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2016 NSSE Hospital Plan

(REDACTED for sharing)

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Contents

Forward

During the NSSE, REGIONAL hospitals anticipate a higher than normal operational tempo. This increased tempo is a result of the increased number of visitors to the city, increased presence of media personnel, deployment of support agencies and increased number of personnel participating in peaceful or non-peaceful protests. This plan addresses the hospital preparations, coordination and response activities to support varying levels of response to address the medical management of casualties.

This plan reflects the integrated planning completed by the HOSPITAL WORKGROUP NAME in preparation for NSSE activities.

This NSSE Hospital Plan Template was developed by the emergency management managers from The Cleveland Clinic, University Hospitals of Cleveland, The MetroHealth System, the Cleveland VA Medical Center and the Center for Health Affairs in preparation for the 2016 Republican National Convention.

Concept of Operations

Plan Scope

Hospitals' medical management of patients and casualties during NSSE is conducted through three phases: elevated operations tempo phases (saturation and extended saturation states), crisis response phase and consequence management phase. This plan addresses patients and casualties at or presenting to the hospital and identifies the constraints, impacts of those constraints, mitigation strategies, and triggers for achieving the phases. This plan does not address pre-hospital activities.

Situation

The EVENT is a designated National Security Special Event (NSSE) being held in the CITY OR REGION NAME with planned activities extending into the 10 surrounding counties for the time period of ADD EVENT DATES. Special significance for this event is that there are expected to be over 50,000 extra persons in and around the NSSE venues with up to 1/4 of those persons considered VIPs. Although the numbers of extra persons within the city is not of significant consequence, the fact that so many VIPs will be in proximity is out of the norm.
Because this EVENT will include many high-ranking officials extra, security measures will be in place, such as increased police presence and road closures around the NSSE SITE OR VENUE, the downtown area, and the venue sites. 10,000+ media from around the country will be in CITY OR JURISDICTION NAME to cover the EVENT.

There are expected to be large numbers of protesters, which will be both organized and unorganized. The protests are expected to begin as much as 1-2 weeks before the EVENT.

The U.S. Secret Service will be in charge of security during the EVENT and at the NSSE SITE OR VENUE. Local law enforcement will be on duty with support from police from other localities, FBI, U.S. Secret Service and other law enforcement organizations. Security will increase before the NSSE begins and be in full force throughout the EVENT. Hospitals maintain security procedures and protocols at their facilities daily and those procedures, along with heightened surveillance, will be enhanced during the time of this EVENT.

Hospital command centers within the NSSE activity area will be on alert and some will be fully activated depending upon the risk they feel is necessitated for the NSSE activity level within their jurisdiction.

Mission

1. Save and sustain lives
2. Ensure the safety of deployed personnel
3. Maintain situational awareness
4. Maintain health and medical infrastructure
5. Have a plan for demobilization.

Planning Process

Discussions within the hospital workgroups placed the priority hospital objectives/goals listed below:
1. Prepare for a mass casualty incident (Burns/Trauma)
2. Prepare for a VIP medical emergency (Secret Service, Capital Police escorts)
3. Prepare for protesters and crowd dispersal agents (unknown irritants)
4. Maintain the integrity of the healthcare system (security system lockdown or controlled access)
5. Imagine a system to manage all medical contingencies based on situational awareness

Definitions

Normal State
REGION OR JURISDICTION hospitals day-to-day routine with expected patient volumes and expected conditions.

Saturation State
REGION OR JURISDICTION only beyond normal day-to-day activities due to increased population and EVENT timing; sustainable for up to 10 days.

Extended Saturation State
Resources may be strained/limited due to staffing shortfalls and/or decreased bed availability; support from CONTIGUOUS REGION OR JURISDICTION NAME or implementation of plans (decompression, SIP, etc.) may be needed to maintain an essential level of support; sustainable 10-14 days.

Crisis Management
EVENT occurs but response is within planned resources and capabilities for REGION OR JURISDICTION and CONTIGUOUS REGION OR JURISDICTION regions as well as other State of Ohio resources; response can be sustained for 12-72 hours.

Consequence Management
EVENT(s) occur with magnitude or expected duration that will quickly exhaust REGION OR JURISDICTION /CONTIGUOUS REGION OR JURISDICTION resources (space, staff, and

stuff) and will require a federal response.

Medical Evacuation

Medical evacuation includes patients in healthcare facilities and those with special medical needs residing in the community. In addition to the individual, medical evacuation includes medical equipment, medical or non-medical attendants, and service animals.

Patient Movement

Patient movement is defined as the *process* of moving sick, injured, or wounded persons within a given population from a dangerous area due to a threat or occurrence of a natural or man-made incident to a safer area to obtain needed medical and/or dental care. Also included are individuals in the community with special medical needs, such as those with chronic illness or disability, who under normal conditions require assistance to obtain medical care or to have their health care needs met in the community. Patient movement starts with movement from point of origin, which can include hospitals, long-term care facilities and other types of healthcare facilities; in the field at the point of injury; or in the homes of home-based patients. Patient movement, within the National Disaster Medical System (NDMS), includes patient evacuation, medical regulating, enroute care, and patient tracking/in-transit visibility.

Casualty Collection Point

This function should be located close to a transportation location to support transportation of patients/casualties out of the area, region or state. Patients/casualties are pre-triaged and categorized as needed transport to definitive care out of the area due to moderate (Yellow) or severe (Red) injuries/trauma. Typically, patients must be stable to endure the transportation process. This function can support either/both patients from local definitive care location, medical evacuees, or casualties directly from an incident site.

Casualty Staging Area

This is a pre-hospital function. This function is used to hold minor (Green) or less severe moderate (Yellow) casualties to allow time for the definitive care facilities to handle the high acuity trauma casualties and implement necessary surge or decompression plans. Medical care, nutrition, and comfort care is anticipated to be provided at these location(s) to prevent decompensation of injured casualties.

Patient

A patient is an individual who is currently being provided care in a definitive medical care facility.

Casualty

A casualty is an individual who requires medical care but has not yet been transported to/receive treatment in a definitive medical care facility.

Pre-hospital Medical Care

This is medical care provided at locations outside of a definitive medical care facility.

Definitive Medical Care
This is medical care provided at a treatment facility that is commensurate with the patient's medical need to conclusively manage the patient.

Level "1" Surge
An external emergency with victims received and immediate support for Emergency Departments is required. Additional support for other hospital departments including perioperative services, diagnostic areas and inpatient units may be required.

