are established in State Emergency Operations Plan related to recovery operations.  2. Healthcare Facility Rapid Assessment Team established to assist in post event recovery, but capabilities and feasibility is unclear.  3. Recovery operations have not been trained on or exercised routinely at a state level. |

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| State Strategies: |
| 1. Ensure roles and responsibilities are accurately reflected and updated appropriately.  2. In coordination with Department of Health and Human Services, evaluate whether Healthcare Facilities Rapid Assessment Team is needed based upon gaps and needs.  3. Based on results of this gap analysis, ensure planning, training, and exercise needs for recovery are supported at the state, healthcare organization, and jurisdiction level.  4. Collaborate with healthcare preparedness regional staff on evaluating and updating the Regional Response and Recovery Plans as needed. |

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| **Regional Status/Gaps:** |
| 1. Communication and coordination between healthcare entities within the region, but outside their respective jurisdictions, is a challenge. There are two large healthcare systems that are in the Metrolina region that have good communication between systems, but the communication with outside entities does not occur with consistency. This includes planning and response initiatives.  2. The role and responsibility of the MHPC as an entity, as well as region leadership and region staff, is unclear.  3. The process for request and provision of assistance to local partners and how their organizational needs will be integrated into planning and/or a response are unclear. This specifically includes logistics and planning and communication between regional and state organizations.  4. Recovery plans at the healthcare organization level are incomplete or inadequate due to lack of coordinated guidance or standards and lack of planning and training assistance. These plans are not coordinated between jurisdictions and healthcare organizations. CHCs, LTCs, and dialysis plans are not coordinated and largely unknown. Stakeholders are not familiar with state recovery plans due to lack of dissemination.  5. Healthcare organizations expressed a need for additional training and education in recovery activities, specifically reimbursement processes and related administration/finance items. |

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| **Regional Strategies:** |
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| Function 2: Assist healthcare organizations to implement Continuity of Operations (COOP) |
| P1. COOP planning assistance for healthcare organizations |
| P2. Healthcare organization COOP implementation assistance |
| P3. Healthcare organization recovery assistance |

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| State Status/Gaps: |
| 1. Emergency Support Function 8 roles and responsibilities are established in North Carolina Emergency Management plans related to Continuity of Operations Planning, but have not been tested or evaluated.  2. Healthcare regulatory entities require healthcare organizations to develop and maintain Continuity of Operations Plans and do not have associated standards. |

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| State Strategies: |
| 1. Ensure roles and responsibilities are accurately reflected and updated appropriately and written into statewide training and exercise plan.  2. ASPR has developed a Continuity of Operations Planning template for healthcare facilities that will be rolled out along with associated training for planners. |

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| **Regional Status/Gaps:** |
| 1. Roles and responsibilities for state and region personnel are unclear and partners perceive as disconnected.  2. There is no formal coordination of healthcare organizations COOP planning and response.  3. Due to lack of formal education, available planning assistance, and of training and exercises, healthcare organizations report gaps and inconsistency in COOP development.  4. COOPs for region CHCs, LTCs, skilled facilities and other related entities are unknown. Representation of these healthcare organizations, with the exception of hospitals, is not generally represented in any way at local EOCs.  5. Plans, specifically triggers and associated actions implementing COOP and move back to normal operations, across regional stakeholders and partners are not coordinated |

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| **Regional Strategies:** |
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# CAPABILITY 3: Emergency Operations Coordination

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| Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the public have relevant and timely information about the status and needs of the healthcare delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community response and according to the framework of the National Incident Management System (NIMS). |

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| Function 1: Healthcare organization multi-agency representation and coordination with emergency operations |
| P1. Healthcare organization multi-agency coordination during response |
| P2. Healthcare organization and emergency operations decision coordination |

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| State Status/Gaps: |
| 1. The State Emergency Operations Plan is structured by ESF and that structure is utilized both in the EOC and in the regional coordinating centers. It is unclear how healthcare organizations communicate and interact with Emergency Support Function 8 lead during an event.  2. Coordinated plans for communication and resource request and allocation between healthcare organizations and Emergency Support Function 8 lead agency do not exist.  3. Decision making and communication between healthcare organizations or local jurisdictions, healthcare preparedness region personnel, and Emergency Support Function 8 lead agency are not clear and standardized.  4. The majority of Emergency Support Function 8 personnel are primarily grant-funded positions. |

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| State Strategies: |
| 1. A standardized plan for coordinated decision-making and communication will be developed in collaboration between North Carolina Office of Emergency Medical Services, North Carolina Emergency Management, North Carolina Hospital Association, and healthcare organizations. Regional Response and Recovery Plans will be included in evaluation and development of additional planning needs.  2. An education needs assessment will determine if there is an education or training gap related to emergency operations coordination.  3. With the decrease in current federal grant funding, the absence of the identified critical personnel would be detrimental to preparedness and response efforts. Alternative funding for critical positions will be investigated in collaboration with relevant partners. |

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| **Regional Status/Gaps:** |
| 1. There is no standard plan for representation for healthcare partners other than hospitals, EMS and public health in the local EOCs.  2. It is unclear if non-represented partners (i.e. long-term care centers, dialysis centers, etc.) are aware of the process to request assistance.  3. Roles and responsibilities of ESF-8 personnel at the state level, region, and local are unclear.  4. Emergency operations plans are not shared adequately between jurisdictions and healthcare organizations and often, planning is completed in a silo.  5. Resource allocation and communications plans are unclear or have not been fully developed across the region. Processes are unclear between jurisdictions and healthcare organizations. |

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| **Regional Strategies:** |
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| Function 2: Assess and notify stakeholders of healthcare delivery status |
| P1. Healthcare organization resource needs assessment |
| P2. Incident information sharing |
| P3. Community notification of healthcare delivery status |

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| State Status/Gaps: |
| 1. A formal resource assessment has not been completed.  2. State Medical Asset Resource Tracking Tool is utilized for notification of healthcare delivery status. However, the system is reporting-focused and does not update real-time and the information that is able to be populated is not comprehensive and does not meet the essential elements needed for emergency operations.  3. WebEOC is utilized to share information and communicate during an event. However, personnel are not familiar with the system and functions, specifically healthcare organizations.  4. There is not established information sharing plans or established pathways for communication of essential information between healthcare organizations, healthcare preparedness region stakeholders and partners, and Emergency Support Function 8 lead.  5. Community notification is managed at the local or organizational level and plans are not standardized across the state. |

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| State Strategies: |
| 1. In coordination with North Carolina Emergency Management, North Carolina Division of Public Health, and North Carolina Hospital Association a resource assessment should be completed based upon inventory, risk, and gap analysis results.  2. A multi-disciplinary working group will evaluate the efficacy of State Medical Asset Resource Tracking Tool and determine a recommendation for system changes or additional system options.  3. WebEOC training and education targeted to healthcare organizations will be rolled out and implemented across the state. Training and exercises will identify needs and future gaps with system.  4. The planning action team or working group will develop a standardized information sharing plan in coordination with partners.  5. North Carolina Office of Emergency Medical Services and healthcare preparedness region staff will assist local jurisdictions and healthcare organizations with recommendations for community notification triggers. |

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| **Regional Status/Gaps:** |
| 1. There is a developed region information sharing plan that has not been disseminated or tested.  2. There are no written plans for how and when WebEOC and SMARTT will be utilized. Due to staff turnover and lack of available training, additional training is required on both systems.  3. There is no regional knowledge of the NCOEMS or NCEM information sharing plans.  4. An inventory or information regarding other vulnerable healthcare assets (i.e. dialysis centers, etc.) or potentially available healthcare assets has not been obtained.  5. The status of written plans for the state and region, specifically healthcare organizations, to provide community notification during a disaster is unclear. |

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| **Regional Strategies:** |
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| Function 3: Support healthcare response efforts through coordination of resources |
| P1. Identify available healthcare resources |
| P2. Resource management implementation |
| P3. Public health resource support to healthcare organizations |
| P4. Managing and resupplying resource caches |
| E1. Inventory management system |

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| State Status/Gaps: |
| 1. Healthcare assets and resources are maintained in multiple locations by multiple personnel and organizations and not in a standardized manner.  2. Roles and responsibilities are not clear for Emergency Support Function 8 operational components and of coalition members during State Emergency Operations Center activation.  3. During a State Emergency Operations Center activation, public health resources are managed through the Emergency Support Function 8b lead. The epidemiologic and surveillance resources available during preparedness are unclear at a state, regional, and local level.  4. North Carolina Emergency Management and North Carolina Office of Emergency Medical Services manage resupply during an event, but the approved vendor list has not been updated recently.  5. A statewide inventory management system has been implemented and is in process towards completion. Due to the system being new and on multiple time constraints and staff responsibilities, the system is in process of completion at both state and regional level. |

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| State Strategies: |
| 1. Identify healthcare resources, validate information, and ensure disseminated to partners and stakeholders and maintained in single location such as WebEOC.  2. In collaboration with North Carolina Emergency Management and North Carolina Department of Health and Human Services, roles and responsibilities and processes need to be established and clearly communicated vertically and horizontally.  3. North Carolina Office of Emergency Medical Services and North Carolina Division of Public Health will collaborate on available public health resources and disseminate information to healthcare preparedness partners.  4. A coordinated plan for completion of inventory will be established based on feedback from regional personnel and evaluation of scope of work. |

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| **Regional Status/Gaps:** |
| 1. There are multiple systems utilized to track healthcare resources. The systems do not interface and do not provide for a comprehensive tracking mechanism.  2. A complete list of available resources at the region and state level is incomplete.  3. Deconfliction planning has not been completed at the region and stakeholders and partners are unaware if it has occurred at the state level.  4. There is a gap in knowledge with the healthcare centers regarding how resource implementation will occur. There are seldom incidents large enough to require outside assets so this process has not been practiced.  5. The role of the healthcare coalition in the coordination of resources is unclear.  6. There is a lack of communication regarding planning for medical needs shelters on the county and regional level. Hospitals have all designated an alternate care site, but they have not been tested. Minimum standards and requirements for alternate care facilities do not exist.  7. Some hospital and EMS assets are listed in SMARTT, but the list is not complete or comprehensive.  8. There is no system to track the healthcare assets of the regional partners. A process for rapid resupply does not exist at the coalition level and it is unknown if it exists at the state level.  9. Hospitals have MOUs with vendors for rapid resupply, but the vendors are used by several hospitals and deconfliction planning has not been completed.  10. As equipment reaches the end of life cycle or expiration, a needs assessment should be conducted to ensure the necessary inventory and equipment is maintained.  11. Finance and administrative roles and responsibilities have not been adequately trained or tested.  12. The region utilizes the statewide inventory system, but there is variance in system or process utilized by region stakeholders and partners for inventory management. |

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| **Regional Strategies:** |
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| Function 4: Demobilize and evaluate healthcare operations |
| P1. Resource demobilization |
| P2. Evaluation and continuous program improvement |
| S1. Evaluation training |

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| State Status/Gaps: |
| 1. Demobilization of resources during an State Emergency Operations Center activation are completed per State Emergency Operations Plan. There is a lack of familiarity with process outlined in State Emergency Operations Plan. Additionally, standardized processes are not in place for resources deployed outside of a State Emergency Operations Center activation. Specifically, legal accountability and responsibility are unclear.  2. Healthcare Preparedness, Response, and Recovery has developed a strategic road map, but not a formal strategic plan, and partners are unfamiliar with that road map and associated program evaluation.  3. Available Homeland Security Exercise and Evaluation Program training for partners and stakeholders has not included evaluation or continuous program improvement. There is not a standardized process or identified personnel responsible for follow up on identified corrective action plans and monitor completion. |

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| State Strategies: |
| 1. The operations action team will develop appropriate demobilization processes for resources deployed outside of the State Emergency Operations Center.  2. Strategic planning summits will take place annually to increase transparency of state gaps and priorities, as well as to engage stakeholders and partners in the development of the strategic plan. Additionally, quarterly Healthcare Preparedness, Response, and Recovery meetings are scheduled and extended to all partners and stakeholders.  3. Based on identified educational needs and in coordination with North Carolina Emergency Management, exercise evaluation and program evaluation and improvement training will be offered. |

