

Northern Utah Healthcare Coalition

Northern Utah Regional Medical Surge Capacity Plan

A guideline for the most effective use of regional
resources during a medical surge event



Approved by the Northern Utah Healthcare Coalition
Executive Committee, 12/7/2010

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APPENDICES IN A SEPARATE ELECTRONIC FOLDER

PREFACE

This regional medical surge plan is designed to be used as a guideline in the event of a medical surge in any of the following counties: Box Elder, Cache, Rich, Morgan, Weber, or Davis. Its intent is to effectively integrate region medical, health and community resources during a large-scale emergency which exceeds the ability of the health care system.

This plan will work in conjunction with the jurisdictional authorities and responsibilities as outlined in the emergency operations plans of the hospitals, local health departments, primary care clinics, skilled nursing facilities, and county emergency management and service agencies.

This plan is compliant with the National Incident Management System (NIMS), and depends on strong working relationships, and effective networking efforts between all partners using a multiagency coordination (MAC) approach.

****The Northern Utah Healthcare Coalition shall not act as an independent response body. Each member of the coalition has a primary organization to which they are accountable. The primary purpose of the coalition is planning and preparedness, not response. However, the relationships developed through the coalition are invaluable for a well-coordinated response. This plan delineates how the resources of the Northern Utah Healthcare Coalition may be leveraged in an emergency response.****

DEFINITIONS

Medical Surge--- An incident which exceeds the capacity (or threshold) of the normal medical infrastructure.

Medical Surge Capability---the ability (in relation to personnel, facilities, supplies, equipment, processes) of an affected jurisdiction to manage patients during a medical surge incident.

Crisis Standard of Care---This is a standard of care used when the medical needs outstrip the available resources, and the focus changes from appropriate individual care to care that is most appropriate for the group (see Assumption #10).

PLAN INITIATION

This plan can be initiated by any of the region's hospitals, local health departments, emergency medical services, or County Emergency Operations Centers when the local jurisdiction's capabilities are exceeded.

ASSUPTIONS

1. Crisis standards of care are used when this plan goes into effect. These are triggered by shortages of equipment, supplies, pharmaceuticals, beds, personnel, and sources of transportation. Responding agencies have these standards of care, and their use is outlined in their Emergency Operations Plan. There are also Utah Crisis Standards of Care to be used only upon a declaration of a disaster by the Governor of Utah.
2. All Northern Utah Healthcare Coalition members are trained and knowledgeable regarding the implementation and execution of this plan.
3. The regional resources will work in full cooperation with the appropriate Emergency Operations Centers and Hospital Incident Command Centers.
4. All regional hospitals have emergency plans which address medical surge capacity and capabilities. A target measure is for the 8 hospitals in Northern Utah (Davis, Weber, Morgan, Cache, Box Elder and Rich counties) to have a total of approximately 355 additional beds beyond their normal capacity for a medical surge event.
(www.fema.gov/pdf/government/training/tcl.pdf)
5. Full cooperation, collaboration, communication and coordination between the region's hospitals and the County Emergency Operations Centers must be established in order to maximize the effectiveness of this plan.
6. Each of the 6 northern counties in Utah has a mass casualty plan
7. Bed availability is not the same thing as emergency room capacity. Emergency room care may be available when beds are not.
8. Each coalition member will make a concerted effort to provide its employees with information on how to effectively prepare personally (themselves and their families) for a disaster situation.
9. The plan participants will work together to see that patients not needing hospitalization will be referred to appropriate alternate care.
10. Medical Legal Liability – In a mass disaster situation, the quality of medical care may well be compromised due to the need to care for large numbers of patients injured in the incident as compared to the number of medical professionals available to work with them. The focus in a disaster with a medical surge involves changes from individualized care to group care out of necessity to do the best possible for those involved. The START triage process outlines this reality. Each responding agency has crisis standards of care and identified conditions for their activation in their emergency operations plan, and there are Utah-wide crisis standards of care which can be activated by the Governor during a disaster (see www.uha-utah.org, Disaster Preparedness Resource Page). Liability protection for volunteers and first responders is noted in the Good Samaritan Act and the Uniform Volunteer Practice Act.
11. If a Multiagency Coordination Center (MAC) is deemed necessary by incident command leadership, members of this coalition, especially the Regional Medical Surge Director or a trained backup person, may be tasked with setting up a healthcare MAC to assist with the response. Whether or not a MAC is deemed necessary for coordination of medical surge capacity, the protocols and resources in this plan are available to help guide the response.