Level "2" Surge
An escalating or evolving external emergency lasting days to weeks with an overwhelming number of victims received requiring admission to the hospital. Significant operational issues including supply chain interruption and a need for increased security may occur. Utilization of most traditional patient care areas by critical patients and expansion of non-critical patient care to non-traditional areas of the hospital may be necessary. Extensive support and State Guidelines for Allocation of Scarce Resources may be activated to provide the best care possible for the largest number of patients with scarce resources. Standard of care and caregiver to patient ratios are expected to change at Level Two depending on the severity and duration of the incident.

Trigger Point for Escalation to Level 2
When 100% of traditional patient care areas have become saturated with, patients and all L-1 procedures have been initiated or implementation of altered standards of care is necessary due to scarce resources, and surge demand has exceeded L-1 capacity. Level Two (L-2) Surge Capacity Response should be initiated.

Level "3" Surge
An overwhelming number of victims are received with complex injuries or illnesses at hospitals throughout the region. Hospitals are no longer able to care for all victims on campus. Patient care is extended outside the boundaries of the hospital campus to community buildings and alternate care sites.

Assumptions

Assumptions outline those events or circumstances that are expected to occur during the plan lifecycle. To support planning several assumptions are outlined. While these assumptions should be fairly valid, any events or incident that would occur to change the baseline hospital readiness may invalidate some or all of the assumptions. The following assumptions are based on the state of resource (space, staff, stuff) readiness as of the date of this plan:

1. CITY OR REGION NAME hospitals will transition from normal to saturated state prior to the start date of the NSSE.

2. No known credible threat for adverse activity at or during the NSSE period.
3. Fatality response will be handled by the Medical Examiners (ME) office.
4. The region's hospitals are already at or near capacity for emergency services and inpatient care.
5. Due to NSSE EVENT timing, a higher level of medical support is needed during non-standard hours (weekend, evenings)
6. Staff impact/reduced flexibility due to increased support to:
    a. Multiple venues
    b. EOCs/response
    c. Surge/increased care
7. Protestors at/near hospitals
8. Increased ED patient traffic (protestors, heat, insect, food etc.)
9. Increased reporting/status requirements
10. Staff traffic patterns/timing disrupted
11. Decreased parking availability potential (location dependent)
12. Increased media requests
13. Longer LE/Fire response time (access, communications, traffic, competing priorities etc.)
14. Competing resources
    a) Medical staffing (first aid stations, response, shelters etc.)
    b) Non-medical staffing (EOCs, shelters, response, etc.)
15. Personnel availability impacted
    a) Perennial loss of experienced residents/influx new residents in July
    b) Sharing across hospital systems

Planning Factors

Planning factors are those considerations that are taken into account to identify and mitigate risks

1. The healthcare system will be quickly overwhelmed in a large-scale mass casualty incident.
2. Hospitals may be without external assistance for 96 hours in a region-wide acute event with limited or no ability to transfer or divert.
3. Current "Just in Time" supply chain management may not allow for sufficient and appropriate supplies for response. Sufficiency of care standards may be implemented (i.e. re-use single use products).
4. Communication and coordination with transportation dispatch is critical to support equitable distribution of patients to care facilities as well as provide transportation assets to support hospital decompression or surge activities.
5. Staff and volunteers will experience physical and emotional fatigue that may require behavioral health oversight and intervention.
6. There will be a crisis shortage of critical care beds locally and regionally.
7. A concurrent aggravating condition at a hospital (i.e. cyber-attack, utility loss, infrastructure damage etc.) will require response assets and impact bed availability for event/incident response.
8. Surge capability reduced
    a) Staffing support at multiple venues, DMATS, etc.

b) Potential for staffed surge beds decreased
c) Implementation timelines increased (traffic, parking, staffing availability/rest periods, etc.)

Roles and Responsibilities

Hospital Command Centers
Domain Operational Control for their respective hospitals.

Emergency Operations Centers
City of CITY OR JURISDICTION NAME: NSSE Lead Operational Control
Cuyahoga County: Regional Support and Coordination Activities

Federal EOCs
Support & Coordinate Consequence Management Response Activities

Hospitals (REGION OR JURISDICTION and CONTIGUOUS REGION OR JURISDICTION regions)
Hospital #1: Event Medicine Support
Hospital #2: LEO Medical Support
Hospital #3: Specialty Care Emergencies (i.e. dentistry)
Hospital #4: Behavioral and Mental Health Emergencies

Regional Healthcare Coordinator—Regional Hospital Association

Joint Information Center (JIC)
A JIC will be established at the CITY OR REGION NAME EOC. All media and press issues are to be vetted through the JIC and secret service prior to release of any messages or interviews.

Public Health Resources
State and Local epidemiologists will be reviewing the bio-surveillance systems periodically before, during, and after the event. These systems include:

a) NAME OF SYSTEM is the web-based electronic disease reporting application for the STATE HEALTH DEPARTMENT. With NAME OF SYSTEM, providers can quickly and securely notify the STATE HEALTH DEPARTMENT of the occurrence of communicable diseases and other reportable conditions.
b) NAME OF SYSTEM is the syndromic surveillance system for the STATE HEALTH DEPARTMENT. It monitors over 3 million visits to emergency rooms from 160+ emergency departments a year. It simultaneously monitors 1000+ retail stores in NAME OF STATE for disease outbreaks. NAME OF SYSTEM collects data from multiple data sources (currently healthcare ED registration chief complaint and over the counter medications). These data are stored in a database and data warehouse

where they are made available to outbreak algorithms and shared with infection preventionists statewide with a daily report.