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| **Regional Status/Gaps:** |
| 1. There is no operational resource demobilization plan for the region or individual coalition partners. Healthcare responsibilities to recondition equipment in a large disaster have not been defined. There is no known written agreement when one healthcare facility loans equipment to another. Demobilization has not been tested.  2. The use of after action reports and corrective action plans is sporadic across the region between partners and stakeholders. The MHPC has developed corrective action plans and after action reports, but has not documented corrective actions that have been made.  3. Information sharing between healthcare entities regarding lessons learned has been limited. Long-term care are rarely included in exercises and the MHPC does not know what the status is of long term care exercise evaluation and program improvement. Additional training is needed for healthcare entities regarding the development of exercises and evaluation and continuous program improvement.  4. HSEEP is the only course offered for exercise development, design and evaluation. Additional training is needed for healthcare entities regarding the development of exercises, evaluation and continuous program improvement. The HSEEP course is too long for many of the hospital personnel and it is too generic. An exercise design course and an evaluation and continuous improvement course that are based on HSEEP principles but more geared towards the healthcare entities would be helpful. |

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| **Regional Strategies:** |
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# CAPABILITY 5: Fatality Management

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| Fatality management is the ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during periods of increased deaths at healthcare organizations during an incident. |

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| Function 1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations |
| P1. Anticipate storage needs for a surge of human remains |
| P2. Healthcare organization human remain surge plans |
| E1. Mortuary storage equipment and supplies. |

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| State Status/Gaps: |
| 1. Casualty and fatality estimates have not been completed based on established risks and hazard to anticipate mortuary space in state.  2. There is not an established state mass fatality plan or it has not been adequately disseminated. Healthcare organization plans cannot be accurately developed and evaluated without an existing state plan.  3. Mortuary supplies exist—refrigerated trailers, mass fatality unit, fatality management equipment—but an accurate inventory is not available. |

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| State Strategies: |
| 1. North Carolina Office of Emergency Medical Services, in collaboration with North Carolina Emergency Management, North Carolina Division of Public Health, Office of Chief Medical Examiner, NC Funeral Directors Association and North Carolina Cemetery Commission will develop a working group to address mass fatality planning.  2. Funeral homes and mortuary services will be engaged to assist with planning process based upon casualty and fatality estimates.  3. Mortuary supplies will be inventoried, evaluated for efficacy, and resource lists updated and disseminated through North Carolina Emergency Management. This process should begin with the supply cache located in Buncombe County and any regional caches available. Program staff will work with Office of Emergency Medical Services regional staff to ensure completion.  4. Developed plans will be trained and exercised. |

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| **Regional Status/Gaps:** |
| 1. The regional risk assessment conducted in FY12-13 did not include estimates of fatalities. It is unknown if local or healthcare organization plans include planning based on fatality estimates.  2. Region hospitals, EMS agencies, and emergency management have developed mass fatality plans, but these plans have not been recently exercised. These plans are not consistently shared with local and regional partners.  3. A state and regional operational plan for a mass fatality event, to include recovery, does not exist or has not been effectively disseminated.  4. Of the 21 healthcare facilities in region, three do not have any morgue capacity.  5. State and regional protocols for recovery and storage of remains, specifically culturally sensitive and legal issues, do not exist.  6. Based on the current population within region and associated risks, the current regional mass fatality equipment may be inadequate.  7. There are currently no personnel formally trained in the recovery of remains, outside of initial training ongoing with one law enforcement agency. Based on the completion of that training and assessment of needs, there may be additional equipment gaps. |

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| **Regional Strategies:** |
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| Function 2: Coordinate surges of concerned citizens with community agencies responsible for family assistance |
| P1. Procedures for a surge of concerned citizens |

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| State Status/Gaps: |
| 1. Coordinated plans to address surges of concerned citizens and family assistance centers are not developed or have not been disseminated at a state level. State, healthcare organization, and local jurisdiction plans are inconsistent.  2. North Carolina Department of Social Services, as well as Volunteer Organizations Active in Disaster, such as the American Red Cross, that are responsible for managing these operations have not been fully engaged and/or incorporated in healthcare preparedness activities. |

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| State Strategies: |
| 1. Appropriate state agencies, law enforcement, healthcare organizations, healthcare preparedness regional staff, American Red Cross and other Volunteer Organizations Active in Disaster, will be integrated into the planning process or into previously developed mass fatality or casualty plans to address family assistance or surge of concerned citizens.  2. Ensure that capabilities of American Red Cross and other identified Volunteer Organizations Active in Disaster are able to meet the needs of healthcare organizations and partners during an event. Ensure that plans include roles and responsibilities for when the American Red Cross or Volunteer Organizations Active in Disaster are unable to fully execute this need. |

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| **Regional Status/Gaps:** |
| 1. The MHPC has conducted no planning to receive concerned citizens. Local plans are unknown.  2. The regional role in family assistance or management of concerned citizens has not been clearly established based on state guidance and regional stakeholder and partner needs. |

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| **Regional Strategies:** |
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| Function 3: Mental/behavioral support at the healthcare organization level |
| P1. Mental/behavioral health support |

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| State Status/Gaps: |
| 1. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS) has a disaster coordinator that has not been integrated into planning for mental/behavioral health support.  2. Available mental/behavioral health support resources are unknown.  3. An established plan and process to request mental/behavioral health support has not been developed. |

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| State Strategies: |
| 1. North Carolina Office of Emergency Medical Services, in collaboration with divisions of the North Carolina Department of Health and Human Services, will increase collaboration in planning for addressing the mental/behavioral health needs of vulnerable populations and for requesting and coordinating available mental/behavioral health support resources. |

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| **Regional Status/Gaps:** |
| 1. While there are resources available through the healthcare systems and state, the region has no written plan for mental/behavioral health support during an event or for deployed team members.  2. Current capabilities and/or resources of region stakeholders and partners related to mental/behavioral health or identified needs, are unknown. |

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| **Regional Strategies:** |
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# CAPABILITY 6: Information Sharing

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| Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of public health and medical related information and situational awareness between the healthcare system and local, state, Federal, tribal, and territorial levels of government and the private sector. This includes the sharing of healthcare information through routine coordination with the Joint Information System for dissemination to the local, state, and Federal levels of government and the community in preparation for and response to events or incidents of public health and medical significance. |

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| Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture |
| P1. Healthcare information sharing plans |
| P2. Healthcare essential elements of information |
| P3. Healthcare incident information validation |
| P4. Healthcare information sharing with the public |
| E1. Healthcare information systems |
| P5. Bed tracking |
| E2. Bed tracking system |
| S1. Bed tracking system training |
| P6. Patient tracking |
| E3. Patient tracking system |
| P7. Patient record tracking |

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| State Status/Gaps: |
| 1. Information sharing plans at the state and regional levels are in process and have not been completed.  2. Essential Elements of Information has not been reviewed in several years and it is not standardized across state.  3. Public communications are coordinated per Department of Health and Human Services policy and protocol day-to-day and through the State Emergency Operations Center during activation. Public information is a local or organization function and policies are in place.  4. There are multiple healthcare information systems in use, but systems do not communicate, are redundant, or unclear monitoring responsibility or dissemination.  5. State Medical Asset Resource Tracking Tool tracks bed availability, but not in real-time for use operationally.  6. There is not a statewide patient tracking plan or system for use by healthcare organizations or for use by deployed response teams.  7. The primary Electronic Medical Records systems utilized in hospitals are EPIC and Cerner systems. Sharing of records inter-facility and organization is difficult. The legal and liability issues related to patient information are unclear.  8. Healthcare preparedness program does not have a functioning website or portal for pertinent information to be shared to stakeholders and partners. Additionally, a regular sit-rep is not pushed to partners and stakeholders with program updates.  9. WebEOC is newly implemented for information sharing however there are currently less than 70% of hospitals using the system, and it has not been expanded to other healthcare organizations and agencies. |

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| State Strategies: |
| 1. A working group will be established to develop a common framework to be vetted and used by the program statewide. This group will have multi-jurisdictional representation.  2. As a part of the State Medical Asset Resource Tracking Tool review mentioned previously, Essential Elements of Information should be evaluated and reviewed to ensure relevance, as well as functionality of system.  3. As previously mentioned, a review of State Medical Asset Resource Tracking Tool will be undertaken. WebEOC fusion will be supported and further investigated in collaboration with the Hospital WebEOC users group and North Carolina Emergency Management. Clear roles and responsibilities and associated education and training will be developed and implemented for systems. Roll out of WebEOC to other healthcare organizations and agencies will be addressed by the user group.  4. SMARRT FAQs will be released and targeted user training implemented through Emergency Medical Services Performance Improvement Center, in addition to the system review.  5. North Carolina Office of Emergency Medical Services in collaboration with state and regional partners will evaluate available systems to be implemented across the state. A multi-disciplinary planning group will assist in development of plan for use prior and post system implementation.  6. As Electronic Medical Records systems are implemented, North Carolina Office of Emergency Medical Services and healthcare preparedness regional personnel will monitor additional gaps and issues.  7. North Carolina Office of Emergency Medical Services, in collaboration with healthcare preparedness regions, will investigate non-traditional options for web page or portal development to allow for adequate availability of vital program information and allow sharing of ideas and best practices.  8. In collaboration with North Carolina Emergency Management, ensure Emergency Support Function8 incident reporting and information dissemination through the North Carolina Emergency Management Warning Point during non State Emergency Operations Center activations. |

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| **Regional Status/Gaps:** |
| 1. MHPC revised the Information Sharing Plan from the Metrolina Response and Recovery Plan. The information sharing plan has not been shared with the region or exercised.  2. Region stakeholders and partners have varying standards of standardized information and methods to disseminate. There is not a standardized form across the region or state.  3. The region has inadequate contact with Long Term Care, Community Health Centers and Dialysis to determine their status. Additional guidance from the state will be required.  4. Information sharing plan for the MHPC has not been coordinated with partners' plans. There is no current plan for healthcare incident information validation. The MHPC information sharing plan needs to be shared with region and plans should be compared across the region. Additional guidance regarding best practices will be required for this.  5. All county EMs, hospitals, and EMS agencies have an individual agency or organization policy or process for health information sharing. It is usually through a Joint Information Center/Network.  6. WebEOC is new to the hospitals and it is unclear how it will be used. Additional education and training will be required to ensure compliance and effectiveness.  7. A state wide patient tracking system that is compatible with hospital/ EMS systems does not currently exist.  8. SMARTT does not provide real time bed status or tracking, and its value to healthcare organizations and other stakeholders is unclear.  9. The region website will need to be evaluated once it is revised to ensure that it is meeting the needs of the region. One of the purposes of the website is as a document resource. Additional storage for the documents may be needed. Additional revisions may be needed based upon the feedback from the region once it is implemented.  10. Training exists for the SMARTT system and is shared with regional partners on a regular basis, but a more robust and in-person training would help partners understand all of the benefits of the SMARTT system.  11. There is no unified patient tracking system in use across the region or state. All the hospitals have access to JPATS, but EMS does not. The hospitals do not like JPATS because it is additional system to maintain and is only used in NDMS events. |

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| **Regional Strategies:** |
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| Function 2: Develop, refine, and sustain redundant, interoperable communication systems |
| P1. Interoperable communication plans |
| E1. Interoperable communication system |
| S1. Communication training |

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| State Status/Gaps: |
| 1. A statewide interoperable communications plan has been developed, but there is not a specific plan for the healthcare preparedness program or State Medical Response System. Additionally, needs are not incorporated into the statewide exercise plans in a standardized method.  2. Voice Interoperability Plan for Emergency Responders is the primary interoperable system, with North Carolina Medical Communications Network, satellite phones and radios as redundancies. However, not all jurisdictions utilize Voice Interoperability Plan for Emergency Responders and the inventory of additional Voice Interoperability Plan for Emergency Responders needs is in process. Additionally, the sustainability of North Carolina Medical Communications Network is unknown.  3. Additional redundant systems, such as Amateur Radio Emergency Services, have not been engaged in planning at the state level.  4. 800mHz compatible radios are not currently available in all ambulances and medical transport units.  5. North Carolina Office of Emergency Medical Services communications staff are not effectively utilized in training or providing technical support statewide.  6. Feasibility of continued financial support for new radio units, equipment for new facilities, and ongoing maintenance costs of units is unknown based on current budget projections and trends.  7. Training needs for hospitals, as well as expanded coalition membership such as Community Health Centers, Long Term Care Facilities, and related facilities are unknown. |

