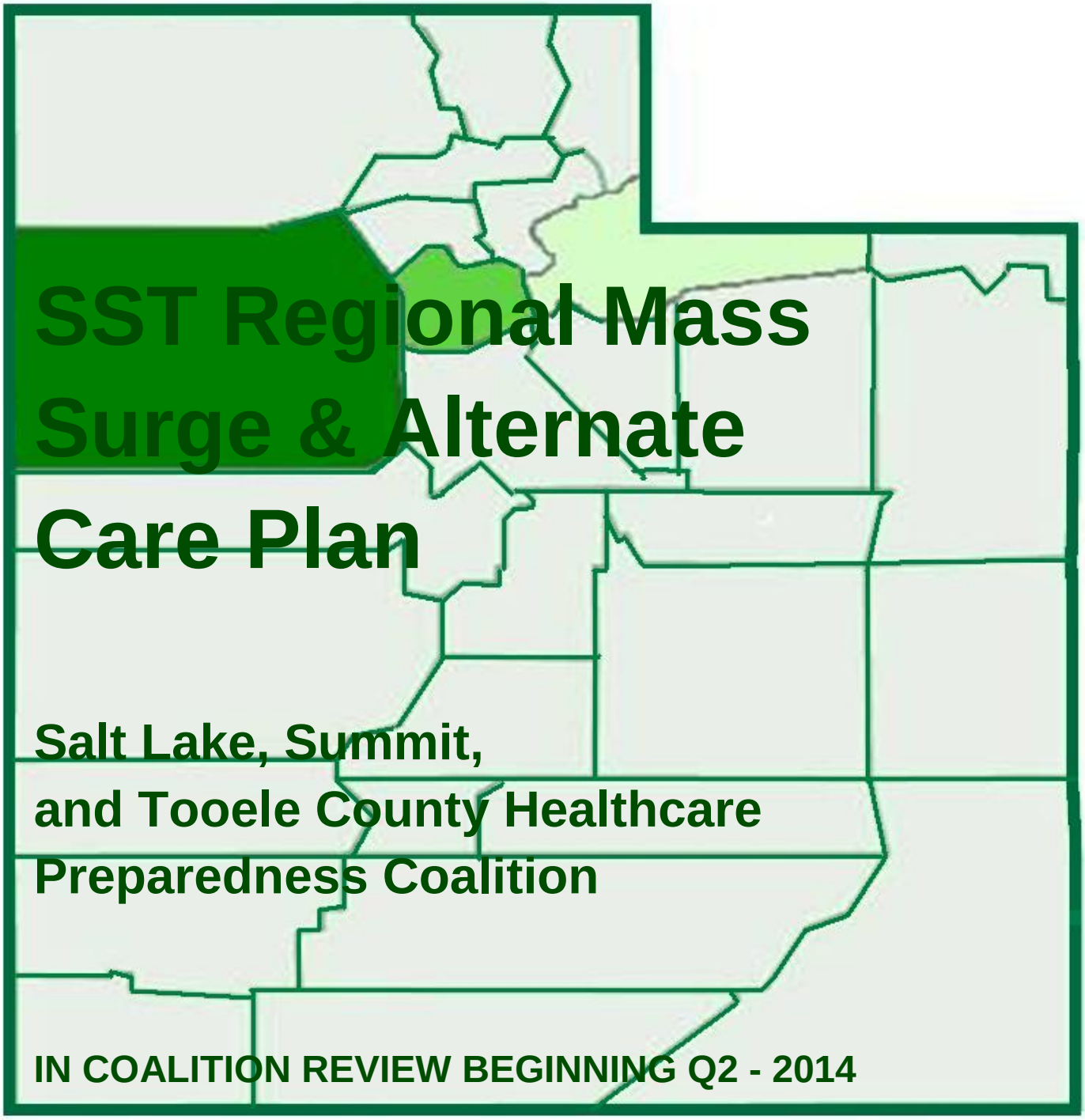

SST Regional Mass Surge & Alternate Care Plan

Salt Lake, Summit, and Tooele County Healthcare Preparedness Coalition

IN COALITION REVIEW BEGINNING Q2 - 2014

SLVHD Salt Lake Valley Health Department

SUMMIT COUNTY HEALTH DEPARTMENT

TOOELE COUNTY HEALTH DEPARTMENT

SST Healthcare Preparedness Coalition Partners

Hospitals

HEALTHSOUTH

IASIS HEALTHCARE

Intermountain Healthcare

MountainStar a family of hospitals

Mountain West Medical Center

University of Utah Health Care

Community Partners

Association for Utah Community Health

ASC

Indian Walk-In Center

North Tooele County Fire Rescue

PCFD Park City Fire District

Home Care

Unified Fire Authority

Utah HealthCARE

UHA Utah Hospitals & Health Systems Association

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Executive Summary

Acronym List

ABD	Assessment Branch Director
AERC	Panflu Assessment and Referral Clinic
BP	Blood Pressure
CAH	Critical Access Hospitals
CDC	Centers for Disease Control and Prevention
COOP	Continuity of Operations Plan
DOC	Department Operations Center
ECC	Emergency Command Center
ED	Emergency Departments
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Active Labor Act
EOC	Emergency Operations Center
ESF	Emergency Support Function
GRAMA	Government Records Administration & Management Act
HHS	U.S. Department of Health and Human Services
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
IAP	Incident Action Plan
IC	Incident Command
ICS	Incident Command System
ICU	Intensive Care Unit
ID	Identification
IRMS	Inventory Resource Management System
JIC	Joint Information Center
LBD	Logistics Branch Director
MCS	Medical Care Sites
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
NDMS	National Disaster Management System
PHE	Public Health Emergency
POD	Point of Dispensing
POS	Point of Service

PPE	Personal Protective Equipment
SLCo	Salt Lake County
SLVHD	Salt Lake Valley Health Department
SNS	Strategic National Stockpile
SOG	Standard Operating Guide
UCA	Utah Code Annotated
UCR	Utah Administrative Code Rule
UDOH	Utah Department of Health
UHA	Utah Hospital and Healthcare2 Assn
VBD	Vaccination Branch Director
VOAD	Volunteer Organizations Active in Disasters

Preface