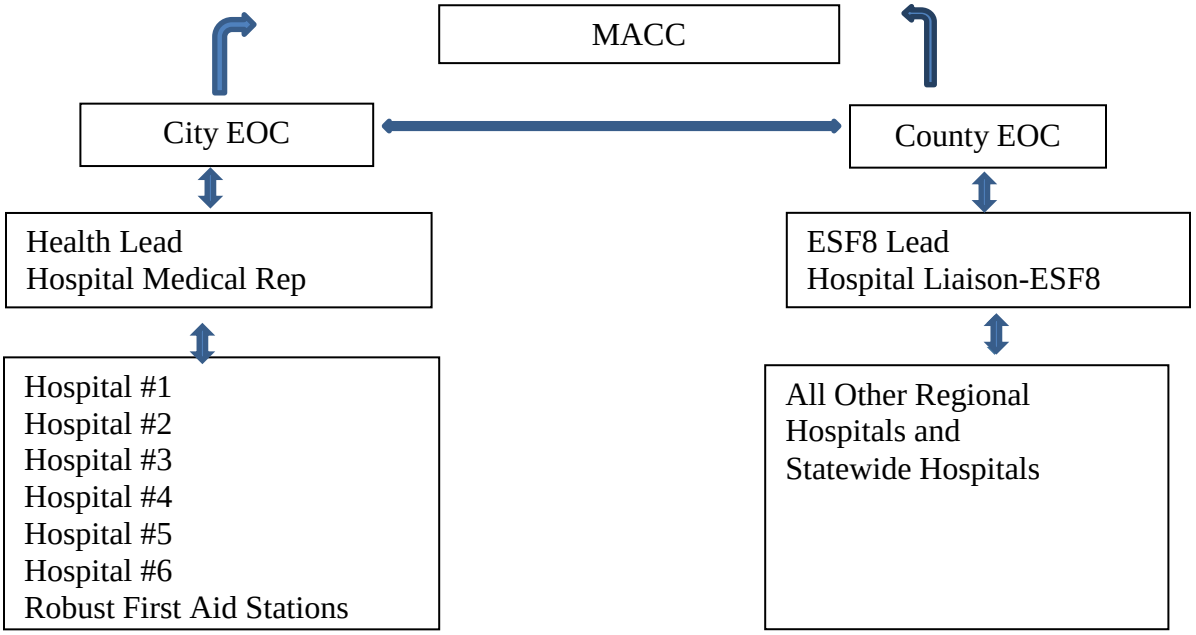
c) FIRST AID STATIONS (FAS): FAS will provide care inside/outside the hard perimeter for any delegate or spectator. Staffing and security for First Aid Stations are tailored to the EVENT. First Aid Stations can be tents, ambulances, or they can be located in shelters of opportunity. First Aid Stations provide robust, basic medical care but can also see acute medical problems. If transport is needed, the transport will be coordinated IAW the Emergency Medical Plan.
d) The NSSE Epi CONOPS plan will be implemented to support monitoring and surveillance activities.

Medical Examiner

The County Medical Examiner's Office is authorized to direct fatality management operations during mass fatality incidents per STATE LAW OR ADMINISTRATIVE CODE CITATION and the LOCAL LAW OR ADMINISTRATIVE CODE CITATION.

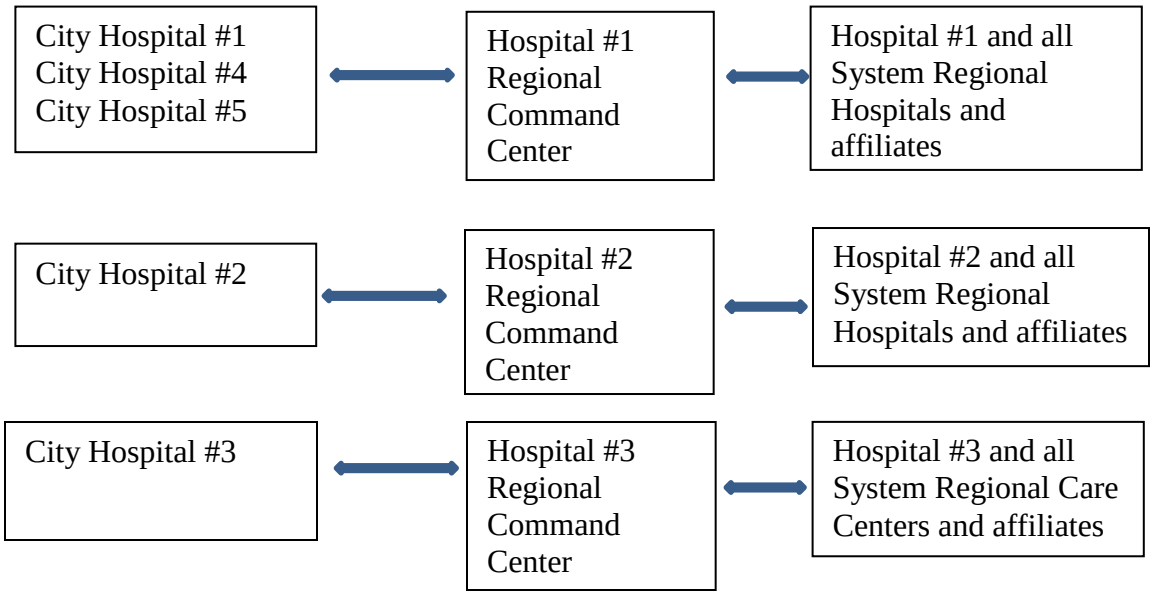
Communications Flow

Normal Operations Hospital Communication Flow for NSSE



Crisis Operations Hospital Communication Flow

During crisis when all hospital command centers would be open, the addition to the flow for all supporting/responding hospitals/systems and affiliates would add the respective Command Center (see below diagrams) as first call for situational awareness and local hospital resource allocation then follow the above algorithm with regional hospitals reporting to County EOC and City Hospitals reporting to City EOC for situational awareness and subsequent resource requests.



Hospitals Used in Response Planning

Trauma

City (Level 1):
Hospital #1
Hospital #2
Hospital #3

City (Level 2):
Hospital #4

Burn

City (Level 1):
Hospital #1

Trauma

REGION (Level 2):
Hospital #5

REGION (Level 3):
Hospital #6
Hospital #7
Hospital #8

Trauma

Contiguous Region (Level 1):
Hospital #1
Hospital #2
Hospital #3

Contiguous Region (Level 2):
Hospital #4
Hospital #5
Hospital #6
Hospital #7

Contiguous Region (Level 3):
Hospital #8
Hospital #9
Hospital #10
Hospital #11
Hospital #12

Saturation

Crisis

Consequence Management

Needs Assessment Response Capability Needed: 12-hour operational period

Incident/Event / Capability Needed	TRIGGER NUMBER (R/Y) Casualties Trauma (Crisis)	TRIGGER NUMBER (R/Y) Casualties Burn (Crisis)	TRIGGER NUMBER Casualties Chemical (Crisis)	> TRIGGER NUMBER (R/Y) Casualties Trauma (Consequence)	> TRIGGER NUMBER (R/Y) Casualties Burn (Consequence)	> TRIGGER NUMBER Casualties Chemical (Consequence)	Biological Actionable Result (Consequence)
Patient Tracking							
Mass Care							
Shelters							
Triage							
Mass transport							
ACLS transport							
Family Assistance Center							
Media/PIO							
Security							
Casualty Staging							
Medical Equip							
Trauma beds							
Coordination Center (transport)							
Resilient Comms							
PPE							
Gross Decon							
Fine Decon							
Technical Decon							
Pharmaceuticals							
Fatality Management							
Staffing (Admin)							
Staffing (Clinical)							
Staffing (Technical)							
Behavioral Health							
Volunteer Credentialing							
Supply Staging							
Blood Products							
Tissue Products							
ICU Beds							
Monitored Beds							

