ASPR TRACIE Technical Assistance

On March 12, 2019, ASPR TRACIE hosted the webinar *Hospital-Based Incident Command Systems: Small and Rural Hospitals* with speakers from small and rural hospitals who have experienced a recent emergency and activated their hospital-based incident command systems. They provided a brief overview of the incident, described how they implemented their incident command system, discussed tools and share lessons learned for small and rural hospitals, and discussed how they have incorporated these lessons into their current systems and plans. Links to the presentation, speaker bios, recording, and additional handouts are available.

Due to time constraints, speakers were not able to respond to all of the questions received during the Question and Answer (Q&A) portion of the webinar. ASPR TRACIE sent remaining questions to panelists and their answers are provided below.

Questions for All Panelists

**Note: each response was provided by a different speaker.*

Q1. Do your HICS Incident Management Teams (HIMTs) coordinate with your healthcare coalition (HCC) IMTs?

- If it is a response to an internal incident within the healthcare facility that involves the activation of an HIMT and no community support is needed, the answer is no. Whereas, if community support is needed (e.g., healthcare coalition partners) the answer is yes.
- If the response is to another provider within the organization (e.g., critical access hospital or long-term care facility) a resource request is generated for specific HIMT command and/or general staff positions. Again, if community support is needed and it involves healthcare coalition support, the answer is yes.
- I do not work for healthcare facility. However, having just observed the communication during a flooding response, it is clear that we have some work to do. Most of our healthcare coalitions are designed to have their role in disaster response to be one of communication/ coordination/ information sharing. The HCC Coordinator is the only employee of the coalition. Other coalition members respond as part of their own facility's Incident Command.
- Yes, we contact our coalition RCH at a minimum for each exercise or real world incident.

Q2. How often do facilities actually evacuate patients during an exercise? (Note: each response was provided by a different speaker.)

- We either work with cardboard cut outs or use volunteers to role play.
- As a FEMA Master Exercise Practitioner, it depends on the facilities that are conducting the exercises.
  - For my hospitals, I use actors as patients.
  - For my clinics during their annual fire drills, I use actors, but if real patients present early for their appointments, they are also included in the fire drill.

    - For LTCs, I use actors and some residents with their permission.
- Prior to our active shooter incident, we only practiced evacuations by actually moving patients once per year. In our state, severe storms are what we typically use for our actual drill to move patients. Since the event we always have a section of our drills where we play out the need for the evacuation of patients (if the drill is large enough or appropriate for the exercise).
- We do not evacuate actual patients during an exercise.

Q3. What is the involvement of your local health department (LHD) in any of the responses cited by panelists? (Note: each response was provided by a different speaker.)

- We utilize our LHD in almost all of our exercises. They are on our campus so we frequently use them as volunteers or observers/evaluators. This also allows them to become familiar with our processes in case we need them in a true emergency.
- My event did involve our LHD because the healthcare coalition operates through them. The healthcare coalition has assets and resources that were purchased. The water filtration equipment was a resource request that Garfield Memorial Hospital used during their 6-day water incident.
- In the event I spoke about, we had little involvement from LHD until the end of the incident where they reached out to us to see if there was anything needed that they could assist with (basically to get us back to the new normal and accepting patients).
- The LHD was not involved during the Fannin Regional Incident.

Q4. Which facilities presenting are Joint Commission accredited?

- One hospital is DNV accredited, Fannin Regional Hospital is Joint Commission accredited, and others are not or not applicable. However, one facility noted that within their healthcare system, many are Joint Commission accredited and they utilize their standards when applicable.

Q5: Was a Joint ICS set up for all entities or did all have separate ICS only?

- For my event, no unified command was established. Instead, we established daily briefings to external community partners (county emergency manager, state department emergency manager liaison, healthcare coalition coordinator, local health department, city manager).
- In reality I had two ICS's established during my incident. One inside (me) and the other involved the massive amount of law enforcement outside the building (FBI, sheriffs, highway patrol, etc.). Both worked together simultaneously, however what we learned from this was that no ICS assumed total command, and recommend that should take place. Too many situations were being handled without a unified command having total situational awareness.
- Joint ICS was stood up for Fannin Regional.

Q6. One thing our hospital struggles with is patient tracking during an influx of patients in a disaster situation (practiced through drills). Any best practices or tips?

- Since the most common incident we see at the hospital are school bus wrecks accidents that cause an influx of between 20 to 30 pediatric patients), we stop EMS at the entrance and collect patient information. Two of our staff write down where we take patients and we have someone escort them to the location. We have two people assigned at the end location tracking patients and doing frequent roll calls. Because most of our actors are not injured, we keep them all in one room. An observer carries a list that includes patient location, and our patient access representative carries another list. We conduct "check in's" via radio and update everyone of who was discharged or moved, etc.
- The biggest thing I would add here is to make sure that the actual patient data be accessible in many areas of the facility. If ours was only in the nurse's station, we would not have been able to know exactly who our patients were at the time of the incident. Same goes with staff. We recently switched to a badge system for entry into our building and for payroll/timecard. Without that data we would not have known who and how many staff members were actually in the building when we went on lockdown. This would have posed a big problem. Again have this data of what staff are in the building readily available in multiple areas.
- I use HICS 254 (Disaster Victim Patient Tracking form).