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| State Strategies: |
| 1. Communications action team will be tasked to develop draft plan for review.  2. The Voice Interoperability Plan for Emergency Responders equipment inventory survey will be completed and additional gaps identified.  3. An evaluation of North Carolina Medical Communications Network will be executed to make recommendations on future of system.  4. Additional communications assets and resources will be engaged through implementation of coalitions and expansion of membership. Training needs for expanded membership will be evaluated and addressed in statewide training plan.  5. Communications staff will have clear roles and responsibilities established and will be incorporated into statewide training plan. Any identified training and education gaps for the communications staff will be addressed to ensure sustainability of system.  6. North Carolina Office Emergency Medical Services, in partnership specifically with North Carolina Emergency Management and North Carolina Highway Patrol, will develop a sustainability plan for support and funding of additional radios and related equipment.  7. Evaluate FirstNet and determine the implications and impact on current interoperable communications systems within North Carolina. This will be done in collaboration with ongoing state and federal initiatives. |

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| **Regional Status/Gaps:** |
| 1. There is a Metrolina Interoperable Communications Plan, but the plan needs to be shared and exercised. The jurisdictional county plans have not been shared to ensure they are consistent with the regional plan.  2. VIPER radios have been purchased for 100% of the ambulances in the Metrolina region. All hospitals have a VIPER radio. The NCMCN towers are no longer being serviced. Most of the Metrolina region uses the Charlotte 800mHz system. HAM radio operators are limited.  3. Many of the hospitals in the region use VIPER as a secondary form of communication and are unfamiliar with VIPER system.  4. WebEOC is new to the hospitals and it is unclear how it will be used. Additional education and training will be required to ensure compliance and effectiveness. |

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| **Regional Strategies:** |
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# CAPABILITY 10: Medical Surge

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| The medical surge capability is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community. This encompasses the ability of healthcare organizations to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised. |

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| Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge |
| P1. Healthcare Coalition preparedness activities |
| E1. Multi-agency coordination during response |

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| State Status/Gaps: |
| 1. The healthcare preparedness program has focused historically on response and has a lack of infrastructure to effectively address preparedness needs of partners and stakeholders.  2. Roles, responsibilities, and processes for coordination during an event are not clearly established, or effectively disseminated, to partners and stakeholders at a state level. Refer to Capability 3. |

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| State Strategies: |
| 1. Development and implementation of healthcare coalitions in North Carolina will assist in improving preparedness focus.  2. In coordination with North Carolina Emergency Management, establishing or clarifying defined roles and responsibilities and defined program structure at a state level will assist in decreasing inefficiencies and redundancies. A scope of work for healthcare preparedness regions that is clearer and more concise will assist in clarification of roles and responsibilities. |

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| **Regional Status/Gaps:** |
| 1. Due to already full schedules, attendance at regional meetings is difficult for stakeholders and partners.  2. Clarification is needed regarding licensing and utilization of tents during a response, specifically for healthcare organizations and EMS agencies.  4. The roles and responsibilities of ESF-8 state, region, and local entities and organizations during a response is unclear.  5. There is no representation for healthcare partners other than hospitals, EMS and public health in the local EOCs. It is unclear if non-represented partners (i.e. long-term care centers, dialysis centers, etc) are aware of the process to request assistance. |

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| **Regional Strategies:** |
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| Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations |
| P1. Healthcare organization coordination with EMS during response |
| P2. Coordinated disaster protocols for triage, transport, documentation, CBRNE |
| S1. Training on local EMS disaster triage methodologies |
| S2. Coordinated CBRNE training |

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| State Status/Gaps: |
| 1. During a State Emergency Operations Center activation, North Carolina Office of Emergency Medical Services coordinates Emergency Support Function 8 medical operations and communications. The associated plans are unclear to healthcare organization partners and stakeholders.  2. Statewide Emergency Medical Services protocols are in place that address items listed.  3. SMART and Jump START are the established triage methodologies established in the state, but implementation barriers or gaps are unknown.  4. Chemical Biological Radiological Nuclear and Explosives training is available through a number of avenues in the state. However, these resources are not coordinated in a multiyear training plan or effectively disseminated to partners such as healthcare organizations. |

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| State Strategies: |
| 1. Clearly established roles, responsibilities, and plans or process should be reviewed in collaboration with partner agencies and ensure accuracy and understanding.  2. Continue to collaborate with North Carolina College of Emergency Physicians and Emergency Medical Services to ensure that statewide protocols continue to address disaster response.  3. Working with Office of Emergency Medical Services regional staff and Emergency Medical Services directors, evaluate needs for additional training resources or assistance and identify gaps or barriers to implementation.  4. Ensure development of a multiyear training plan that includes courses to address identified gaps in Chemical Biological Radiological Nuclear and Explosives-related incidents from local and regional levels. |

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| **Regional Status/Gaps:** |
| 1. SMARTT does not allow for bed status reporting real time during an event. There are no plans developed and disseminated regarding triggers and processes for SMARTT in normal and emergency mode.  2. There is not a standardized definition of “at-risk” that can be utilized to develop effective EMS transportation plans.  3. The provision of situational awareness of EMS activities during surge operations to healthcare organizations has not been tested and varies between each county.  4. Many stakeholders and partners are unclear on the status and capabilities of the Ambulance Strike Team. This includes details of the composition of personnel, ambulances, and equipment as well as the method to request it.  5. SMART triage is the established triage methodology, however due to the expense, cards are rarely used for training. Triggers to implement are not standardized and defined.  6. There is a lack of coordination and communication of disaster protocols between EMS agencies and healthcare organizations, as well as the inability to transfer patient information between pre-hospital and hospital systems.  7. As each EMS agency utilizes a different documentation tool or mechanism, there are no standard protocols for documentation during a CBRNE event specifically.  8. Based on the educational needs assessment, hospital personnel have inadequate training levels for SMART and Jump START.  9. Standards related to “acceptable” levels of decontamination do not exist. There is a lack of coordination of plans between pre-hospital and hospital regarding decontamination levels and ability of patients to enter medical facilities.  10. Due to frequent staff turnover and other resource issues, there is a lack of adequate training and education for hospital decontamination teams. Additionally, this has not been recently exercised in many facilities. |

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| **Regional Strategies:** |
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| Function 3: Assist healthcare organizations with surge capacity and capability |
| P1. Medical surge planning |
| P2. Medical surge emergency operations coordination |
| P3. Assist healthcare organizations maximize surge capacity |
| P4. Assist healthcare organizations maximize surge capability |
| P5. Medical surge information sharing |
| P6. Healthcare organization patient transport assistance |
| P7. Medical surge considerations for at-risk individuals and those with special medical needs |
| E1. Specialty equipment to increase medical surge capacity and capability |
| S1. Special training to maximize medical surge competency |
| P8. Mobile medical assets for surge operations |
| E2. Mobile medical assets |
| P9. Decontamination assistance to healthcare organizations |
| E3. Decontamination assets |
| S2. Decontamination training |
| P10. Mental/behavioral health support |

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| State Status/Gaps: |
| 1. Medical surge plans, specifically patient movement and bed coordination, have not been addressed at a state level.  2. Coordinated planning for medical surge events including Emergency Support Function 8 lead agencies and healthcare organizations has not occurred.  3. As previously identified, there is not a state level information sharing plan or standardized region plans due to a lack of guidance.  4. Processes for healthcare organizations to request assets or resources are unclear. Additionally, available resources are not located in a single location and regularly updated.  5. The ambulance strike team concept of operations is not clearly developed or implemented across the state.  6. State Medical Support Shelter plans have been developed and exercised. It is unclear if corrective actions have been fully implemented. The current number of sites does not ensure adequate space and access to care for at-risk individuals during an event.  7. State psychiatric facility plans exist, but contents are unknown.  8. There is a lack of clarity of “at-risk” populations and the need for clear definition of “functional needs” versus “special medical needs”, specifically how these definitions relate to planning for the state of North Carolina.  9. With consolidation of health departments into human services agencies, many are divesting clinical care duties to community health centers and vulnerable populations have to look elsewhere for medical care.  10. A comprehensive equipment and resource inventory has not been completed. Also, available assets and resources are not well known across the state. The operational mission of various State Medical Response System components is unclear.  11. Medical surge training and decontamination training and equipment needs are unknown.  12. Clinical care guidelines for the State Medical Response System are incomplete. |

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| State Strategies: |
| 1. In coordination with partners, a working group or action team will develop a draft plan that addressed patient movement and bed coordination.  2. Development of healthcare coalitions that have an appropriate focus on preparedness, specifically planning and associated exercises, with personnel equipped to assist region partners and stakeholders with related items will assist in addressing overarching medical surge planning needs.  3. Education sessions will be developed to disseminate updated information regarding immediate bed availability (IBA) standards and evaluate additional planning needs for healthcare organizations.  4. In coordination with partners, a working group or action team will develop a draft plan framework to be reviewed and implemented statewide.  5. As previously identified, additional training and education is needed on roles and responsibilities for resource requests during a State Emergency Operations Center activation and during a localized event, as well as a readily accessible updated transportation assistance assets and resources.  6. The efficacy and validity of the Ambulance Strike Team concept will be evaluated. A development plan with established benchmarks will be established to ensure accountability on completion.  7. State Medical Support Shelter exercise After Action Reports and Improvement Plans need to be reviewed to ensure that corrective actions are completed related to planning. State Medical Support Shelter plans should be disseminated to state and local emergency management to improve awareness. North Carolina Emergency Management will be included in review process.  8. Additional State Medical Support Shelter sites will be surveyed in collaboration with North Carolina Department of Health and Human Services, North Carolina Emergency Management, North Carolina Division of Public Health, and other partners.  9. Division of State Owned Facilities and Division of Mental Health, Development Disabilities, and Substance Abuse Services will be engaged by North Carolina Office of Emergency Medical Services to begin dialogue and review of emergency plans.  10. In collaboration with North Carolina Division of Public Health, Community Care of North Carolina, and the Community Health Center Association, develop a pilot program for healthcare preparedness and response support to rural and underserved areas in the state. This program will be evaluated upon completion for possible replication to other CCNC networks.  11. Completion of inventory at the state and regional levels will increase knowledge of what the system contains related to medical surge equipment.  12. The missions of State Medical Response System operational team components, such as National Mobile Disaster Hospital, State Medical Assistance Team II, III, MRCs, Ambulance Strike Team, will be evaluated based upon risks and hazards and the needs of stakeholders and partners.  13. Updated resource lists will be maintained at the state and regional levels, disseminated regularly to North Carolina Emergency Management and North Carolina Division of Public Health, and accompanied by established resource request process.  14. Based on needs identified by regional partners and stakeholders, incorporated medical surge and decontamination training into multiyear training plan that is disseminated to all stakeholders and partners. |

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| **Regional Status/Gaps:** |
| 1. There is not a standard definition of “surge” that healthcare organizations currently utilize in planning efforts.  2. There is no consistent, standardized, formal system for sharing information, response objectives and resource status between healthcare organizations, EMS partners and EM partners (outside of local county systems). This holds true in vertical and horizontal communications.  3. Regional medical surge plans and processes do not exist. This includes real time surge and bed status, decompression of patients, family assistance/concerned citizens, fatality management, and credentialing.  4. Roles and responsibilities related to resource allocation and management are unclear between local jurisdiction emergency management and healthcare organizations, regional personnel, and state ESF-8 agencies.  5. The region information sharing plan has been developed, but not reviewed or disseminated to region partners and stakeholders.  6. There are systems currently available for situational awareness, but training and education are lacking for WebEOC and functionality of SMARTT during an event is unclear.  7. A patient transportation plan does not exist regionally or at the state level or it has not been effectively disseminated.  8. Current transportation assets, such as ambulance buses, are aging and were developed prior to a number of updates and redesigns. The buses currently lack capability of transporting patients in positions others than supine, difficult patient access, and wheelchair-bound patients or those with mobility issues.  9. There is variation in levels of engagement and planning with at-risk, mental/behavioral health, special medical needs populations. There are multiple agencies that work with these populations that vary from jurisdiction to jurisdiction.  10. Mobile medical assets and related equipment both internal and external to the region is not well disseminated, specifically to healthcare organizations outside of hospitals.  11. The needs of LTCs, CHCs, dialysis, and related entities are unknown related to training, planning, and response equipment capabilities.  12. Financial and travel restrictions in many facilities and organizations has prevented personnel from partaking in training and educational offerings. Training frequency and modality needs to be evaluated in light of restrictions.  13. The capabilities of the SMRS and the related roles and responsibilities related to request, deployment, management, and operational requirements of receiving agency of mobile medical assets and personnel are unclear.  14. Many region stakeholders have limited understanding of ServNC and how the system could be utilized by their agency or how credentials verified through the system will be received by the healthcare organizations.  15. Capabilities, specifically decontamination, of the region healthcare organizations are unclear. First receiver vs. responder and related training, OSHA requirements, etc. are unclear as well.  16. Mental/behavioral health resources are limited and an accurate inventory of what is available has not been completed. These resources have not been taken into account during planning efforts. |