Event/Incident Specific Response Capabilities Needs Assessment

Incident/Event	Response (examples)	Resources available	Resources Needed (examples)	Resources Timeline	Shortfall Predicted
TRIGGER NUMBER ***(R/Y) Casualties Trauma (Crisis)*** ****Choose casualty*** **TRIGGER NUMBER** ***for your planning scenario i.e. 1-24 or 10-30 etc.***	Resources and Assets		Critical Care transport - ground		
	Resources and Assets		Critical Care transport - air		
	Resources and Assets		Blood products – O negative		
	Patient Management		OR capacity (beds and staff		
	Staff Management		Trauma surgeons		
	Patient Management		Monitored beds		
	Safety and Security		Traffic barriers		
	Communications		Radios		

Incident/Event	Response	Resources available	Resources Needed	Resources Timeline	Shortfall Predicted
TRIGGER NUMBER ***(R/Y) Casualties Burn (Crisis)***	Resources and Assets		Blood products		
	Resources and Assets		Ventilators		
	Resources and Assets		Medical Supply chain		
	Communications		Establish/maintain COP		

Incident/Event	Response (examples)	Resources available	Resources Needed (examples)	Resources Timeline	Shortfall Predicted
TRIGGER NUMBER ***Casualties Chemical (Crisis)*** ****Choose casualty*** **TRIGGER NUMBER** ***for your planning scenario i.e. 10-50 or 100-150 etc.***	Resources and Assets		Critical Care transport - ground		
	Resources and Assets		Critical Care transport - air		
	Patient Management		Monitored beds		
	Resources and Assets		Ventilators		
	Resources and Assets		Imaging capability		
	Resources and Assets		PPE/testing supplies		
	Communications		Establish/maintain COP		
	Resources and Assets		Portable suction		
	Safety and Security		Traffic barriers		
	Patient Management		Decon capability		

Incident/Event	Response (examples)	Resources available	Resources Needed (examples)	Resources Timeline	Shortfall Predicted
> **TRIGGER NUMBER** ***(R/Y/G) Casualties Trauma (CM)*** ****Choose your Tipping Point*** **TRIGGER NUMBER** ***for your scenario***	Resources and Assets		Critical Care transport - ground		
	Resources and Assets		Critical Care transport - air		
	Resources and Assets		Mass transport		
	Resources and Assets		BLS/ambulette transport		
	Resources and Assets		Blood products – O negative/positive		
	Patient Management		OR capacity (beds and staff		
	Staff Management		Trauma surgeons		
	Patient Management		Monitored beds		
	Staff Management		Cardiothoracic surgeon		
	Resources and Assets		Ventilators		
	Resources and Assets		Imaging capability		
	Resources and Assets		Ultrasound capability		
	Resources and Assets		Medical Supply chain		
	Communications		Establish/maintain COP		
	Resources and Assets		Portable suction		
	Safety and Security		Traffic barriers		
	Resources and Assets		Family Assistance Center		
	Resources and Assets		Shelters		
	Resources and Assets		Mass Care (ESF 6)		
	Safety and Security		Security Personnel		
	Communications		Media/PIO		
	Patient Management		Fatality Management		
	Staff Management		Behavioral Health		
	Patient Management		Clinical staffing		
	Staff Management		Admin staffing		
	Staff Management		Technical staffing		

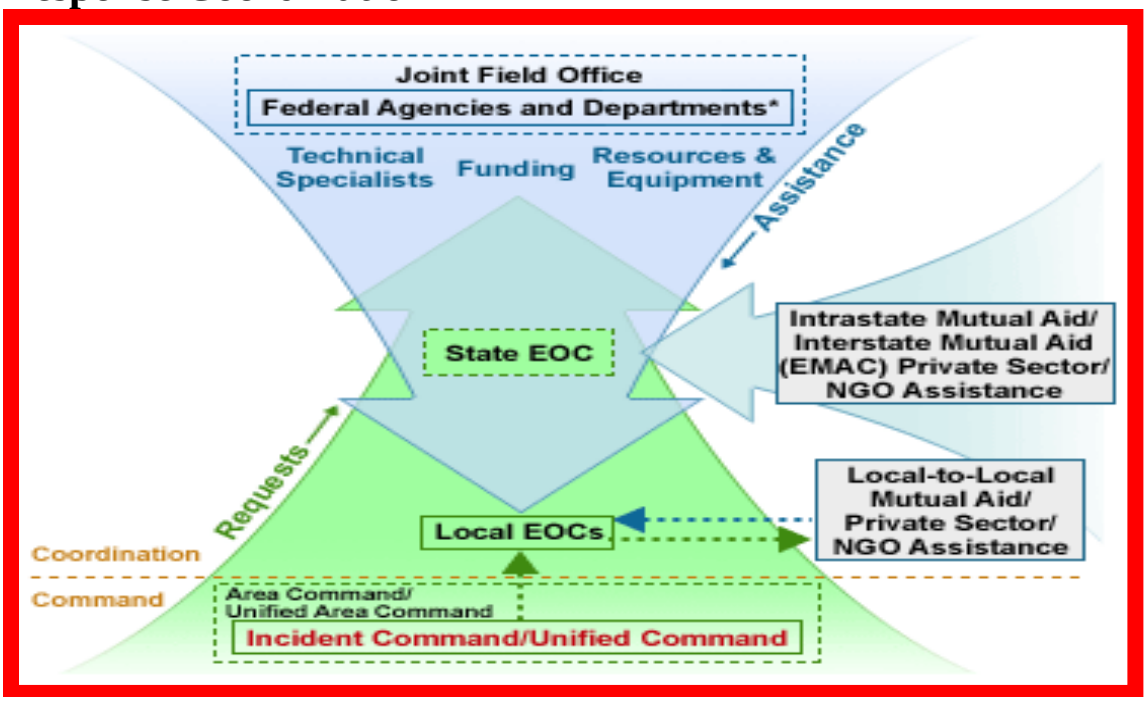
Incident/Event	Response (examples)	Resources available	Resources Needed (examples)	Resources Timeline	Shortfall Predicted
> **TRIGGER NUMBER** ***(R/Y) Casualties Burn (CM)*** ****Choose your Tipping Point*** **TRIGGER NUMBER** ***for your scenario***	Resources and Assets		Blood products		
	Resources and Assets		Ventilators		
	Resources and Assets		Medical Supply chain		
	Communications		Establish/maintain COP		
	Resources and Assets		Critical Care transport - ground		
	Resources and Assets		Critical Care transport - air		
	Resources and Assets		Family Assistance Center		
	Resources and Assets		Mass Care (ESF 6)		
	Safety and Security		Security Personnel		
	Communications		Media/PIO		
	Patient Management		Fatality Management		
	Staff Management		Behavioral Health		
	Patient Management		Clinical staffing		
	Staff Management		Admin staffing		
	Staff Management		Technical staffing		