Questions for Steve Ikuta, Intermountain Healthcare

Q7. Can you please send us a copy of your revised Planning P?

- Yes. Keep in mind it has been modified to be used in a healthcare setting. Please go to https://files.asprtracie.hhs.gov/documents/hospital-based-incident-command-systems-webinar-additional-materials.pdf for access to the fillable Planning P.

Q8. Did the Garfield County Nursing Home utilize the Nursing Home Incident Command System in their response?

- I am not familiar with a Nursing Home ICS. We activated HICS using the HICS v2014.

Question for Michael Patterson, Fannin Regional Hospital

Q9. Who took care of in-house hospital environmental services for the areas this patient was utilizing? Did HazMat take care of it, or did your in-house employees take care of it after the fact?

- In-house environmental services staff took care of decontaminating and cleaning the areas where the patient had been with guidance from HAZMAT.

Questions for Michael O'Keefe, Redfield Community Memorial Hospital

Question 10. You mention that cell phone service was overwhelmed during the active shooter incident. Are any of your cell phones registered with WPS through the GETS program with Homeland Security? If so, was WPS/GETS utilized?

- On the hospital side, we had no phones on the WPS or GETS program. AT&T is the only carrier in South Dakota that has the program. However their service in our area is marginal so we have not had anyone switch over yet.
- Emergency management personnel in the city and county did have and utilize the program to get emergent calls out. So it was utilized by the outside ICS group.

Q11. When the potential shooter was isolated in the ER waiting area but the event was still very active, were other patient care areas allowed to resume "normal" patient care?

- We went into full lockdown, meaning no one could enter without permission or those who have access during a lockdown.
- All patient care areas were halted from providing care until the situation was over. Discussions were had during the event about reopening some areas but the federal authorities and outside ICS was not in favor of that. Also we didn't have the proper amount of staffing onsite to fully open the other areas due to the incident.
- By the time the situation was over, it was too late in the day to resume normal operations for clinic, home health, and outpatient care areas so they did not resume until the following morning. However our ED opened and was very busy immediately following the incident.
- Our EMS and Ambulance service stayed open and did respond to calls during the event with proper communication from ICS and the EMS center. No patients were transported to my facility during the incident.

Q12. Will the blood bank be evacuated if there is a shooter in the hospital and there are some people injured who potentially may need a blood transfusion? How is that handled?

- Initially all staff were evacuated to a safe zone. Once the situation was contained we began making the necessary arrangements for blood in the event of a shootout; this was handled though inside and outside ICS communicating to arrange for staff to be protected while accessing what is or may be needed. Essentially, we had put in place a system to retrieve necessary blood in the event it was needed. Much like dietary needs, access to medications for our inpatients that were moved to a save zone as well as other needed supplies. All were planned and arranged through incident command.

Q13. Did you use any or review lessons learned from Orlando's Pulse nightclub shooting?

- Prior to the incident we had not utilized any learning from the Orlando incident. However, in our debriefings and situational reviews we did have some discussions about other recent events involving shooters.

Q14. Do you use a system for alerting in coming staff, or is it an old-fashioned call tree?

- It is both the calling tree and we utilize the eICS alert system which sends a call to every staff member (who is signed up with it). Prior to the event we had about 65% of staff on this alert system. Currently we are at 98% and this is checked quarterly to ensure we still have everyone on the system and that they receive the test calls.

Q15. With multiple agencies "setting up ICS," how was overall command established?

- This was really one of the biggest takeaways form our end and that of local authorities. We did not establish primary command. There should always be one ICS that is the decision maker for all things. Both FBI and local authorities handled outside things while I assumed command inside and handled internal things. Although we worked together closely, there should have been one established command rather than having two commands.

Q16. Why did you "relinquish" command to sheriff's office instead of implementing unified command? Should a hospital ever relinquish command when their facility is involved?

- Command was never relinquished to sheriff's office or the FBIs that were set up outside the building. Nor was a unified command established. This proved to be one major takeaway from the event. A unified command would have eased some of the communication challenges as well as the announcement that the hospital is back to normal operations. Outside and inside command had no idea, nor were we ready to, open the facility. Establishing unified command was missed but won't be missed again. Part of this issue was the fact that we are a small town and everyone knows each other. So it worked more like a buddy system to reopen the facility rather than with clear and concise questions and answers to determine when or if we should reopen the facility. We still had evidence and caution tape around our ED waiting area while patients were coming to the ED. Ultimately it is my call (or that of the CEO/Administrative team) on when we reopen for business. The CEO or Administrative Team should never relinquish command but they should be ultimately vested and on the unified command center to handle this very thing.

Question for Rocky Jones, Indian Health Services

Q17. When will the next training be held for Tribal Nations?

- The Tribal Nations Training Week typically occurs around the same weeks each year (mid-late March). Please check with the FEMA Center for Domestic Preparedness for advertising of upcoming trainings.

Question for Barbara Dodge, University of Nebraska Medical Center

Q18. Are you aware of command response guides that address specific emergency situations (e.g., power failure, severe weather)?

- Yes! In the HICS Guidebook, there are both Planning and Response Guides for specific threats. They are available to download in either PDF or Word format. Those can be found on the CAL-ESMA website: https://emsa.ca.gov/hospital-incident-command-system-incident-planning-guides-2014/.