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| **Regional Strategies:** |
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| Function 4: Develop Crisis Standards of Care guidance |
| P1. State crisis standards of care guidance |
| P2. Indicators for crisis standards of care |
| P3. Legal protections for healthcare practitioners and institutions |
| P4. Provide guidance for crisis standards of care implementation processes |
| P5. Provide guidance for the management of scarce resources |
| S1. Crisis standards of care training |

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| State Status/Gaps: |
| 1. Crisis standards of care have not been developed. |

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| State Strategies: |
| 1. Utilizing Institute of Medicine (IOM) guidance, utilize a working group with multi-jurisdictional representation to develop a standard guidance for the state.  2. Once standards vetted and approved, develop training and incorporate into multiyear training plan. |

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| **Regional Status/Gaps:** |
| 1. Crisis standards of care do not currently exist at the region or state levels. This includes triggers for implementation, legal issues, scarce resource management, and associated training. |

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| **Regional Strategies:** |
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| Function 5: Provide assistance to healthcare organizations regarding evacuation and shelter in place operations |
| P1. Healthcare organization evacuation and shelter in place plans |
| P2. Healthcare organization preparedness to receive evacuation surge |
| P3. Transportation options for evacuation |
| E1. Specialized equipment needed to evacuate patients |

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| State Status/Gaps: |
| 1. There is variation in stage of development and evaluation of evacuation and shelter-in-place plans for healthcare organizations.  2. The daily census of healthcare organizations in the state is over 90% daily and impacts the ability to receive evacuated patients internal to the state or external.  3. For external evacuation, there are currently 7 Ambulance Strike Teams, but the operational ability is unknown and has not been tested. Additionally, there are 11 evacuation buses statewide. The evacuation plans and associated equipment and training for evacuation in Long Term Care Facilities, Community Health Centers, mental/behavioral health and related ancillary facilities are unknown. A formal resource assessment has not been conducted for larger healthcare organizations. |

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| State Strategies: |
| 1. Finalize evacuation plan template developed by the State of Massachusetts and edited for North Carolina, vet template with regulatory agencies, review with healthcare organization emergency planners, and roll out statewide.  2. Ensure National Disaster Medical System exercise After Action Report and Improvement Plan findings are incorporated into state level plans and shared with partners and stakeholders.  3. As identified previously, Ambulance Strike Team plans and status of teams will be evaluated and future sustainment will be evaluated. Plans for mass mobilization of buses, as well as localized request and mobilization process will be completed and disseminated in coordination with agency and North Carolina Office of Emergency Medical Services leadership.  4. In collaboration with North Carolina Community Health Center Association, Division of Health Service Regulation regional ombudsman, advocacy and/or regulatory groups, and regional personnel, Long Term Care Facilities, Community Health Centers, etc. will be engaged to assess evacuation planning, equipment, and training needs.  5. Based on identified gaps in evacuation equipment from region healthcare organizations, plans will be supported to fill those gaps.  6. In coordination with North Carolina Emergency Management, ensure effective dissemination and technical assistance of updated LTC template. |

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| **Regional Status/Gaps:** |
| 1. Evacuation plans have been developed across healthcare organizations, but not completely. Dissemination of and training on those plans vary for the organizations that have developed them.  2. During an evacuation, patient information has not been standardized among healthcare organizations.  3. Roles and responsibilities during a single or multiple full facility evacuation are unclear related to transport, patient tracking and management, etc.  4. Outside of NDMS, there is not an established plan for receipt of a mass evacuation of patients. There is also not a system that allows for centralized patient tracking, monitoring, and allocation.  5. An inventory and evaluation of evacuation equipment and capabilities compared to needs has not been completed. |

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| **Regional Strategies:** |
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# CAPABILITY 14: Responder Safety and Health

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| The responder safety and health capability describes the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This includes processes to equip, train, and provide other resources needed to ensure healthcare workers at the highest risk for adverse exposure, illness, and injury are adequately protected from all hazards during response and recovery operations. |

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| Function 1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers |
| P1. Pharmaceutical needs assessment |
| P2. Pharmaceutical cache storage, rotation, replacement, and distribution |
| P3. Medical countermeasure dispensing |
| E1. Pharmaceutical cache protection |
| S1. Pharmaceutical cache training |

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| State Status/Gaps: |
| 1. A pharmaceutical needs assessment has not been completed, to include both operational components and healthcare organizations.  2. State Medical Response System operational components maintain pharmaceutical caches, but are not standardized in storage, rotation, or replacement. It is financially prohibitive to maintain eight State Medical Assistance Team II, thirty State Medical Assistance Team III, and the National Mobile Disaster Hospital pharmaceutical caches that vary in cost, contents, storage, rotation, etc.  3. Medical countermeasure dispensing is managed by North Carolina Division of Public Health. North Carolina Office of Emergency Medical Services will collaborate in planning and training needed for dispensing. |

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| State Strategies: |
| 1. Based upon established mission and focus of operational components and recommendations of the pharmacy action team, North Carolina Office of Emergency Medical Services in collaboration with Department of Health and Human Services and healthcare preparedness regional staff, determine the necessary contents and established protocols for storage, rotation, etc.  2. North Carolina Office of Emergency Medical Services and healthcare preparedness regional staff will support North Carolina Division of Public Health planning and training needs related to medical countermeasure dispensing. Training and exercises will be included in the multiyear training plan.  3. In conducting a pharmaceutical needs assessment, planning will be completed with relevant partners to ensure gaps are met through supply, Memorandum of Agreement or Mutual Aid Agreement, contract, or related strategy. |

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| **Regional Status/Gaps:** |
| 1. A pharmaceutical needs assessment has not been conducted that includes both the deployable cache and healthcare organizations stockpiles.  2. Under normal operations, the regional pharmaceutical cache is stored securely and rotated as a part of the pharmacy stockpile. However, there is not a plan for resupply of pharmaceuticals while on deployment. Additionally, the developed retrieval plan has not been updated or exercised recently.  3. The regional trailer retrofitted to store and dispense pharmaceuticals has inadequate security measures in place.  4. Due lack of available training and education and planning assistance, there are a limited number of closed POD plans developed in regional healthcare organizations, outside of the SNS and associated public health plans, and there is a lack of standardization. The plans that are in place have not been adequately trained on or exercised. |

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| **Regional Strategies:** |
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| Function 2: Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during response |
| P1. Personal protective equipment needs assessment |
| P2. Personal protective equipment caches |
| P3. Personal protective equipment supply and dispensing |
| E1. Personal protective equipment for healthcare workers |
| S1. Personal protective equipment training |

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| State Status/Gaps: |
| 1. A Personal Protective Equipment inventory has been conducted, but a formal assessment has not.  2. Healthcare organizations vary in levels Personal Protective Equipment available for staff.  3. State Medical Response System operational component, as well as stakeholder and partner Personal Protective Equipment stocks are reaching end of life and expiration.  4. First receiver training is available, but is not standardized for healthcare organizations and financial sustainability is questionable. |

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| State Strategies: |
| 1. North Carolina Office of Emergency Medical Services, in coordination with healthcare preparedness region staff, will assess needs of State Medical Response System operational components and of stakeholder and partner healthcare organizations.  2. A formal assessment will allow for a purchase, rotation, and replacement plan to be developed to ensure financial viability and stewardship. Inventory system upload completion will also assist in data gathering for Personal Protective Equipment needs.  3. Based on the evaluation of State Medical Response System operational missions and tasking, Personal Protective Equipment needs can be more accurately identified.  4. In collaboration with North Carolina Division of Public Health and North Carolina Hospital Association, identify appropriate standards for healthcare organizations and facilities first receiver training and implement a standard recommendation. |

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| **Regional Status/Gaps:** |
| 1. All regional SMAT III and the SMAT II have decontamination supplies. Healthcare organizations within the region have varying levels of equipment and training. There is no consensus regarding the level of decontamination equipment and supplies that a facility should have.  2. While a regional inventory was initiated FY-12-13, a needs assessment for PPE has not been conducted.  3. The operational role for the SMAT II regarding decontamination and the sustainment of that capability are unclear.  4. SMAT III equipment caches are reaching the end of life cycle or expiration. As a result, equipment packages among region SMAT III are not standardized.  5. Processes for deconfliction of PPE resources and plans for resupply and distribution of PPE, especially to region healthcare organizations, do not exist.  6. Region healthcare organizations do not have a standard established for PPE.  7. There is not a current standard for hospitals regarding decontamination equipment and training.  8. Four to six hospital first receiver courses are generally conducted each year. EMS agencies conduct their own training and most have not trained recently. Additionally, this training is not completed in coordination with healthcare organizations.  9. Due to the staff turnover and lack of use of equipment, there is a lack of training or familiarity with decontamination equipment and processes in hospitals and EMS agencies.  10. Decontamination exercises have not been recently conducted. The exercises that are conducted do not cross jurisdiction or functional lines. |

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| **Regional Strategies:** |
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# CAPABILITY 15: Volunteer Management

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| Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with the medical preparedness and response to incidents and events. |

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| Function 1: Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations |
| P1. Volunteer needs assessment for healthcare organizations response |
| P2. Collect, assemble, maintain, and utilize volunteer information |
| E1. Electronic volunteer registration system |

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| State Status/Gaps: |
| 1. ServNC, the Emergency System for Advanced Registration of Volunteer Health Professionals system in place in North Carolina, is within 750 users of the cap of 10,000 users.  2. Sustainment of existing system based on function and associated cost is unclear.  3. There is a lack of available adequate training for system administrators of ServNC.  4. Healthcare organization volunteer needs assessment and associated planning has not been fully completed across the state. |

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| State Strategies: |
| 1. Contracted staff is managing the system to delete, merge, and/or address unused or duplicate accounts.  2. North Carolina Office of Emergency Medical Services will continue discussion with the vendor to address additional system needs and conduct a cost benefit analysis for sustainment of current system versus more cost-effective solutions.  3. Contract ServNC staff will develop administrator training and execution of that training.  4. In collaboration with relevant healthcare partners, assist with coordinated assessment and planning for healthcare organization volunteers during a medical surge event. |

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| **Regional Status/Gaps:** |
| 1. Outside of specific or extreme situations, a volunteer needs assessment has not been conducted.  2. Most healthcare organizations do not have written plans for credentialing or legal approval of incorporating volunteers.  3. Coalition partners have a limited awareness of how the state could or would assist them with healthcare volunteers. There does not seem to be a consistent set of trigger points for when healthcare volunteers should be requested by partners or assistance provided by the state.  4. There is a deficit of understanding due to lack of usage and training and education for region stakeholders and on ServNC and related benefits for healthcare organizations.  5. When there is a request for healthcare volunteers, there needs to be a clearer understanding of how volunteers are selected or assigned, as well as who does the selecting and assigning.  6. In terms of the SMRS volunteers, there needs to be a consistent minimum standard for education, training, and credentialing established for those volunteers to be considered deployable to the region, state, or federally. Currently, each SMAT is using their own standard for determining if volunteers are deployable.  7. Hospitals have an internal system to manage volunteers and these systems have largely not been tested. |

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| **Regional Strategies:** |
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| Function 2: Volunteer notification for healthcare response needs |
| P1. Process to contact registered volunteers |
| P2. Process to confirm credentials of responding volunteers |
| P3. Volunteer request process |

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| State Status/Gaps: |
| 1. ServNC provides the notification and request functions, but standardized processes have not been established for roles and responsibilities of state and regional personnel to perform these tasks. The process has varied from event to event and there is a general confusion.  2. The system allows for credential verification of responders; however, there is a charge for each external system integration and verification of credential. There are legal and liability issues for healthcare organizations that have not been fully addressed or discussed related to credentialing and usage of volunteers. |

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| State Strategies: |
| 1. In collaboration between North Carolina Office of Emergency Medical Services and healthcare preparedness regional staff, standardized protocols will be established, trained, and exercised to allow for a more efficient and smoother notification, request, and deployment process of volunteers.  2. North Carolina Office of Emergency Medical Services will conduct a cost benefit analysis for sustainment of current system versus more cost-effective solutions. |

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| **Regional Status/Gaps:** |
| 1. Coalition partners are aware the ServNC is currently used to collect, register, verify, and manage healthcare volunteers in NC. Coalition partners need a better understanding of how the volunteers managed through ServNC can benefit them, and under what situations. When there is a request for healthcare volunteers, there needs to be a clearer understanding of how volunteers are selected or assigned, as well as who does the selecting and assigning. Regional partners do not have a method to contact volunteers other than the ones available through ServNC.  2. Healthcare facilities do not have knowledge of the credentialing process through ServNC and there are unaddressed legal barriers related to credentialing.  3. There is no information regarding the ability of Long Term Care to accept volunteers. |