Incident/Event	Response (examples)	Resources available	Resources Needed (examples)	Resources Timeline	Shortfall Predicted
> **TRIGGER NUMBER** ***Casualties Chemical (CM)*** ****Choose your Tipping Point* TRIGGER NUMBER *for your scenario***	Resources and Assets		Critical Care transport - ground		
	Resources and Assets		Critical Care transport - air		
	Patient Management		Monitored beds		
	Resources and Assets		Ventilators		
	Resources and Assets		Imaging capability		
	Resources and Assets		PPE/testing supplies		
	Communications		Establish/maintain COP		
	Resources and Assets		Portable suction capability		
	Safety and Security		Traffic barriers		
	Patient Management		Decon capability		
	Resources and Assets		Family Assistance Center		
	Safety and Security		Security Personnel		
	Communications		Media/PIO		
	Patient Management		Fatality Management		
	Staff Management		Behavioral Health		
	Patient Management		Clinical staffing		
	Staff Management		Admin staffing		
	Staff Management		Technical staffing		

Incident/Event	Response (examples)	Resources available	Resources Needed	Resources Timeline	Shortfall Predicted
Biological Actionable Result (Consequence Management)	Closed POD activations		Pharmaceuticals		
	Communications		Establish/maintain COP		
	Safety and Security		Security Personnel		
	Communications		Media/PIO		
	Patient Management		Fatality Management		
	Staff Management		Behavioral Health		
	Patient Management		Clinical staffing		
	Staff Management		Admin staffing		
	Staff Management		Technical staffing		
	Patient Management		Decon capability		
	Resources and Assets		PPE		