The Salt Lake, Summit, and Tooele County (the Region) Medical Surge and Alternate Care Plan (the Plan) focuses on guiding health care facilities and personnel in working with hospital surge issues. Surge issues may arise from natural or human-caused disasters of large scope encompassing natural, technological and terrorism based emergencies and disasters or combination thereof rather than localized accidents or emergencies that are routinely experienced by hospitals.

The *Utah Medical Surge Capacity Plan* (2007) reflects the federal goal of increasing the number of beds for the triage, treatment and disposition of 500 more patients per 1,000,000 population than are currently available to respond to disasters. Based on the U.S. Census Bureau 2009 population estimate for Utah (2,784,572), to meet the goal requires an increase of 1,392 beds for the State. Of these beds, the State has determined that 140 should be reserved as critical care or burn beds. For the Region this means an additional 564 beds[1] with 56 reserved as critical care or burn. A second goal is to increase the number of patient care personnel by 125 per 1,000,000 population. Using the above figures this would be an increase of 348 providers for the State; 141 additional healthcare providers[1] to staff the beds in the Region.

This Plan provides guidelines and methods to increase the capacities and capabilities of public health and healthcare facilities in the Region through the use of alternate care facilities. Specifically, the Plan identifies and outlines the steps that need to be taken to free up hospital resources to increase the Region's current patient bed capability during a disaster by 571, with 30 of these additional beds designated as critical care or burn beds, providing equipment and supplies for additional facilities, locating 143 additional personnel, providing security, and ensuring adequate communications. It also identifies what actions may be taken by the Region to prepare for, and reduce the vulnerability of this Region's population stemming from natural, human-caused disasters and homeland security emergencies. In order to augment Regional resources, the plan considers resources within and outside of the Region that may be employed in responding to different emergencies.