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| **Regional Strategies:** |
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| Function 3: Organization and assignment of volunteers |
| P1. Volunteer deployment protocols |
| P2. Briefing template for healthcare volunteers |
| P3. Volunteer support services |

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| State Status/Gaps: |
| 1. Standardized deployment protocols, to include briefing templates, have not been developed.  2. During a State Emergency Operations Center activation and deployment, support services will be managed through other Emergency Support Functions. It is unknown if there are standardized processes for localized events. Mental/behavioral health support services are also unknown. |

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| State Strategies: |
| 1. North Carolina Office of Emergency Medical Services, in collaboration with healthcare preparedness region staff and team leaders, will capitalize on those teams that utilize established protocols to develop standardized deployment protocols, treatment policies and protocols, and briefing templates for use by all deploying teams across the State Medical Response System.  2. Through identified gaps in regional analysis, plans or processes will be developed collaboratively to address deficiencies in support services at the local stakeholder or organization level. |

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| **Regional Status/Gaps:** |
| 1. Coalition partners understand that they can request assistance with volunteer personnel from Emergency Management and the Office of EMS. Beyond the usage of ServNC, coalition partners have not developed protocols and are unaware of any established protocols at the state level related to volunteer deployment, tracking, and personal information management. There are no internal protocols for volunteer deployment at hospitals.  2. Coalition partners currently use their own different templates, many HICS based, to share information during an event or incident. There is no specific briefing template for healthcare volunteers.  3. Minimal just in time training is planned.  4. Coalition partners and stakeholders are not completely aware of how or under what plans the region, NCEM and NCOEMS will provide support to healthcare volunteers. Regional partners are not sure what their responsibility is for volunteers they receive from the state. |

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| **Regional Strategies:** |
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| Function 4: Coordinate the demobilization of volunteers |
| P1. Volunteer release processes |
| P2. Volunteer exit screening protocols |

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| State Status/Gaps: |
| 1. Similar to identified gap in previous section, standardized demobilization protocols have not been developed. |

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| State Strategies: |
| 1. North Carolina Office of Emergency Medical Services, in collaboration with healthcare preparedness region staff and team leaders, will capitalize on those teams that utilize established protocols to develop standardized deployment protocols, treatment policies and protocols, and briefing templates for use by all deploying teams across the State Medical Response System.  2. Through identified gaps in regional analysis, plans or processes will be developed collaboratively to address deficiencies in volunteer management at the local stakeholder or organization level. |

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| **Regional Status/Gaps:** |
| 1. Currently, there are no demobilization protocols. The need for further volunteers is determined by the local impacted entity and the unified command. In many cases, demobilization planning has been left up to the incident management personnel.  2. There is no standardized exit screening for personnel among the SMRS and among coalition partners and stakeholders. |

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| **Regional Strategies:** |
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# ANNEX A

# Capability 1: Healthcare System Preparedness

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 1: Healthcare System Preparedness. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

**Capability Definition**

* Healthcare system preparedness is the ability of a community’s healthcare system to prepare, respond, and recover from incidents that have a public health and medical impact in the short and long term. The healthcare system role in community preparedness involves coordination with emergency management, public health, mental/behavioral health providers, community and faith-based partners, state, local, and territorial governments to do the following:
  + Provide and sustain a tiered, scalable, and flexible approach to attain needed disaster response and recovery capabilities while not jeopardizing services to individuals in the community
  + Provide timely monitoring and management of resources
  + Coordinate the allocation of emergency medical care resources
  + Provide timely and relevant information on the status of the incident and healthcare system to key stakeholders
* Healthcare system preparedness is achieved through a *continuous cycle of planning, organizing and equipping, training, exercises, evaluations and corrective actions.*

**Healthcare System Preparedness**

* Follows the steps of the Preparedness Cycle as outlined by FEMA
* Concentrates on community based collaborative planning as outlined by PPD-8 and CPG 101
* **Intent:** A guide for local healthcare planners for coalition development, planning, organizing & equipping, training, exercises, evaluation
* Also includes mitigation
  + Capability 1, Function 3: Identify and prioritize essential healthcare assets and services
  + Addresses healthcare priorities and needs
* At-Risk Individuals
  + Capability 1, Function 7: Coordinate with planning for at-risk individuals and those with special medical needs
  + Mandated by PAHPA

*In capability 1, Healthcare Coalition development is described and the preparedness cycle is outlined in detail as it relates to healthcare system preparedness. In the cycle, the required steps for planning, equipping, training, exercising and evaluation activities are defined. Preparedness is defined as "a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response."  This 'preparedness cycle' is one element of a broader National Preparedness System to prevent, respond to, recover from, and mitigate against natural disasters, acts of terrorism, and other man-made disasters.*

The planning process should provide a forum for collaborative planning for healthcare and public health

**Plan:**

* Addresses:
  + Collaborative planning (Healthcare Coalition)
  + Hazards and risks that the community faces
  + Coordination and Control throughout the hierarchy of response
  + Healthcare system organization
  + Roles and responsibilities of each agency
  + Sequence of Actions for response
  + Recovery operations
  + Resources and support
  + Finances
  + Training and exercise schedules
  + Improvement processes

**EVALUATE/ IMPROVE**

**PLAN**

**ORGANIZE/ EQUIP**

**EXERCISE**

**TRAIN**

**Organize and Equip:**

* Performs resource assessments
* Performs gap analysis
* Deconflicts resources

**Train:**

* Provides healthcare responders with the **knowledge, skills, and abilities** to complete the mission
* Based on the unique needs of the healthcare organizations

**Exercise:**

* Exercises the plan to see if it works

**Evaluate and Improve:**

* Identifies **best practices, gaps, and corrective actions** in the plan and applies these findings in improvement plans

**EVALUATE/ IMPROVE**

**PLAN**

**ORGANIZE/ EQUIP**

**EXERCISE**

**TRAIN**

Expectations based on the functions of the healthcare system preparedness capability

* 1. Collaborative preparedness
  2. Coordinated and comprehensive planning based on risk
  3. Prioritization of essential healthcare services
  4. Resource management / gap analysis
  5. Training based on priorities and needs
  6. Exercise and evaluation

**Function 1**: **Healthcare Coalition Development**

Formation of a collaborative planning group is one of the first steps of planning and preparedness. In function 1, the collaborative planning group is described as the Healthcare Coalition and the outline for development is flexible and requires the following components:

* The geographic boundaries of the region are defined in 1 of 2 methods:
  + Formation of Healthcare Coalitions as a component of a larger planning organization or region (e.g., EMS or EMA regions).
  + Formation of Healthcare Coalitions around healthcare delivery areas (e.g., Regional Coordinating Hospital Region, Trauma Region, etc.)
* The participants should encompass a well-established core membership representing key healthcare and emergency response sectors to ensure a broad perspective on healthcare response operations
* A governance structure is defined to include leadership and ESF#8 integration
* Methods of sustainment are developed to ensure ongoing participation.
* The Healthcare Coalition is established for purposes of preparedness and to represent healthcare organizations’ priorities and needs in preparedness and response.

The State or awardee role in Healthcare Coalitions is vital. The State should be a partner and/or a supporter of the coalitions. The goal is comprehensive representation of healthcare organizations priorities and needs in incident response. How the State manages this is varied and flexible largely dependent on State government and jurisdictional authority.

***Objectives:***

* *Stage 1: Establish the healthcare coalition for purposes of preparedness*
* *Stage 2: Collaborative planning, organizing and equipping, training, exercising and evaluation*
* *Stage 3:Multi-agency coordination during response by planning/representation*

***Resource requirements for successful completion of this function*:**

* Evidence based documents that detail the organizational structure and function of the Healthcare Coalition

**Function 2**: **Coordinate healthcare planning to prepare the healthcare system for a disaster**

In this function, strategic and operational healthcare planning is developed to establish priorities, identify expected levels of performance and capability requirements, provide the standard for assessing capabilities, and helps stakeholders learn their roles. The plans identify what an organization’s Standard Operating Procedures (SOPs) or Emergency Operations Plans (EOPs) should include for ensuring that contingencies are in place for delivering the capability during a large-scale disaster. This planning at the regional or Healthcare Coalition level should be reflective of and integrate into ongoing regional based planning initiatives for healthcare. This function addresses the healthcare risk assessment and the courses of action that are required to prepare for identified risks. Operational plans for surge management, information sharing, continuity of operations and fatality management are produced. This function is based on the FEMA document, Comprehensive Preparedness Guide 101 Version 2.0.

***Objectives:***

* *Coordination of local risk assessments and hazard vulnerability assessments*
* *Coordination of healthcare priorities and response needs in ESF8 plans*
  + *Medical Surge*
  + *Fatality Management*
  + *Recovery/COOP*
  + *Communications*

***Resource requirements for successful completion of this function*:**

* Coordinated regional public health and medical risk assessments
* Coordinated regional public health and medical EOPs or SOPs specific to Medical Surge, COOP, Fatality Management, Information Sharing, Volunteer Management

**Function 3: Identify and prioritize essential healthcare assets and services**

Prevention and Protection (mitigation) is the focus of function 3 and includes Critical Infrastructure Protection [CIP] planning. This step in healthcare planning is guided by the healthcare risk assessment performed in the previous function. The intent is to address the community’s healthcare critical infrastructure and key resources (CI/KR) that are vital to maintain a continuation of essential services for healthcare delivery throughout the lifespan of the disaster. The focus is to provide alternative regional-based methods to enhance critical services. These include the vital data and business processes of the healthcare system as well and patient services, security and physical plant operations. It is important to note that regional priorities are based on local risk assessment but funding is based on the larger multi-regional priorities of the State or awardee.

***Objective:***

* *Identification and planning for essential healthcare services required to continue the delivery of critical healthcare services*

***Resource requirements for successful completion of this function*:**

* Risk assessment that identifies vulnerabilities of healthcare delivery
* Prioritization of the regional essential services and assets for healthcare delivery
* Plans, protocols or processes to address CI/KR resource deficiencies

**Function 4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps**

Organizing and equipping provides the physical manpower and equipment resources necessary to build capabilities and address modernization and sustainability requirements. It includes identifying what competencies and skill sets people delivering a capability should possess and ensuring an organization possesses the correct personnel. Additionally, it includes identifying and acquiring standard and/or surge equipment an organization may need to use when delivering a specific healthcare capability. Decisions to organize and equip healthcare is guided by stakeholder needs, State and community healthcare priorities, capabilities-based planning, and relevant legislation, policies, doctrine, and risk assessments.

***Objective****:*

* *Resource management*
  + *Gap analysis and deconfliction of resources*

***Resource requirements for successful completion of this function*:**

* A complete resource assessment of the healthcare assets used for response
* Deconfliction matrix that ensures resources are not over allocated
* Plans, protocols or processes that provide resources from multiple sources to fill the gaps in response

**Function 5**: **Coordinate training to assist healthcare responders to develop the necessary skills in order to respond**

Specific healthcare training and overarching disaster training provides Healthcare Coalition responders and their partner Healthcare Organizations with the knowledge, skills, and abilities needed to perform key healthcare response tasks required by specific capabilities. This training also assists support agencies, organization officials, governmental, private and non-governmental partners, and other personnel to understand how healthcare response will be integrated with the incident response. Overall healthcare training decisions should be based on information derived from risk assessments, improvement plans, and gap analysis determined in continuous improvement cycle. Healthcare training should integrate into the larger multijurisdictional or State training initiatives.

***Objective:***

* *Healthcare disaster response training based on capabilities and healthcare organization need*

***Resource requirements for successful completion of this function*:**

* Coordinated training plans for specific healthcare response
* Coordinated training plans that address ESF #8 (Public Health and Medical) integration
* Training plans that addresses healthcare integration into the National Incident Management System (NIMS)

***North Carolina Note:*** *Training to assist healthcare responders to develop the necessary skills in order to respond is coordinated at the State level, to ensure standardization and decrease the workload of the healthcare coalition. Planning is a collaborative effort between OEMS, Public Health and other response partners and healthcare organizations. Training is determined through the planning process including but not limited to risk assessment, gap analysis and specific needs of the ESF8 community.*

**Function 6: Improve healthcare response capabilities through coordinated exercise and evaluation**

Healthcare exercise implementation and the overall improvement process are described in Function 6. Exercises assess and validate the speed, effectiveness and efficiency of capabilities, and test the adequacy of policies, plans, procedures, and protocols in a risk-free environment.  Aside from actual events, they provide the best means of evaluating the healthcare capabilities. Exercise should be conducted in conjunction with jurisdictional/regional, State or Federal based exercises when possible. This improves integration efforts and may be more efficient. Exercises should be based in HSEEP and monitored/evaluated by the State level awardee. Exercise decisions are determined based on planning priorities, risk assessments, gap analysis and the continuous improvement process to address the required corrective actions identified in improvement plans.