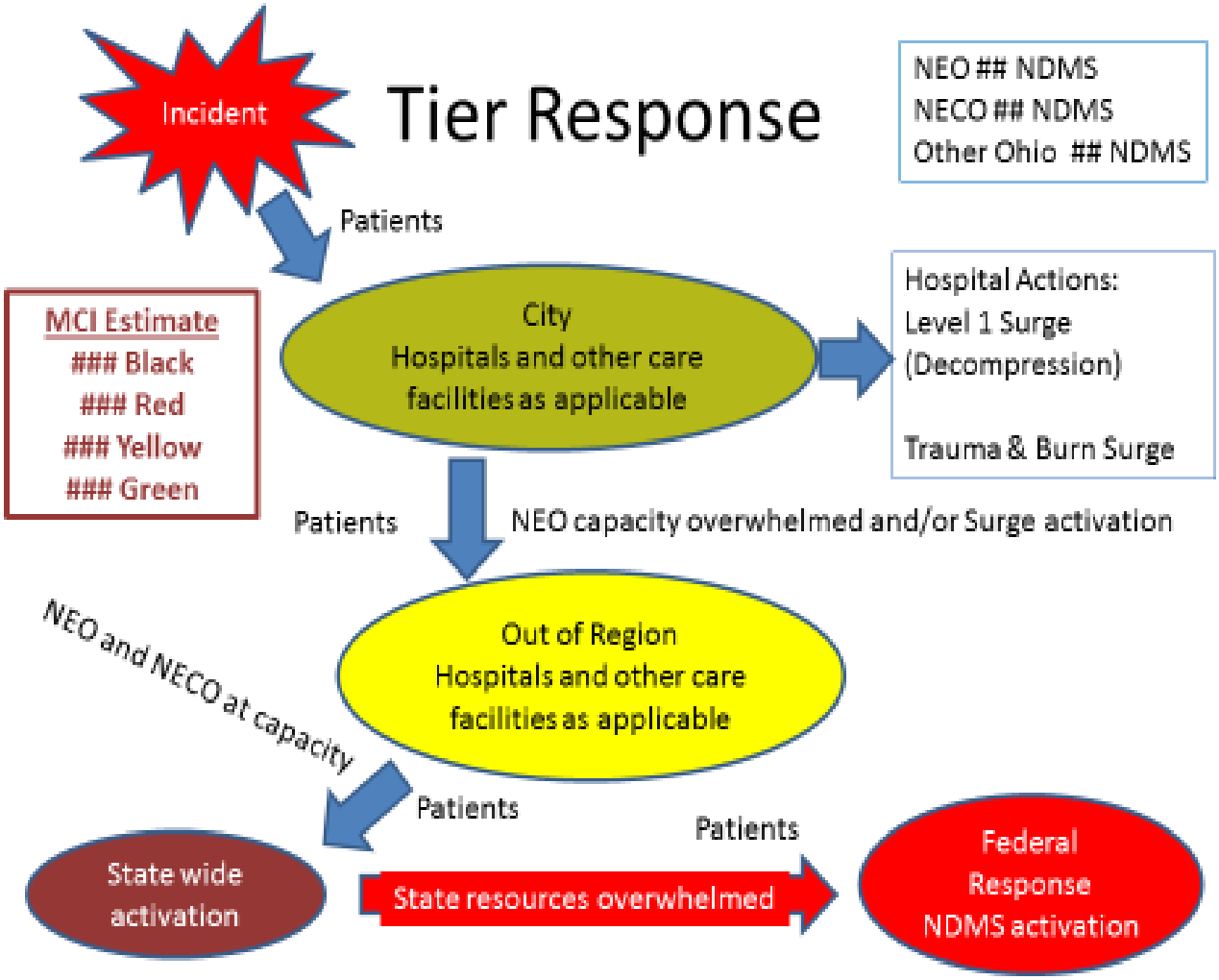
Response Operations

Response Coordination

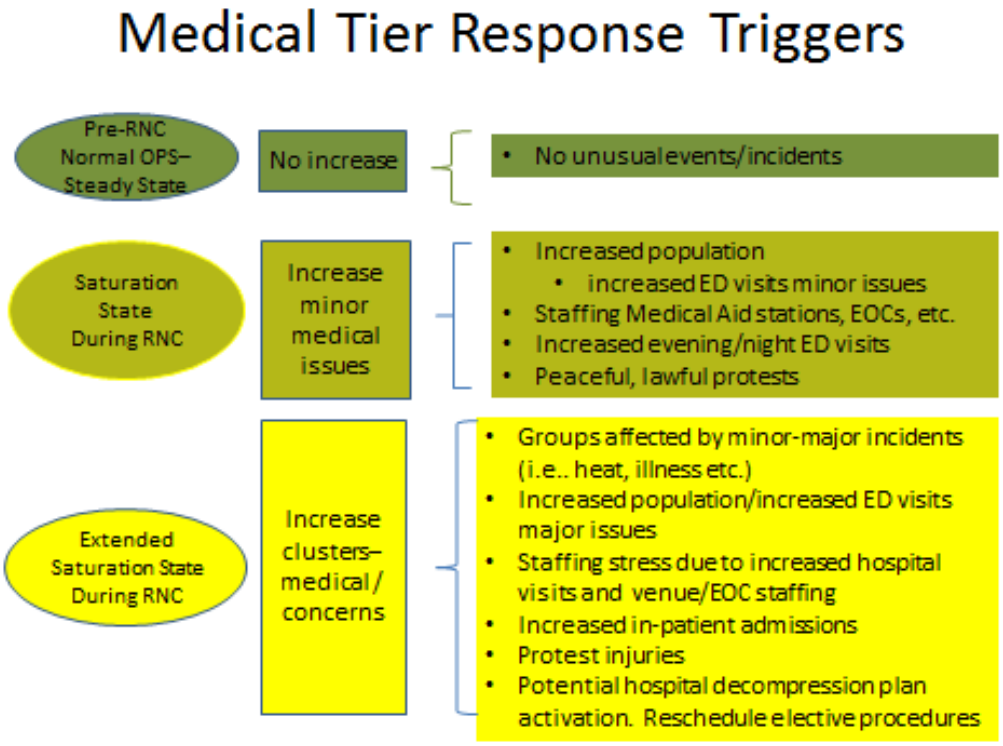


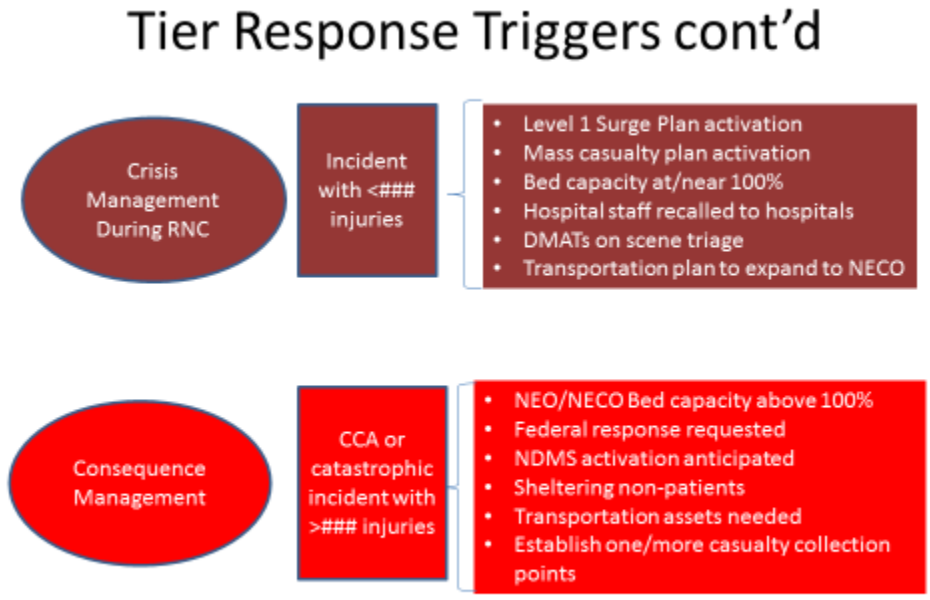
*From IS-100; FEMA Independent Study Accessed May 2016

Tier Response



Medical Tier Response Triggers





Mass Fatality

Transportation

Five deaths at any one single scene is considered a mass fatality event. The County Medical Examiner (or his designees i.e. Administrator, Chief Deputy Medical Examiner) may activate this annex of the Emergency Operation Plan, at their discretion, at any time, by notifying Office of Emergency Management. In such an instance, the Medical Examiner is added to the Unified Command under the ICS structure. The County Medical Examiner's Office (CMEO) has sole jurisdiction over the deceased and unless life saving measures are needed, the body is considered evidence and should not be touched until authorized by the CMEO for transport. The CMEO Recovery and Removal teams document the scene and prepares deceased for transport. They will work in conjunction with federal, state and local law enforcement and emergency services agencies as required. Extenuating and special circumstances may require a call to other agencies for assistance with body recovery, such as contamination of scene and bodies by biological, chemical or radioactive means, or site stability and security such as active shooters or unstable or immovable debris. Scene security and transport in such an event may require days to complete. All attempts to move bodies to the CMEO facility will be expediently attempted. A mobile morgue unit can be dispatched, with room for up to ## bodies at a time. The CMEO facility has the capacity for ## bodies in addition to normal caseloads. There will be no mobile exams done in the field, unless extraordinary circumstances require it.
CMEO has a privately contracted transport service (with #-# designated ambulances and personnel) that will assist to move bodies to CMEO and to other counties morgues as required. If those assets are overwhelmed, assistance from the Funeral Directors will be requested and subsequently the Mortuary Response Team (MORT). Hospitals may have to hold any deceased in their facilities morgues until county morgue space at the CMEO facility is made available. If a mass fatality event occurs, consideration has been given to use the adjacent Cemetery, across from the hard zone, as a victim-staging site until the bodies can be moved to the CMEO facility. Increased security at the CMEO facility will be requested through the County Sheriff.
The Mass Fatality Incident Annex to the County Emergency Operations Plan will be followed.

Patient Tracking

Victim tracking for mass fatality EVENTs is imperative. Hospitals will use the PATIENT TRACKING AND FAMILY REUNIFICATION SYSTEM NAME for patient tracking and to document any identifying marks that could assist with victim identification. The tracking system is available to CMEO, as they have been trained, and will be utilized. Triage tags are placed by EMS at the scene. Paper forms will be used if the system goes offline or the power is cut to computers.