This Plan identifies resources, and outlines mitigation, preparedness, response, and recovery actions, which may be taken by health officials and local responders. The purpose for this plan is to provide a general overview of medical surge and healthcare system response followed by immediately applicable methods for dealing with surge that provides the responder with what, where, when, and how to respond.

The plan is not intended to replace any existing Standard Operating Guidelines (SOG's) within the hospitals or health departments, nor is it intended to replace laws or rules. It has been developed to facilitate meeting the needs of the healthcare system in emergency response related to providing additional hospital beds, personnel, equipment and supplies, etc. necessary to provide the level of care required in a large emergency. It is the responsibility of each individual party within the Region to maintain and review their own SOG's as needed.

The Plan is not intended to replace individual facility or agency Continuity of Operations Plan (COOP) or all hazards disaster response plan that provides for individual hospitals' internal solutions to handling surge. The Region's Plan is intended to describe how facilities and

[1] Based on the Region containing 40.56% of Utah's population based on 2009 census data.

agencies will work together to mitigate, respond to and recover from a disaster type of any origin that results in medical surge beyond the facility's or agency's capacity to handle surge.

Overview

Novel Influenza H1N1 arrived in the United States mid-April, 2009. First identified in San Diego and San Antonio, the virus quickly spread throughout the United States by the end of May. While not highly virulent, the virus transmitted rather easily between people. However, the illness was milder than seasonal H1N1 for most people[2] and most people recovered easily at home with or without antiviral medication. In the Region, 2009 H1N1 did not overtax the healthcare system's ability to provide care, however it nearly taxed emergency departments ED) with individuals who did not require emergency care. A few hospitals activated flu triage sites on their grounds to relieve surge in their emergency departments. However, 2009 H1N1 surged public health resources requiring additional vaccination sites, mass clinics, and the use of temporary staff. Other potentially epidemic or pandemic diseases may overtax the system with both severely ill requiring hospitalization and walking wounded or worried well. In addition, natural disasters and human-made disasters may also surge the system in local or regional areas (Appendix A.1)

A mass-casualty event is by definition a complex, catastrophic, and multifaceted problem. Structuring an inter-organizational response to extreme events on a regional level should be a blueprint for emergency planners to use to ensure coordination, communication, and common goals among all stakeholders in the planning for and response to catastrophic events[3].

The Nature of Threats

Terrorism

Terrorism, natural disasters and accidents have the potential to produce large numbers of casualties requiring urgent care. The "unknown" aspects of many terrorism agents can be expected to add to care requirements as the "worried well" arrive at medical treatment facilities demanding treatment. The seriousness of the event will depend in part on whether the terrorists involved are more "professional" or are more amateur. Professionals can be expected to target multiple sites, as happened on 9/11/01, and they may use more than one category of agents. They could also target decision-makers who would be responsible for initiating and controlling responses. Due to the crucial role of major medical facilities in responding to a terrorist event, it is reasonable to expect that these activities could also be attacked. Similarly, major transportation arteries and other critical infrastructure businesses may be destroyed.

Natural Disasters

Natural disasters may evolve over time allowing for time to prepare (e.g. hurricanes) or may occur suddenly without warning (e.g. earthquakes). Numbers of casualties may range from only a few to very large numbers. Natural disasters often occur in weather extremes and cause widespread destruction or compromise of roads and equipment for accessing victims.

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[2] CIDRAP. WHO: H1N1 flu more contagious than seasonal virus. Posted 5/11/09, obtained 9/17/08 from http://www.cidrap.umn.edu/cidrap/content/influenza /swineflu/news/may1109severity.html.