CONCEPT OF OPERATIONS

All disasters should be managed locally. When local resources are overwhelmed, a tiered system is used, moving from local, to county, to the region, to the state (intrastate and interstate), and the federal level in order to secure the needed resources.

The intent is to create a coordinated network between the region's hospitals, clinics, local health departments, emergency management services, county EOCs, and long term care facilities, which enables these critical entities to respond to, and recover from, a medical surge in the northern region of Utah.

STRATEGIC GOALS

1. Triage
2. Treatment
3. Bed and other resource coordination
4. Communications
5. Transportation
6. Public/media information
7. Recovery

These goals are addressed in the following sections:

TRIAGE

All members of the coalition should be familiar with START (Simple Triage and Rapid Transport) triage system as it is the accepted disaster triage system for the region's EMS agencies. The Northern Region will also use the JUMP START Triage system for pediatric patients, ages 1-8. Both of these triage systems will be exercised, weaknesses noted, and corrective action plans implemented and retested.

In order to manage the medical surge brought on by a regional disaster, patients must be effectively evaluated and referred to the site where they can receive appropriate treatment. Only the most acutely injured or ill should be treated at the hospitals. Others should be cared for at primary care clinics, by home health agencies in their homes, by private physician offices (if available), skilled nursing facilities, at alternate care sites or special needs shelters. It is important for those in charge of triage to be familiar with local and regional service resources.

HOSPITAL BED CAPACITY/EMERGENCY ROOM ACCESS

Each Northern region hospital has a medical surge plan in place which identifies the hospital's bed surge capacity (20% required by state rule) in a local or regional disaster, and the policies and procedures to be implemented during a surge. This plan addresses a medical surge which exceeds the 20% required capacity of affected hospitals. The medical surge capacity refers to inpatient beds, not emergency room temporary beds. Each hospital should familiarize itself with the capacity and capabilities of other hospitals in our region (as well as in the state) in order to facilitate appropriate

patient transfer when required.

Emergency room services may be available even when inpatient beds are full, and vice versa.

Depending on the extent of the disaster, it may be necessary for hospitals outside the Northern Utah Region to prepare to activate their individual Medical Surge Capacity plans.

Each hospital will keep the Utah Department of Health, Bureau of Emergency Medical Services and Preparedness informed of their bed availability at 866-364-8824. This can also be done using the Utah Health Management Resource System (UHRMS) at www.healthcareresources.utah.gov.

Alternative care arrangements are available throughout the region through alternative care arrangements such as skilled nursing facilities, the BluMed response system and Disaster Response Units (DRUs). Each county emergency operations center (plus city emergency operations center where available), and medical ESF coordinator should be very familiar with what is available in their area, and know how to reach into other areas of the region for additional assistance when needed.

TRANSPORTATION

Transportation of patients is a vital part of the triage and treatment process and should be well coordinated between the triage sites, the hospitals and emergency medical services with the assistance of the emergency operations centers (ESF 8 coordinator) as is required. The assistance of dispatch centers is available if needed in an emergency situation by calling 911. (See Overcrowding and Diversion below.)

OVERCROWDING AND DIVERSION

Multi-agency coordination with local transportation resources will be required in the event of a mass casualty incident (MCI). During an MCI, it will be a critical function of the emergency management system to arrange transportation of casualties to designated hospitals, and from hospitals to facilities capable of caring for additional patients, such as skilled nursing facilities or alternate care sites. The County Emergency Operations Center can assist if needed.