Personnel

CMEO will utilize all its investigative staff and forensic pathologists staff in a mass fatality event, as well as numerous forensic specialist and office staff. If the event overwhelms the office, assistance from other counties will be requested. There may be a need for more pathology assistants than physicians. Mutual aid from surrounding counties and OMORT/DMORT could be requested. There will be a CMEO representative in place at the County EOC, as requested,

and may work virtually for situational reporting of numbers of fatalities.

Victim Identification Center/Family Assistance Center

CMEO will work in conjunction with ESF6 Mass Care to identify a location for a Victim Identification Center (VIC), which will support the Family Assistance Center (FAC) to ensure the provision of information, and the access to services for family members awaiting victim identification is guaranteed. There will be a separate room identified for privacy for family notification. CMEO will direct death notifications with federal, state and local authorities. Funeral Directors and their staff will be registered through NAME OF WEBSITE to assist the CMEO with administrative duties such as getting information from families. They may assist with operations of the VIC as well as mental health and other support. Local clergy will be requested for family support and Red Cross Mental Health resources, as well as Board of Health social workers, could assist with family trauma, due to the event. The American Red Cross has the ability for continuing mental health care for out of state visitors by referring them for follow up with the other states' American Red Cross services.
The CMEO and American Red Cross will work through the Joint Information Center (JIC) to apprise the public of any phone banks or websites set up to assist families.

Response Execution

Command/Coordination

Hospitals will staff their Hospital Command Centers as appropriate. They will inform the Hospital Group Supervisor or Medical Branch Director of their command activation status on a daily basis.

The Hospital Association will serve as a coordination point for situational reporting and hospital resource requests through the City EOC, County EOC or MACC and will report through Knowledge Center situational reports to and from hospitals for those operational periods. The CITY OR REGION NAME has requested Hospital Representation for the ICS Hospital Group Supervisor under the Health and Medical Branch Director (Public Health) for the duration of the event. City Hospitals and Hospital Association will be staffing this seat with Resource Personnel as requested.

The impact of normal system function could extend far beyond the five counties in the region, therefore surge and operations planning for hospitals was extended to the NW and CONTIGUOUS REGION OR JURISDICTION regions. The ADD NUMBER hospitals around the state will be asked to update their bed census and mass casualty capabilities daily. Situational reports will be shared with the Regional Hospital Coordinators in those other five regions.

REGION OR JURISDICTION hospitals will report bed status though the State bed-reporting tool "Surgenet" twice daily and will include the casualty capabilities (red, yellow and green) this tool will also be used in an incident to track patients from scene to hospital utilizing the PATIENT TRACKING AND FAMILY REUNIFICATION SYSTEM NAME Patient Tracking feature. DESIGNATED PSAP has access to this tool and can utilize it for the mass casualty patient distribution in addition to creating an alert for suburban Fire/EMS departments to be

notified that their assistance may be necessary. The tool can be visualized in the EOCs.

Civilian Aeromedical Coordination

If needed and requested by DESIGNATED PSAP, The aeromedical designated hospital, will request and coordinate civilian air medical helicopters.
Aeromedical Communications Office: ###-###-####

Hospital Communications Methods

A Hospital Communication Plan is included within this document for ease of communication to and from hospitals and first aid stations. The plan is designed for not only daily activities, but to be able to escalate to an incident management level if necessary.

Cell/Landline/Email

Hospitals will primarily communicate via cell phone and email using their command center emails or personal emails if the hospital command center is not open.

700/800 MHZ TRUNKED RADIO/OPHCS/PATIENT TRACKING AND FAMILY REUNIFICATION SYSTEM NAME

Other communication options will be available including OPHCS, and 700/800 MHZ TRUNKED RADIO as well as the PATIENT TRACKING AND FAMILY REUNIFICATION SYSTEM NAME Patient tracking system alerts. In an event where usual communication lines are not available, the Hospital Representative in the EOC will have access to the 700/800 MHZ TRUNKED RADIO system and will use that resource to actively manage any emergent unexpected activity during the event that could impact hospitals in the region. These radios will be utilized when rapid notification or two-way communications are required though XXXX-XXX talk group. The 700/800 MHZ TRUNKED RADIO radios can also be utilized to coordinate with transportation officers in the field regarding patient destinations or between hospital transfer centers. All information received by the Hospital Representative in the EOC by situational report or the 700/800 MHZ TRUNKED RADIO system or any other means, will be posted to the Knowledge Center as necessary and appropriate after conferring with the hospital affected.

Backup Communications (GETS/WPS/Satellite/ARES etc.)

If telephone service is disrupted, hospitals will activate their back-up communications plans including 800 MHz, county radio systems, satellite telephone, and amateur radio (ARES), where applicable. Facilities that have subscribed to the Government Emergency Telecommunications Service can use Government Emergency Telecommunications Service (GETS) to make and receive telephone calls. ARES is requested through the EOC.

Notification Methods

OPHCS

If a related or unrelated event occurs that could impact the hospitals in the region, the hospitals will be notified by OPHCS alert as usual protocol. The other five regional hospital coordinators, STATE HOSPITAL ASSOCIATION, and STATE HEALTH DEPARTMENT will subsequently be notified of any event that could cause a need for support or hospital surge through the

standing notification matrix.
STATE HEALTH DEPARTMENT or other hospitals throughout the state may also be notified by 700/800 MHZ TRUNKED RADIO radios, as needed using the 700/800 MHZ TRUNKED RADIO template.

CECOMS/EOCs
If a hospital facility has a need to report an emergency department Status Change, notification should be made to the DESIGNATED PSAP or following regular day-to-day processes. Hospitals should also place this into their situational report to the EOC Hospital Group Supervisor.

Mutual Aid Requests
If a healthcare facility has a problem or needs assistance, the regular process for mutual aid requests should be followed.
The healthcare facility requiring assistance should contact the Hospital Group Supervisor in the City EOC utilizing the specific request forms given and/or the emergency management agency for their county. Subsequent REGION OR JURISDICTION Regional Hospital MOU will be activated preemptively for the event The Statewide Hospital MOU activation will be requested if needed through STATE HOSPITAL ASSOCIATION.