[3] Altevogt, B.M., Stroud, C., & Nadig, L , and Hougan, M. (2009). Medical Surge Capacity Workshop Summary. Institute of Medicine of the National Academies, National Academy Press, Washington D.C. Obtained 23 Sept 2010 from http://www.nap.edu/catalog.php?record_id=12798

The counties comprising the north central region of Utah are diverse in both geography and potential for hazards. While all are subject to naturally occurring biological hazards, susceptibility to natural disasters and human mediated disasters vary. For example, Summit County is at high risk for snow-related emergencies and low risk for chemical or radiological accidents. Tooele County's risks are the opposite. Counties should prioritize preparation based on risk of occurrence for that emergency.

Scope of the Threat

Appendix B describes each type of potential emergency in detail. The two scenarios which will cause the greatest surge and require the most resources are a severe influenza pandemic and an earthquake of 7.0 or above. Capability and capacity to surge for both of these emergencies will ensure ability to surge to any other threats be they human-caused or naturally occurring.

Biological

- Pandemic Influenza. H5N1 influenza currently has the greatest potential to cause pandemic disease. While the world was focused on H1N1, H5N1 in birds was found in four more countries, although the number reporting human cases remains at 15. The worst case scenario could be a reassortment of 2009 H1N1 with H5N1 as the two co-exist in numerous countries. If this were to happen, we can expect very large numbers of mild to moderately ill flooding community primary care clinics, urgent care clinics, and hospital emergency rooms. Many more patients will be severely ill and require hospitalization than was experienced during the 2009 H1N1 pandemic. Available resources will be severely limited since all states will be impacted. Given the current case fatality rate for H5N1 extrapolated from the US Department of Health and Human Services (HHS) estimates for the nation[4], of 36%, HHS estimates that:

    - **Salt Lake County.** In Salt Lake County an estimated 303,743 people would become ill. About 151,798 or one half of these would visit healthcare providers as outpatients. Those that are mildly ill will self-care. Approximately 33,395 would be hospitalized over the course of the pandemic waves. Of these 5,009 would be admitted to the Intensive Care Unit and 2,471 will require mechanical ventilation. Total deaths will be about 8,015. In 2008 the county had 3,931 total deaths from all causes[5].

    - **Summit County.** In Summit County an estimated 10,836 people will become ill. About 5,415, or one half, of these will visit healthcare providers as outpatients. Those that are mildly ill will self-care. Approximately 1,191 will be hospitalized over the course of the pandemic waves. Of these 179 will be admitted to Intensive Care Units and 88 will require mechanical ventilation. Total deaths will be about 286. In 2008 the county had 104 total deaths from all causes[4].

    - **Tooele County.** In Tooele County an estimated 17,240 people will become ill. About 8,616, or one half, of these will visit healthcare providers as outpatients. Those that are mildly ill will self-care. Approximately 1,895 will be hospitalized over the course of the pandemic waves. Of these 284 will be admitted to

[4] Figures based on extrapolation from national data. HHS Pandemic Implementation Plan (2006), Introduction, p. 18.

[5] Utah Department of Health. IBIS-PH. Data obtained 20 October 2010 from http://ibis.health.utah.gov/query/

Intensive Care Units and 140 will require mechanical ventilation. Total deaths will be about 455. In 2008 the county had 213 total deaths from all causes[4].