Hospitals should notify their County Emergency Operations Center (EOC) when they are reaching maximum capacity. Hospitals with open beds must be willing to accept patients from hospitals which are overwhelmed. They may request, however, that already screened ,or stable patients, be transferred to another appropriate facility in order to open up more beds and to manage the influx in patient volume. The Utah Department of Health Emergency Control Center will use the hospital status reports to work with the County Emergency Operations Centers, local health departments, and hospitals to reallocate supplies and transfer patients to hospitals with available beds. If all hospitals in the state are full, the Utah Department of Health EOC will begin making arrangements to transfer patients out of state if possible.

STAFFING NEEDS

Staffing will be a concern during implementation of this medical surge plan for all service providers. Each hospital and each other type of service provider is expected to have an established, practiced

plan to deal with the provision of adequate staffing rotation during a disaster. Hospitals and the city and county Emergency Operations Centers will work together to maximize staffing availability when the individual agency actions to achieve needed staffing are not successful.

Working relationships with medical schools, nursing schools, nurse aide and medical assistant training programs, staffing agencies, and the Medical Reserve Corps should be in place with MOUs established in the case of staffing needs in a disaster.

Should adequate staffing not be available despite the region's best efforts, the State EOC should be contacted for assistance by the County EOC.

Each coalition member should strive to assure its staff members are personally prepared at home for a disaster. The local health departments and local emergency management agencies can be of assistance with education on these issues.

EQUIPMENT AND SUPPLIES

It is important for all hospitals to cooperate with each other by performing mutual exchange of needed equipment and supplies as necessary. The County EOC may be able to assist with finding needed equipment and supplies from other than hospital sources. In addition, hospitals in other Utah regions may be able to assist. The Utah Hospital Association's MOU should be used as a guide.

Please see the appendix for lists of resources for supplies and transportation, and information on the Strategic National Stockpile (SNS).

EMERGENCY COMMUNICATION

The primary form of communications will be the use of phones, both land line and cellular. (See appendices for pertinent numbers.)

Radios should be used as the next form of communication. Hospitals should have their 800 MHz hospital commons channel in operation at all times, and should have an additional 800 MHz radio to use as needed to communicate with their emergency medical services providers, public health entity, and County Emergency Managers. Each hospital needs to know the channel their Emergency Operations Center uses, and have it programmed into their EMS services 800 MHz radio by UCAN. The UDOH main channel is programmed on the hospital commons radios in the hospitals and public health departments. HAM radios (VHF, UHF, and HF) can be used when licensed personnel or ARES volunteers are available to operate them. Dispatch can be contacted to cross-patch if needed (hospitals can call 911 to contact dispatch in an emergency, or use their specific hospital's radio channel on their 800 MHz radio). HAM radios cannot be cross-patched by dispatch.

Coalition members should participate in the Utah Notification Information System (UNIS).

Regional emergency communications exercises will be conducted at least annually.

PUBLIC COMMUNICATION/MEDIA

The region will use a Joint Information System (JIS) in a regional disaster, and a Joint Information Center (JIC) will be established as needed. The public information officers at our coalition agencies have developed a plan for this important activity. They will work in concert with Incident Command and with the Emergency Operations Centers involved.

All coalition members should be familiar with the use of public information principles.

RECOVERY

Our strategic goals for recovery are:

1. Rehabilitation for staff and the public.
2. Resupplying the used resources.
3. Getting back to normal as soon as possible.
4. Psychological first aid as needed during the event.
5. Cost recovery.

Actions to help the area of our region affected by the disaster recover, and return to its pre-disaster status (if feasible), are critical. Each involved jurisdiction should follow its pre-established plan for the recovery process.

Psychological first aid should be available locally to responders, patients and their families during and after the event. Arrangements for the availability of this service should be made in advance of a disaster.