Evaluation and improvement of mission and task performance is the final step of the Preparedness Cycle and crucial to informing risk assessments, managing vulnerabilities, allocating resources, and informing the other elements of the Cycle. Organizations develop improvement plans and track corrective actions to address the capabilities identified in plans and tested in exercises or real events. In addition to corrective actions, assessment initiatives provide the means to evaluate regional public health and medical operational preparedness for key critical areas. Using these findings to reassess and revise plans and protocols contributes to a continuous improvement process and ensures that updated strategies and plans can be used to inform new preparedness-building activities.

***Objectives:***

* *Evaluation of the effectiveness of planning through exercise or real event*
* *Corrective actions based on identified gaps*
* *Sharing of best practices*

***Resource requirements for successful completion of this function*:**

* Exercise plans (coordinated at the State level)
* Corrective Action Plans
* A method to share best practices and response gaps

***North Carolina Note:*** *Exercise planning and implantation to improve healthcare response capabilities is coordinated at the State level, to ensure standardization and decrease the workload of the healthcare coalition. Planning is a collaborative effort between OEMS, Public Health and other response partners and healthcare organizations. Exercise needs are determined through the planning process including but not limited to risk assessment, gap analysis and specific needs of the ESF8 community.*

**Function 7**: **Coordinate with planning for at-risk individuals and those with special medical needs**

The authority for this function derives from the Pandemic All-Hazards Preparedness Act (PAHPA). At-risk individuals are defined by the ASPR Office for At-Risk Individuals, Behavioral Health, and Human Services Coordination (ABC). This function describes the healthcare role as participation and assistance with the overall planning of the area related to at-risk individuals. Healthcare should assist, when possible, with the identification of the individuals who would need medical treatment at a healthcare facility during a disaster. Planning is coordinated for the transport options into healthcare facilities from compromised locations. Planning is also coordinated for the transfer options to healthcare facilities from shelters or other facilities. The priority is medical treatment to those who need it at the appropriate healthcare facility.

***Objective:***

* *Coordinated plans for at-risk individuals*

***Resource requirements for successful completion of this function*:**

* Coordinated ESF8 Plans

**Resources:**

* FEMA preparedness: <http://www.fema.gov/prepared/index.shtm>
* PPD-8: <http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm>
* CPG 101: <http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf>

# Capability 2: Healthcare System Preparedness

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 2: Healthcare System Recovery. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

**Capability Definition:**

* Healthcare system recovery involves the collaboration with Emergency Management and other community partners, (e.g., public health, business, and education) to develop efficient processes and advocate for the rebuilding of public health, medical, and mental/behavioral health systems to at least a level of functioning comparable to pre-incident levels and improved levels where possible. The focus is an effective and efficient return to normalcy or a new standard of normalcy for the provision of healthcare delivery to the community.
* Expectations based on the functions of Healthcare System Recovery
  + Healthcare system recovery planning
  + Healthcare organization COOP assistance

**Function 1: Develop recovery processes for the healthcare delivery system**

Healthcare system recovery planning includes assessment of healthcare delivery recovery needs post disaster and the provision of healthcare organization recovery assistance if requested. Encouragement should be provided to healthcare organizations to participate with recovery planning and processes as outlined by the NDRF.

**Objective:**

* Coordination with recovery process as outlined by the NDRF

***Resource requirements for successful completion of this function:***

* Healthcare recovery assistance plan (includes assessment plan)

**Function 2: Assist healthcare organizations to implement Continuity of Operations (COOP)**

COOP is not mandated by the healthcare preparedness capabilities or the Federal government. This function is only a guide to planning for the phases of COOP based on the FEMA Continuity Guidance Circular 2. It is recommended but voluntary and should be encouraged by the awardee. However, the primary responsibility is that of the private entity and may be cost prohibitive. The importance of this planning is based on what services are determined essential to the community and may be addressed in a collaborative forum such as the healthcare coalition. Awardees should be able to assist healthcare organizations with the development of a plan for COOP implementation if requested.

**Objective:**

Develop a plan to assist healthcare organizations with COOP if requested

***Resource requirements for successful completion of this function:***

* COOP assistance plan (implemented upon request of healthcare organizations)

**Function 2 based on phases of COOP**

* + **Phase I** – Readiness and Preparedness.
  + **Phase II** – Activation and Relocation: plans, procedures, and schedules to transfer activities, personnel, records, and equipment to alternate facilities are activated.
  + **Phase III** – Continuity Operations: full execution of essential operations at alternate operating facilities is commenced.
  + **Phase IV** – Reconstitution: operations at alternate facility are terminated and normal operations resume

**Expected resources:**

* Recovery assistance plan
* COOP assistance plan

**Implementation:**

* Coordination with lead recovery agency to develop plans
* Encouragement to critical healthcare organizations to develop COOP plans
* Exercises and evaluations of response plans

**Resources**:

* National Disaster Recovery Framework (NDRF): <http://www.fema.gov/recoveryframework/index.shtm>
* Continuity Guidance Circular 1 (CGC 1), Continuity Guidance for Non-Federal Entities (States, Territories, Tribal, and Local Government Jurisdictions and Private Sector Organizations), January 2009: <http://www.fema.gov/pdf/about/org/ncp/cont_guidance1.pdf>

# Capability 3: Emergency Operations Coordination (Healthcare System Response)

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 3: Emergency Operations Coordination (Healthcare System Response). Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

The intent of preparedness is to enhance response and recovery of healthcare organizations to ensure there is a continuation of essential healthcare services. Comprehensive response is guided by relevant and actionable information (situational awareness) during the decision making process for resource allocation to healthcare organizations. The expectation for healthcare coalitions is multi-agency **integration and representation** at the command and control level of local or State disaster response. **The healthcare coalition does not supplant the authority of the individual public health or medical assets or the authority of the designated lead response and recovery agencies as outlined by local, State and Federal regulations, NIMS, and the NRF.** Emergency Operations Coordination only focuses on healthcare integration into ESF-8 response to ensure healthcare priorities and needs are addressed by incident management. Resource allocation decisions should be based on healthcare organizations’ priorities and needs.

**Capability Definition:**

* Emergency operations coordination regarding healthcare is the ability for healthcare organizations to engage with incident management at the Emergency Operations Center or with on-scene incident management during an incident to coordinate information and resource allocation for affected healthcare organizations. This is done through multi-agency coordination representing healthcare organizations or by integrating this coordination into plans and protocols that guide incident management to make the appropriate decisions. Coordination ensures that the healthcare organizations, incident management, and the public have relevant and timely information about the status and needs of the healthcare delivery system in the community. This enables healthcare organizations to coordinate their response with that of the community response and according to the framework of the National Incident Management System (NIMS).
* Expectations based on the functions of Emergency Operations Coordination
  + Multi-agency coordination
  + Sharing of healthcare delivery status
  + Resource management

**Function 1: Healthcare organization multi-agency representation and coordination with emergency operations**

Multi-agency coordination and representation may be achieved through development of strong healthcare coalitions. The healthcare coalition provides a coordination point for information regarding healthcare priorities and needs. Integration with command and control is accomplished through the ESF8 structure of the jurisdiction/region, State or Federal government during response as outlined by PPD-8, the NRF, the NIMS and guided by the Medical Surge Capacity and Capability (MSCC).

**Objectives:**

* Implementation through multi-agency coordination by healthcare coalitions representing healthcare organizations
* Requires ESF-8 POC
* Requires understanding of local level disaster management

***Resource requirements for successful completion of this function*:**

* Plans for healthcare organization multi-agency coordination during response

**Function 2:** **Assess and notify stakeholders of healthcare delivery status**

The objective of function 2 is the sharing of healthcare delivery status and the ability of healthcare organization to receive incident specific information. There must be a process in place for incident management to ascertain the immediate resource needs of healthcare organizations so that appropriate allocation of resources can be achieved. Note that there must be a two-way sharing of status (healthcare and incident). Another goal of this function is to ensure that the status of the healthcare delivery system is shared with the community using “one voice” of public information

**Objectives:**

* Process for immediate resource assessment
* Horizontal and vertical sharing of status

***Resource requirements for successful completion of this function:***

* Local healthcare resource needs assessments (pre-response)
* Coordinated resource management plans (plans for assessing immediate resource needs during response)

**Function 3: Support healthcare response efforts through coordination of resources**

Resource management is indicated throughout all of the capabilities but actual implementation occurs during emergency operations coordination. Resources are the basis for efficient response and are at the core of medical surge. This includes the “stuff” and the skill to properly manage patients and save lives. In capability 1, resource assessment, gap analysis and resource deconfliction is addressed in planning. In this capability, healthcare organizations and incident management will utilize plans to get the required resources in order to provide essential healthcare services.

**Objective:**

* Resource management

***Resource requirements for successful completion of this function:***

* Coordinated resource management plan
* Matrix of resource availability
* “Stuff” – staff, equipment, supply, space, etc…
* Deconfliction – the process of determining if resources have been over-allocated (assigned to more than 1 course of action) and adjusting the over allocation
* Resource management

**Function 4: Demobilize and evaluate healthcare operations**

Resource management is also the objective of function 4, however this is the reimbursement, reordering, refurbishing of used resources. It also requires evaluation of the resources that were used or needed and not available. This would be addressed in improvement planning and corrective action could be taken immediately or during the next planning cycle.

**Objectives:**

* Resource management
* Improvement planning

***Resource requirements for successful completion of this function:***

* Coordinated resource management plan
* Continuous quality improvement process

**Expected resources:**

* Resource management plan
* Improvement plan

**Implementation:**

* Gap analysis
* Exercises and evaluations of response plans
* Evaluation of real incidents
* Continuous quality improvement

**Resources:**

* Presidential Policy Directive/PPD-8: <http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm>
* National Response Framework. U.S. Department of Homeland Security. Jan 2008: <http://www.fema.gov/pdf/emergency/nrf/nrf-core.pdf>
* National Incident Management System. U.S. Department of Homeland Security. Dec 2008: <http://www.fema.gov/pdf/emergency/nims/NIMS_core.pdf>
* Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery. U.S. Department of Health and Human Services: <http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/default.aspx>
* Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, 2007: <http://www.phe.gov/preparedness/planning/mscc/handbook/pages/default.aspx>
* FEMA IS – 702.A NIMS Public Information: <http://training.fema.gov/EMIweb/IS/IS702a.asp>

# Capability 5: Fatality Management

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 5: Fatality Management. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

Fatality management is a process that occurs in the community and is led by agencies dependent on the state in which the incident occurs. Fatality management needs to be incorporated in the surveillance and intelligence sharing networks, to identify sentinel cases of bioterrorism and other public health threats. Fatality management operations are conducted through a unified command structure.

Fatality Management as related to healthcare organizations is based on surges of deaths at healthcare facilities and the focus is on planning for human remain storage (culturally sensitive). This also addresses surges of concerned citizens during mass fatalities and the provision of mental/behavioral health support for healthcare responders. This planning will requires coordination with community resources for storage and should integrate with fatality management lead agency and relevant partners.

**Capability Definition:**

* Fatality management is the ability to coordinate with organizations (e.g., law enforcement, healthcare, emergency management, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services for family members, responders, and survivors of an incident. Coordination also includes the proper and culturally sensitive storage of human remains during periods of increased deaths at healthcare organizations during an incident.
* Expectations based on the functions of Fatality Management
  + Management of death surge
  + Coordinate surges of concerned citizens
  + Support the mental/behavioral health needs of healthcare workers

**Function 1: Coordinate surges of deaths and human remains at healthcare organizations with community fatality management operations**

The objectives for the function focus on a risk-based needs assessment for human remain storage options and the plan for culturally sensitive storage during death surges. Death surge is a healthcare organization specific phenomenon while fatality management is more community based. However, assets for the storage of human remains are often shared and planning needs to be coordinated accordingly. If determined necessary, equipment to assist with the anticipated need may be developed or refined.