If H5N1 remains as lethal to humans as it is currently, the number of deaths due to all causes, in an average year, will more than double for communities. For the first 8 months in 2010, the survival rate for those with H5N1 is only 50%; the 9 year average for survival is only 36%[6]

Natural Disaster

- Earthquake. A 7.0 or greater earthquake has the potential to cause severe damage in a limited area and mild to moderate damage regionally. Based on the 2009 census estimates, the Region 8 Regional Interagency Steering Committee of the Federal Emergency Management Agency estimates:
    - **Salt Lake County[7]**. 2,289 fatalities and 31,000 injuries might occur in Salt Lake County. Of the injuries, 22,832 are estimated to require no hospitalization; 7,057 may require hospitalization with non-life threatening injuries; and 1,201 may require hospitalization with life threatening injuries.
    - **Summit County[5]**. 80 deaths and 1,109 injuries may occur in Summit County. Of the injuries, 817 are estimated to require no hospitalization; 253 may require hospitalization with non-life threatening injuries; and 43 may be hospitalized with life threatening injuries.
    - **Tooele County[5]**.127 fatalities and 1750 injuries may occur in Tooele County. Of the injuries, 1,290 are estimated to require no hospitalization; 399 may require hospitalization with non-life threatening injuries; and 68 may be hospitalized with life threatening injuries.

Purpose of the Plan

The goal of the Coalition is to facilitate coordination between all agencies involved by providing strategies to minimize, prepare for, respond to, mitigate and recover from emergencies or disasters that threaten life, property, and the environment within the Region, as defined by this Plan.

The Salt Lake, Summit, and Tooele Counties' (SST) Regional Medical Surge and Alternate Care Plan identifies:

- actions that may be taken by the Region's healthcare providers to prepare for and reduce the vulnerability of the Region's population stemming from natural, human-caused disasters, and homeland security emergencies;
- resources within and outside of the Region who may be employed in responding to different and varying emergencies; and roles and responsibilities of the stakeholders and lists members of the State Government and other agencies responsible for plan implementation.

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[6] Derived from WHO: **Cumulative Number of Confirmed Human Cases of Avian Influenza A/(H5N1) Reported to WHO.** Obtained 20 Oct 2010 from: http://www.who.int/csr/disease/avian_influenza/country/cases_table_2010_10_18/en/index.html

[7] Numbers extrapolated from percentage of deaths and injuries provided by FEMA for Salt Lake County.

- This plan identifies a methodology for collaboration between local health departments, acute care facilities, and others to provide solutions for medical surge within the scope of practice for their type of facilities.

Participating Agencies

Mass surge and alternate care site planning and implementation require a bridge between local public health, acute healthcare systems, community clinics, surgical centers, and pharmacies to meet the needs of the community. This is a shared responsibility with shared benefits for all participating agencies. Per requirements of the Utah Department of Health (UDOH), the Coalition's majority voting body is hospitals. There are 15 acute care hospitals (Appendix A.2) within the Region: Salt Lake County, 13 hospitals, Tooele County, 1 hospital, and Summit County, 1 hospital. Two additional specialty hospitals are included: Shriners' Hospital which serves children and HealthSouth Rehabilitation Hospital, an 80 bed rehabilitation hospital with acute care capacity and capability.

In addition, to the general population acute care facilities, Emergency Medical Services (EMS) from the counties, three county health departments, long term care, home health, federally qualified community health centers, the Indian Walk-In Center, and various professional organizations are also represented.

This plan identifies a methodology for collaboration between local health departments, acute care facilities, and others to provide solutions for medical surge within the scope of practice for their type of facilities.

Authority

National

There are a number of national legislative authorities that support the development of alternate care sites during an emergency to relieve surge on the acute care system. A summary of these authorities is located in Appendix C.1 and Appendix C.2.

When a national emergency is declared by the President, a number of laws/rules are set aside. 2009 Novel H1N1 provides an example of this. On October 24, 2009, the President declared the 2009 H1N1 pandemic a National Emergency which allowed the Secretary of the Department of Health and Human Services exercised her right under Section 1135 of the Social Security Act[8] to waive certain requirements related to HIPAA, among other laws. The 1135 waiver allows health care providers to disclose needed information to public health officials under certain conditions. Three waivers are of particular importance to the healthcare system:

1. Disclosure of protected health information without individual authorization to public health officials acting as authorized by law in response to a bioterrorism threat or public health emergency[9] or to prevent or lessen a serious and imminent threat to public health or safety[10], and