If the need for psychological first aid exceeds the availability of local or regional services, requests for assistance are forwarded to the State via the Emergency Operations Centers. The Utah Department of Human Services, State Adult Programs Manager will coordinate the deployment of individuals certified to provide psychological first aid during the event.

DEACTIVATION

This regional medical surge plan will be deactivated by the incident command (MAC or Unified, or single incident commander) when its use is no longer needed.

OTHER IMPORTANT FACTORS

MINIMUM HEALTHCARE CAPACITIES AND CAPABILITIES

Each coalition member should have delineated in their agency's emergency plans what their minimum healthcare capacities and capabilities must be, and should have practiced their plan to assure the minimum level is available. One example is the state required 20% enhanced bed capacity over the normal capacity for hospitals.

SPECIAL NEEDS POPULATIONS

Coalition members are strongly encouraged to have plans in place to handle the special needs of children, the chronically ill, the frail elderly, pregnant women, homeless, disabled of all ages (blind, deaf, cognitively impaired, crippled and in need of ambulation aids, mentally ill, etc.), and those who don't speak English.

Individuals with special needs should be encouraged to register on the Utah Special Needs Registry.

THE REGIONAL MEDICAL SURGE PROCESS

Regional involvement is initiated when the local resources are overwhelmed in a medical surge incident. When the hospital(s) in the local involved jurisdiction is/are unable to get the resources needed (beds, staff, equipment, transportation) locally, they should contact other regional hospitals to determine if the needed resources can be obtained from them. They should contact their county emergency manager or the Emergency Operations Center to let them know they are checking with other agencies, including other hospitals for resources. If the other entities in the region cannot provide resources, then the hospital should notify the Emergency Operations Center and seek assistance. This process is pictured and put in bulleted form in the appendices. This is a multi-agency coordination (MAC) situation in which our coalition members work together to handle the medical surge prior to seeking out of region assistance.

Each county Emergency Operations Plan (EOP) has designated coordinators for the various Emergency Support Functions (ESFs) outlined in the EOP. ESFs include: Medical, Fire, Law Enforcement, Public Works, Public Health, Environmental Health, etc. Each county plan is unique, but for the most part they outline the coordination of an emergency via ESF Coordinators. Each Emergency Support Function has one or more coordinators assigned to manage the coordination of that functional area during an emergency. One of these designated ESF coordinators in the county plans has the responsibility to coordinate emergency medical services during an emergency. Again, each county is slightly different, but in most counties this function is coordinated by either a public health coordinator, or an EMS coordinator from the Fire/EMS Services. Coordination of this function includes transportation, creation of, staffing and supplying of alternate care/treatment sites, public information, patient accounting, supporting local hospitals with resource needs, and supporting on-scene command resource requests to name a few.

By building upon this already established framework, regional involvement for medical surge management is coordinated between the ESF coordinator, the County Emergency Manager and/or Emergency Operations Center in the jurisdiction where the incident has occurred, and the emergency coordinators at the affected hospitals. Hospitals in the county, as noted above, should request assistance from each other, and, as needed, from all the other hospitals in the region, using their Utah Hospital Association Inter-Hospital Master Mutual Aid Agreement as a guide. They also should work with other agencies, such as skilled nursing facilities, the Red Cross, and home health as per their MOUs. The ESF Coordinator can support the needs of the hospitals by coordinating transportation and other resource needs. If this level of communication does not result in the needs (beds, staff, volunteers, equipment, supplies, etc.) being met, then the county will contact the State EOC for additional assistance.

At the onset of an incident, the hospital should contact its local County Emergency Manager, ESF Coordinator, and/or Emergency Operations Center (if already activated or operational). The Emergency Manager/ESF Coordinator or Emergency Operations Center has the responsibility to seek the needed resources. The EOC, Emergency Manager, or EMS ESF Coordinator will work with the county EMS Coordinator to activate and coordinate any additional resources. County ESF coordinators will contact other county ESF coordinators in the region for additional resources and support. The next step in the coordination process, if the situation is not resolved, is for the county to contact the State Emergency Operations Center. In the State EOC, the Department of Health is the coordinating entity for intrastate assistance, interstate assistance, or for requesting the Governor to declare a disaster and to request federal assistance. (Note: In some situations, the County may work with the City to support a hospital surge response.)