***Resource requirements for successful completion of this function:***

* Medical surge plan addressing death surges at healthcare facilities and subsequent human remain storage
* Equipment for human remain storage if determined necessary

**Objectives**:

* Risk based needs assessment for storage options
* Plan for culturally sensitive storage

**Function 2: Coordinate surges of concerned citizens with community agencies responsible for family assistance**

When there are mass fatalities in the community, there are often family members seeking out the location of their loved ones. The objective for this function is to assist healthcare organizations, with a plan to redirect surges of concerned citizens to the appropriate family assistance center.

**Objectives:**

* Coordinate with community family assistance centers

***Resource requirements for successful completion of this function:***

* Medical surge plan addressing surges of concerned citizens at healthcare facilities
* Medical surge plans should also address mass hysteria

**Function 3: Mental/behavioral support at the healthcare organization level**

**Objectives**:

* Provide mental/behavioral health support services or have a process to request from the community network

***Resource requirements for successful completion of this function:***

* Medical surge plan addressing support for healthcare workers mental/behavioral health needs.
* Surge plan addressing human remain storage, concerned citizens

**Implementation:**

* 1st: Assess need
* 2nd: Develop based on risk
* Exercises and evaluations of operational plans

**Resources:**

* Hazard Risk Assessment Instrument Workbook: <http://www.cphd.ucla.edu/hrai.html>
* FEMA: Understanding Your Risks: Identifying Hazards and Estimating Losses: <http://www.fema.gov/library/viewRecord.do?id=1880>
* Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101, Version 2.0, November 2010 (CPG 101, V.2), pgs 4.7-4.11: <http://www.fema.gov/pdf/about/divisions/npd/CPG_101_V2.pdf>

# Capability 6: Information Sharing

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 6: Information Sharing. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

An effective intelligence/information sharing and dissemination system will provide durable, reliable, and effective information exchanges (both horizontally and vertically) between those responsible for gathering information and the analysts and consumers of threat-related information. It will also allow for feedback and other necessary communications in addition to the regular flow of information and intelligence.

Information Sharing is the primary support capability for medical surge response and healthcare organization recovery. The intent of the capability is the utilization of relevant, timely information for proper resource allocation. This information sharing requires Federal, State and local government and private healthcare organizations collaboration to determine the essential elements of information. Capability 6 is highly systems focused and require statewide and federal coordination.

**Capability Definition:**

* Information sharing is the ability to conduct multijurisdictional, multidisciplinary exchange of public health and medical related information and situational awareness between the healthcare system and local, state, Federal, tribal, and territorial levels of government and the private sector. This includes the sharing of healthcare information through routine coordination with the Joint Information System for dissemination to the local, state, and Federal levels of government and the community in preparation for and response to events or incidents of public health and medical significance.
* Expectations:
  + Coordinated information sharing processes to provide vertical and horizontal situational awareness
  + Vertical: ESF-8, Incident Management (local, State, Federal)
  + Horizontal: Partners, stakeholders, and the community
  + Interoperable and redundant communication / information platforms

**Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture**

The objective of function 1 is to develop coordinated information sharing processes that provide vertical and horizontal situational awareness. The agreement upon Essential Elements of Information (EEIs) that provide the who, what, when, where, how and why of information sharing is the primary planning component. However, this may require system development or refinement to adequately address the surge components of bed tracking, patient tracking, and patient record tracking.

**Objectives:**

* Who, What, When, Where, How and Why of information sharing
* Essential Elements of Information (EEIs)
* System development/refinement

***Resource requirements for successful completion of this function*:**

* Information management / communications plan
* Information management systems

**Bed tracking:**

* Provide information on the bed status of the healthcare delivery system
* Provide insight into the ability of the healthcare organization to accept a surge of patients (This is dependent on preplanning accuracy of surge and capacity estimates and current available data from healthcare organizations [e.g., number of available beds, number of beds that can be used based on resources, and contingency plans for surge that are in effect])
* Bed tracking processes may be an automated electronic system with the redundant system being a manual reporting process
* Integrate information into the incident common operating picture
* Assist incident management and healthcare entities with decisions regarding resource allocation, anticipated requests for assistance, and transport decisions

**Patient tracking:**

* Develop, refine, and sustain a process to track patients and/or have access to an electronic patient tracking system during an incident.
* Access relevant and available aggregate patient tracking data from EMS and healthcare organizations (e.g., number of patients requiring receiving facilities, requiring transfer services)
* Integrate the aggregate patient tracking data into the local, state and/or Federal incident common operating picture
* Integrate with the Federal patient tracking system of record
  + Joint Patient Assessment and Tracking System (JPATS) used by the National Medical System (NDMS) patient movement system

**Healthcare essential elements of information:**

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, determine reportable healthcare incident specific information to be used during the response. This information identifies the essential elements of information that can be reasonably shared during an incident. The process should enable the sharing of timely, relevant and actionable information during response that assists incident management with decisions to provide healthcare organizations with immediate resource needs. This information should be coordinated and agreed upon by healthcare organizations and local, state and Federal response partners. Guidelines for these elements should ensure information is incident specific, timely, relevant, actionable, and flexible enough so that appropriate response decisions can be executed.

Minimal information requirements should include, but are not limited to, the following elements:

* The types of information that can be shared
* The frequency that information should be shared
* Participants authorized to receive and share data
* Data use and re-release parameters
* Data protections
* Legal, statutory, privacy, and intellectual property considerations
* Information system security (ISS)
* Examples of types of information to consider when defining reportable elements can include:
  + Facility operating status
  + Facility structural integrity
  + The status of evacuations/shelter in-place operations
  + Critical medical services (e.g., trauma, critical care)
  + Critical service status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning)
  + Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supplies, and medical equipment)
  + Staffing status
  + Emergency Medical Services (EMS) status involving patient transport, tracking, and availability
  + Other information as applicable or determined through coordination

**Function 2: Develop, refine, and sustain redundant, interoperable communication systems**

The focus of this function is interoperable and redundant communication and information platforms. These platforms require collaboration not only during development but also during communication planning. The systems should be able to provide redundant interoperable communication both horizontally and vertically within the response framework.

**Objectives**:

* Communication planning
* System development/refinement

***Resource requirements for successful completion of this function*:**

* Information management / communications plan
* Redundant communication systems

**Implementation:**

* Development / refinement of plans and systems
* Exercises and evaluations of these plans
* System demonstration testing
* Evaluation of real incidents

**References:**

* Statewide Interoperability Coordination: <http://www.dhs.gov/files/programs/gc_1286986920144.shtm>
* Regional Emergency Communications Coordination Working Group: <http://www.fema.gov/about/regions/regioniii/councils.shtm>
* Federal Communications Commission regulations: <http://www.fcc.gov/topic/emergency-communications>

# Capability 10: Medical Surge

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 10: Medical Surge. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

*Medical Surge is the rapid expansion of the capacity of the existing healthcare system in order to provide triage and subsequent medical care. The goal is rapid and appropriate care for the injured or ill from the event and the maintenance of continuity of care for non-incident related illness or injury. This capability is based on the Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources during Large-Scale Emergencies. The emphasis is on hospital surge management and how collaborative planning can assist with pre-hospital coordination of surge, surge assessment, bed decompression, patient movement, and specialized services.*

*Medical surge preparedness is the basis for the Healthcare Preparedness Capabilities. Resource planning for surge capacity and capability is paramount. The functions address common “chokepoints” in healthcare delivery during surge incidents. Whether an individual has a traumatic injury, a medical illness such as influenza, a mental or behavioral health issue or is just looking for a family member, they usually arrive at the hospital emergency department for help. These surges increase during disaster and can severely impact the delivery of essential healthcare services. The capabilities document focuses on preparing and mitigating for the ability to continue essential healthcare services.*

**Capability Definition:**

* Medical surge is the ability to provide adequate medical evaluation and care during incidents that exceed the limits of the normal medical infrastructure within the community. This encompasses the ability of healthcare organizations to survive an all-hazards incident, and maintain or rapidly recover operations that were compromised.
* Expectations based on the functions of the medical surge capability:
  + Coordination of multi-facility surges
  + Pre-hospital surge coordination
  + Coordination of surges (i.e., patients, deaths, concerned citizens)
  + Specialized surges (e.g., pediatric, contaminations, trauma)
  + Planning for the allocation of scarce resources and crisis standards of care
  + Evacuation planning for sending and receiving areas/facilities

**Function 1: The Healthcare Coalition assists with the coordination of the healthcare organization response during incidents that require medical surge**

The objective of this function is multi-agency coordination of medical surge so that healthcare organizations priorities and needs are represented during surge response. This includes resource management to ensure healthcare organizations have the “stuff” they need to operate or the means to request it (e.g., staffing, space, equipment, skills). This function is also meant to coordinate information management so that the information flow assists incident management, healthcare organizations and the public to effectively respond during surge.

**Objectives:**

* Multi-agency coordination of medical surge: Healthcare organizations priorities and needs are represented during surge response
* Resource management: Healthcare organizations have the “stuff” they need to operate or the means to request it
  + Resource assessment (e.g., staffing, space, equipment, skills)
* Information management: The information flow assists incident management, healthcare organizations and the public to effectively respond during surge

***Resource requirements for successful completion of this function*:**

* Evidence based documents that detail the organizational structure and function of the Healthcare Coalition
* Resource management plan (coordinated with ESF8, EM)
* Information management / communications plan (coordinated with ESF8, EM)

**Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations**

The objective of this function is healthcare organization coordination with Emergency Medical Services (EMS). This includes coordination of on-scene and facility level patient movement related to surge status. There should be the ability for healthcare organizations to see the overall pre-hospital patient movement status and also the ability for EMS to see the facility receiving status. A mechanism then could be initiated to divert patients based on status dramatically decreasing surge levels and increasing the availability of essential healthcare services. One of the tenets of this function is for healthcare organization to increase their understanding of EMS disaster methodologies to better prepare.

**Objective:**

* Coordination with EMS:
  + Coordination of on-scene and facility level patient movement related to surge status
  + Healthcare organization understanding of EMS disaster methodologies

***Resource requirements for successful completion of this function:***

* Medical surge plan

**Function 3: Assist healthcare organizations with surge capacity and capability**

This function contains the primary guidance for the medical surge capability. The objective is the maximization of healthcare organization surge capacity and capability. This includes the assessment, decompression, and resource management of surge incidents. It requires planning for known bottlenecks (e.g., critical care, radiology, surgery, blood) and preparation for specialized medical care and evaluation (e.g., pediatric training, trauma training).

A priority of this function is the development or refinement of processes that assist healthcare organizations with daily, continuous, triage of admitted patients and discharge planning to permit the safe discharge of less acute patients, ensuring twenty percent acute bed availability in the event of a disaster. This refers to the ability to clear beds and NOT a surge capacity of 120%. This priority is healthcare organization specific and can be supported by healthcare coalitions through collaborative planning to address maximization.