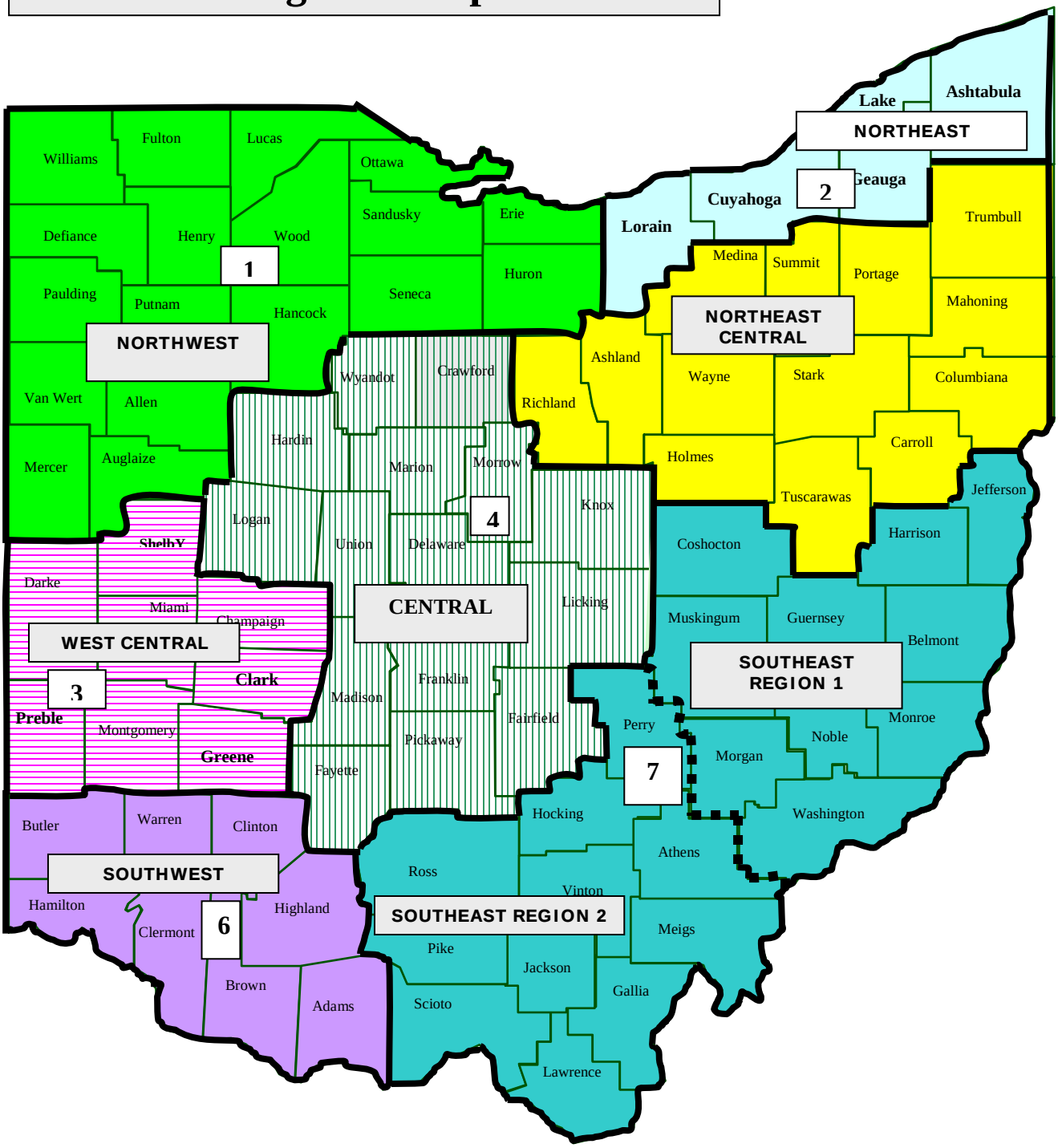
Security
In an EVENT outside the CITY OR REGION NAME where there is a security issue possibly involving a hospital or other facility with affiliated delegates, the local jurisdiction is expected to follow normal procedure. If the EVENT escalates and immediate assistance is needed, specifically for security, hospital security or local Law Enforcement would call the MACC.

Operational Period
It is anticipated that the Incident Commander will declare the demobilization of the MACC at ADD TIME on ADD DATE However, it should not be assumed that the MACC or the Hospital Desk is shut down until your facility is specifically notified. Field EVENTs and operations will drive termination of MACC activities. If a brokered convention is announced, hospitals will be informed to continue with operations as for the previous days until the convention is closed. Hospitals will be notified of any changes by email and/or STATEWIDE DEPARTMENT OF HEALTH ALERTING SYSTEM NAME alert to “STAND DOWN”.

NDMS Activation for Forward Movement of Patients
Under ESF #8, Health and Human Services (HHS) coordinates the Federal response in support of emergency triage and pre- hospital treatment, patient tracking, and distribution. These efforts are coordinated with Federal, State, tribal, territorial, and local emergency medical services officials. It is at the point of debarkation that patients and medical special needs individuals will be distributed to the most accessible, appropriate health care service. Additionally, ESF #8/HHS may request DoD, the VA, and/or DHS/FEMA, via the Federal National Ambulance Contract, to provide support for evacuating patients and individuals with special medical needs. Support may include providing transportation assets, operating and staffing air marshalling points/NDMS FCCs, and processing and tracking patient movements from collection points to their first destination for medical care, destination, or home of record.

Under ESF #8, HHS is responsible for oversight of patient tracking, which may require integration of multiple systems to effectively track patients.

Ohio Hospital Preparedness Regional Map



Acronyms

IAW	In Accordance With
ARES	Amateur Radio Emergency System
CMEO	County Medical Examiner's Office
CEN	Central
COP	Common Operation Picture
DHS	Department Homeland Security
DMAT	Disaster Medical Assistant Team
DMORT	Disaster Mortuary Response Team
DoD	Department of Defense
ED	Emergency Department
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ESF	Emergency Support Function
FAC	Family Assistance Center
FAS	First Aid Stations
FBI	Federal Bureau of Investigations
FCC	Federal Coordinating Center
FEMA	Federal Emergency Management Agency
FOUO	For Official Use Only
GETS	Government Emergency Telephone Service
HCC	Hospital Command Center
HHS	Health and Human Services
ICS	Incident Command System
JIC	Joint Information Center
LE	Law Enforcement
MACC	Multi-Agency Coordinating Center
MCI	Mass Casualty Incident
ME	Medical Examiner
MHz	Mega Hertz
NDMS	National Disaster Medical System
NE	North East
NEC	North East Central
NGO	Non-Governmental Organization
NSSE	National Special Security Event
NW	North West
MORT	Mortuary Response Team
PIO	Public Information Officer
POC	Point of Contact
PPE	Personal Protective Equipment

SE	South East
SIP	Shelter In Place
SW	South West
VA	United States Department of Veterans Affairs
VIC	Victim Identification Center
VIP	Very Important Person
WCEN	West Central
WPS	Wireless Priority Service