THE MEDICAL SURGE MANAGEMENT PLAN

Depending upon the situation and the architecture of the various County EOPs, this plan, which is basically a communication framework, can be activated without the Emergency Operations Center (EOC) being activated. The “system” of ESF coordination is not contingent upon the EOC facility being activated. An EOC is not only a facility; it is personnel, procedures and system for multi-agency coordination. Parts of the system can be activated without the facility being activated. During a surge, counties should be flexible in the EOP to the point of not waiting for the EOC facilities to open before coordinating the response.

It is important to understand this framework depends on strong working relationships, and effective networking efforts between the providers of services. They need to know each other, to know their individual responsibilities, and how to effectively use the framework to maximize the medical surge capacity and capability of the region. They need to have exercised the plan in advance of the need to activate it, to have noted problems, such as the inability to communicate effectively, for example, and to have corrected and retested those issues.

It is important to note the central role of the County Emergency Operations Center in coordinating resources for the hospitals, and for the region overall. A multi-agency coordination system in the region exists within the established emergency management framework. Each county operates an EOC, and with the EOC staffed with personnel assigned the role of emergency medical support and coordination, the surge capacity framework was in place.

The Emergency Operations Center should keep the State EOC, and /or the Utah Department of Health ECC (Bureau of Emergency Medical Services and Preparedness) apprised during a disaster even when the services of the State are not needed at the time.

It is also important to note that hospital emergency preparedness coordinators, local health departments, EMS coordinators, and County Emergency Managers need to take actions not included in this plan as per the scope and severity of the event.

PROCEDURES FOR THE MAINTENANCE OF THIS PLAN

1. The Northern Utah Healthcare Coalition will review this plan biannually to evaluate its effectiveness, completeness, and appropriateness. The executive committee of the Northern Utah Healthcare Coalition will appoint a review committee composed of County Emergency Managers, Medical ESF Coordinators, a local health department representative, a clinic representative, a skilled nursing facility representative, and Hospital Emergency Preparedness Coordinators to complete the review. Suggested revisions will be presented to the coalition membership for ratification.
2. As revisions are made, they will be dated, and changed pages will be provided to all involved individuals and agencies by the Regional Medical Surge Director. It is the responsibility of the copy holder to keep individual copies current.
3. Each person or organization to be notified in the event of a need for regional medical surge management support is responsible for providing the Regional Medical Surge Director with any personnel changes and contact number changes for emergency notification.
4. This medical surge plan for the northern region of Utah will be exercised at least once a year, and each exercise will be followed by a critique to review the plan's effectiveness. A corrective action plan will be established and implemented as necessary.

NORTHERN UTAH HEALTHCARE COALITION MEMBERSHIP

Hospitals: Lakeview, Davis, Ogden Regional, McKay Dee, Brigham City Community, Bear River Valley, Cache Valley Specialty, Logan Regional. The Bear Lake Clinic in Garden City has 6 beds, but is not licensed as a hospital.

Health Departments: Davis, Weber-Morgan, and Bear River.

Primary Care Clinics: Intermountain Medical Group, Ogden Clinic, Tanner Clinic, and Midtown Community Health Center.

Emergency Managers: Davis, Weber, Morgan, Cache, Box Elder, and Rich counties.

County Emergency Services Representatives: Roy Fire, Ogden City Fire, Cache County Emergency Medical Services.

Deputy Director of the Utah Healthcare Association (representing the skilled nursing facilities in the northern Utah six-county area)

Health and Hospital Preparedness Program Manager from the Utah Department of Health, Bureau of Emergency Medical Services

Northwestern Band of the Shoshone Nation