**Objective:**

* Maximize healthcare organization surge capacity and capability:
  + Assessment, decompression, and resource management of surge
  + Planning for known bottlenecks (e.g., critical care, radiology, surgery, blood)
  + Preparing for specialized needs (e.g., pediatric training, trauma training)

***Resource requirements for successful completion of this function*:**

* Medical surge plan

**Surge Assessment:**

***Note:*** *Maximum facility surge capacity is the provision of the highest level of care that can be provided to patients in the available beds that can be staffed and also have the required resources for care. This is guided by risk assessments and gap analysis regarding the estimated surge.*

* Pre-incident assessment of normal operating capacity for healthcare organizations within the healthcare delivery area
* Pre-incident estimate of surge casualties (i.e., medical casualties, mental/behavioral health casualties)[estimates are based on the risk assessment]
* Pre-incident assessment of available resources to address surge estimates
* Development of surge capacity indicators that would trigger different aspects of the medical surge plan (e.g., surge in place strategies; early discharge, cancelled elective surgeries; augmented personnel; extra shifts, volunteers; established alternate care sites or activated mobile units; requested mutual aid)
* Processes to immediately identify an increase in medical surge status during an incident (e.g., medical, mental/behavioral health, concerned individuals)

**Decompression (clearing beds):**

* Develop, refine, sustain, and implement processes that assist healthcare organizations with daily, continuous, triage of admitted patients and discharge planning to permit the safe discharge of less acute patients, ensuring twenty percent acute bed availability in the event of a disaster
* Coordination with non-acute care facilities to accept patients to clear beds (e.g., Community Health Centers, SNFs, and home healthcare )
* State led coordination with Veterans Health Administration and Department of Defense to establish options for assistance with patient care, transfer of patients, and additional assistance during medical surge operations
* Development of viable options to share healthcare assets (e.g., beds, staffing, equipment) between healthcare organizations
* Protocols to request immediate resources needed to decompress beds (e.g., transport, staffing, space, equipment and supply needs)
* Develop, refine, and sustain patient movement options to address psychiatric beds, involuntary holds, and patients with exposure to CBRNE

**Alternate surge sites (healthcare organization or Healthcare Coalition):**

* Protocols to assist with activation of alternate surge sites if requested by the healthcare organization. This may include the following elements:
  + Processes to supply surge tents or trailers and equipment to serve as additional treatment areas for patients when available (e.g., mobile hospital)
  + Processes to assist healthcare organizations request staffing to operate surge sites when requested and available (e.g., mobile medical team)
  + Coordination of alternate surge sites with state and local EMS authorities to ensure these sites can receive and transfer EMS ambulance patients
  + Coordination of assets requested through the Emergency Management Assistance Compact
  + Coordination of Federal assets (e.g., Federal Medical Stations, Disaster Medical Assistance Team)

**Alternate care sites:**

* Coordination with alternate care sites developed at non-healthcare facilities for the surge of individuals that do not require care at healthcare organizations’ surge sites

**Processes for providing specialized medical evaluation and care:**

* Assistance to healthcare organizations with the management of patients requiring unusual or specialized medical evaluation and care. This may include:
  + Process to obtain specialized resources that are not routinely available to the healthcare organization (e.g., burn, pediatric, trauma resources)
  + Coordination with healthcare organizations to identify subject matter expertise (e.g., pediatric, neurology, trauma) that would be requested to assist with special medical evaluation and care
  + Coordination with healthcare organizations to identify services or supplies that would be requested to assist with identified bottlenecks for care such as:
    - Radiology services
    - Critical care services
    - Surgical services
    - Special medical support (e.g., pharmacy, blood)
  + Coordinated processes to request specialty medical teams and equipment (e.g., state and local medical assistance teams, National Disaster Medical Assistance (NDMS) Teams, and Federal Medical Stations)

**Processes to provide assistance with decontamination, isolation, and quarantine:**

* Processes to assist healthcare organizations with special interventions to protect medical providers, other patients, and the integrity of the healthcare organization when there is a surge of patients with conditions that require decontamination, isolation or quarantine. These interventions may include (if available and requested):
  + Coordination for extra Personal Protective Equipment (PPE)
  + Coordination for extra decontamination resources
  + Coordination for state or regionally located caches of pharmaceuticals
  + Processes to contact the responsible public health agency tasked with isolation and quarantine when there is a surge of patients requiring these interventions

**Function 4**: **Develop Crisis Standards of Care guidance**

The objective of the function is to determine the status of crisis standards of care within the State and at the local level. The awardee should determine State government level of involvement and make plans to address the transition into and out of conventional, contingency, and crisis standards of care.

**Objective**:

* Determine the status of crisis standards of care

***Resource requirements for successful completion of this function*:**

* Medical surge plan addressing crisis standards of care

**Function 5**: **Provide assistance to healthcare organizations regarding evacuation and shelter in place operations**

Evacuation planning for sending and receiving areas/facilities is the focus of function 5. Objectives include resource management and evacuation planning for sending regions and surge management for receiving regions. There is an emphasis on transportation and patient movement including that of the NDMS patient movement system and the Federal Coordinating Centers.

**Objectives**:

* Resource management for evacuation of a region
* Surge management for receiving regions

***Resource requirements for successful completion of this function*:**

* Regional evacuation plans (coordinated with ESF8 and EM)

**Expected resources:**

* Medical surge plan
* Resource management plan
* Communications plan
* Evacuation plan

**Implementation:**

* Risk based assessment
* Collaborative planning
* Organizing, equipping, training
* Exercises and evaluations of plans / real incidents

**Resources:**

* + - Medical Surge Capacity and Capability: The Healthcare Coalition in Emergency Response and Recovery. U.S. Department of Health and Human Services: <http://www.phe.gov/Preparedness/planning/mscc/healthcarecoalition/Pages/default.aspx>
    - Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, 2007: <http://www.phe.gov/preparedness/planning/mscc/handbook/pages/default.aspx>
    - The Next Challenge in Healthcare Preparedness: Catastrophic Health Events. Center for Biosecurity of UPMC. Preparedness Report | January 2010: <http://www.upmc-biosecurity.org/website/resources/publications/2010/pdf/2010-01-29-prepreport.pdf>
    - In A Moment’s Notice: Surge Capacity for Terrorist Bombings: <http://www.bt.cdc.gov/masscasualties/pdf/CDC_Surge-508.pdf>
* IOM (Institute of Medicine). 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Washington, DC: The National Academies Press

Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: <http://iom.edu/Reports/2009/DisasterCareStandards.aspx>

* + - CSC 2009: Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: <http://iom.edu/Reports/2009/DisasterCareStandards.aspx>

# Capability 14: Responder Safety and Health

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 14: Responder Safety and Health. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

This capability identifies critical resources needed to ensure that healthcare workers are protected from all hazards. The goal is to assist healthcare organizations ensure no illnesses or injury to any first receiver, medical facility staff member, or other skilled support personnel as a result of preventable exposure to secondary trauma, chemical/radiological release, infectious disease, or physical and emotional stress after the initial incident or during decontamination and incident follow-up.

The focus of the capability is on planning for the provision of critical medication for prophylaxis or immediate treatment of healthcare responders and their families and the provision of incident specific PPE to healthcare workers. This requires coordinated risk assessments to determine hazards and threats. One objective is the development of “extra” regional caches of pharmaceuticals and PPE. These may be private or communal and planning should be done accordingly.

**Capability Definition:**

* The responder safety and health capability describes the ability of healthcare organizations to protect the safety and health of healthcare workers from a variety of hazards during emergencies and disasters. This includes processes to equip, train, and provide other resources needed to ensure healthcare workers at the highest risk for adverse exposure, illness, and injury are adequately protected from all hazards during response and recovery operations.
* Expectations based on the functions of Responder Safety and Health
  + Caches of pharmaceuticals and PPE for healthcare worker protection
  + Coordination with SNS initiatives
  + Do not supplant healthcare organizations’ responsibilities to protect their workers

**Function 1: Assist healthcare organizations with additional pharmaceutical protection for healthcare workers**

The objective for this function is the development of caches of pharmaceuticals for treatment or prophylaxis of healthcare workers during disaster response. This requires risk-based planning and assessment of needs and each developed cache will require an operational plan. Another component of this plan includes countermeasure coordination with the CDC Division of the Strategic National Stockpile.

**Objectives:**

* Assess need for extra cache
* Develop cache and an operational plan

***Resource requirements for successful completion of this function:***

* Pharmaceutical caches with operational plans if determined a priority

**Function 2: Provide assistance to healthcare organizations with access to additional Personal Protective Equipment (PPE) for healthcare workers during response**

The development of PPE caches is the focus of this function. However, this is not to supplant healthcare organizations’ responsibilities to protect their workers. During coordinated planning, local and State planners should assess the need for extra caches of PPE based on risk. If it is determined that these caches are needed, they may be developed to include an operational plan to deploy the supply if needed.

**Objectives:**

* Assess need for extra cache
* Develop cache and an operational plan

**Resource requirements for successful completion of this function:**

* PPE caches with operational plans if determined a priority

**Take home points:**

* Both pharmaceutical caches and PPE caches require planners to “Assess the need” for either/or
* These are redundant response caches and should not be everyday use.
* There must be operational plans

**Expected Resources:**

* Strategically located pharmaceutical caches with operational plans
* Strategically located PPE caches with operational plans

**Implementation:**

* 1st: Assess need
* 2nd: Develop based on risk
* Exercises and evaluations of operational plans

**Resources:**

* NIOSH, Emergency Response Resources: <http://www.cdc.gov/niosh/topics/emres/responders.html>
* OSHA Best Practices for Hospital-Based First Receivers of Victims from Mass Casualty Incidents Involving the Release of Hazardous Substances: <http://www.osha.gov/dts/osta/bestpractices/html/hospital_firstreceivers.html>

# Capability 15: Volunteer Management

*North Carolina Office of EMS, Healthcare Preparedness Response and Recovery Program is providing fact sheets in an effort to better educate all healthcare system partners on the 2012 Healthcare System Capabilities.*

*This document is intended to provide an overview and serve as a learning tool of Capability 15: Volunteer Management. Areas of particular importance in this document are* ***objectives*** *and* ***resource requirements for******successful completion of each function.*** *This guidance is provided directly from ASPR documents and training.*

Volunteer Management is the capability to effectively coordinate the use of volunteers in support of domestic incident management. The goal is to use volunteers to augment incident operations.

The need for volunteer management is based on historical needs for qualified, trained assistance during a disaster. The focus of this capability’s guidance is on determining the need for volunteer assistance within healthcare organizations. The liability issues related to patient safety are a big factor in private healthcare facilities and cannot be ignored. However, during catastrophic events, volunteers may become an option if there is appropriate planning. In general, the requirements for volunteer management are more community focused for assistance outside of healthcare facilities (e.g., alternate care sites). Volunteer management for healthcare system should coordinate with community planning so there is an understanding of risk-based need and implementation of this vital resource. Healthcare planners should utilize the ESAR-VHP system and the MRC to develop the implementation plan for these volunteers.

**Capability Definition:**

* Volunteer management is the ability to coordinate the identification, recruitment, registration, credential verification, training, engagement, and retention of volunteers to support healthcare organizations with the medical preparedness and response to incidents and events.
* Expectations based on the functions of Volunteer Management
* Volunteer assessment and planning:
  + During risk-based planning, healthcare organizations and their partners plan for scenarios in which volunteers may be required at healthcare organization
* Coordinate volunteer management implementation
* ESAR-VHP / MRC:
  + Utilize the ESAR-VHP system and the MRC to develop the implementation plan for these volunteer

**Function 1**: **Participate with volunteer planning processes to determine the need for volunteers in healthcare organizations**

Volunteer assessment and healthcare organization planning is addressed in this function. The first step is for healthcare organizations and their partners to plan for scenarios in which volunteers may be required at healthcare organization during the incident. This is coordination between healthcare organizations to determine when or if they may ever request volunteers. Appropriate planning commences around this anticipated need.

**Objectives:**

* Assess the need for volunteers
* ESAR-VHP system required

***Resource requirements for successful completion of this function:***

* Coordinated volunteer management plan
* ESAR-VHP system

**Function 2: Volunteer notification for healthcare response needs**

The next step to coordinate volunteer management implementation is the actual collaborative volunteer management planning. This function addresses planning and integration with local volunteer organizations to develop courses of action for volunteer assignment and deployment. This is coordinated with local agencies such as MRC and also within the ESF8 and emergency management plans.

**Objectives:**

* Collaborative volunteer planning
* Integrate with local volunteer organizations

***Resource requirements for successful completion of this function:***

* Coordinated volunteer management plan
* ESAR-VHP system

**Function 3: Organization and assignment of volunteers**

Function 3 addresses volunteer management implementation. The coordination of volunteer management implementation includes ensuring volunteers understand what is needed. This entails healthcare organization safety briefs and on the job training protocols. The volunteer management plan must also outline the steps to coordinate with volunteer organizations and emergency management to ensure volunteers have appropriate living conditions

**Objectives:**

* Ensure volunteers understand what is needed
* Coordinate with volunteer organization and emergency management to ensure volunteers have appropriate living conditions

***Resource requirements for successful completion of this function:***

* Coordinated volunteer management plan

**Function 4**: **Coordinate the demobilization of volunteers**

The coordination of volunteer management implementation includes ensuring that the volunteers’ medical and mental/behavioral health needs are documented and treated or referred upon demobilization. This is the intent of this function.

**Objective:**

* Ensure volunteers medical and mental/behavioral health needs are documented and treated or referred

***Resource requirements for successful completion of this function:***

* Coordinated volunteer management plan

**Expected Resources:**

* ESAR-VHP System
* Volunteer management plan

**Implementation:**

* 1st: Assess need
* 2nd: Develop based on risk
* Exercises and evaluations of operational plans

**Resources:**

* Medical Reserve Corps: <https://medicalreservecorps.gov/HomePage>
* Emergency System for Advance Registration of Volunteer Health Professionals: <http://www.phe.gov/esarvhp/pages/about.aspx>
* Citizen Corps, Community Preparedness Principles: <http://www.citizencorps.gov/about/principles.shtm>
* National Voluntary Organizations Active in Disaster (VOAD): <http://www.nvoad.org/>