[8] [42 USC §1320b–5]
[9] [45 CFR 164.512(b)]
[10] [45 CFR 164.512(j)]

2. Requests by hospitals to set up an alternative screening location for patients away from the hospital's main campus. [11]
3. Requests by hospitals to facilitate transfer of patients from ERs and inpatient wards between hospitals.[12]

In addition, the Privacy Rule specifically states that it does not preempt contrary state laws that are necessary for purposes of serving a compelling need related to public health, safety, or welfare. Under Part 164, if a state law conflicts with a standard, requirement, or implementation specification, then the state law will not be preempted if the intrusion of privacy is warranted when balanced against the need to be served. [13]

State – (Review after 2011 legislative session)

Section 26A, Utah Administrative Code Rule (UCR) 386-702-4, of the Utah Code Annotated (UCA), gives the Salt Lake Valley Health Department (SLVHD) the authority to take the following actions during an emergency or disaster event:

- Responsible to provide public health services to include administration, waste management, water waste management and safe drinking water management.[14]
- Enforce state health laws, rules and regulations.[15]
- Enforce the Detection of Public Health Emergencies Act.[16]
- Conduct disease surveillance and collect information of cases of disease or injury.[17]
- Conduct public health investigations into public health threats, disease outbreaks or dangerous environmental situations.[18]
- Quarantine persons or mass populations.[19]
- Decontaminate persons or mass populations.[20]
- Administer antidotes, antibiotics and vaccines to persons of mass populations.[21]
- Issue a public health emergency declaration.[22]

County

Salt Lake County Ordinance 2.28.160 and Salt Lake Countywide Policy 1410 *Emergency Management* give broad authority and procedural guidelines to the *SLVHD to respond to emergency situations. Emergency Support Function (ESF)* #8 Health and Medical Services…" identifies the responsibilities of the SLVHD in "providing assistance in identifying and meeting the health and medical needs of victims of a disaster or emergency." Also the SLVHD serves as a support agency on ESF 3--Public Works and Engineering, ESF 6--Mass Care, ESF 10--Hazardous Materials, ESF 11--Food and Potable Water, ESF--18 Animal Services, and as a

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[11] Section 1867 of the Emergency Medical Treatment and Labor Act
[12] Section 1135(b) of the Social Security Act (the Act) (42 U.S.C. § 1320b-5),
[13] [45 CFR 160.203 (a)(1)(iv)].
[14] (UCA 26-A-1-106 (1999) Amended by Chapter 249, 2002 General Session
[15] (UCA 26-A-1-108 (1999) Amended by Chapter 249, 2002 General Session
[16] (UCA 26-A-1-108 (1999) Amended by Chapter 249, 2002 General Session
[17] 386-702-4 (UACR)
[18] 386-702-4 (UACR) Date of Enactment or Last Substantive Amendment: October 14, 2005
[19] (UCA 26A-1-114 (1999)
[20] (UCA 26A-1-114 (1999) Amended by Chapter 171, 2003 General Session
[21] (UCA 26A-1-114 (1999)
[22] (UCA 26A-1-114 (1999) Amended by Chapter 171, 2003 General Session

component of the Salt Lake County (SLCo) Terrorism Incident Response Annex. In addition, the SLVHD Board of Health has policy-making authority and as such has approved several health regulations, primarily in the areas of environmental health.

Confidentiality

Confidentiality and security of records are governed by Utah Government Records Administration & Management Act (GRAMA). The SLVHD is not required to release records unless approved through current County procedures and/or ordered by the County Mayor and District Attorney.[23] The confidentiality and security of records in the private sector is governed by the Health Insurance Portability and Accountability Act (HIPAA)

Ethical Principles and Standards of Care

The federal Agency for Healthcare Research and Quality brought together an expert panel to discuss ethical and legal issues related to maintenance of Standards of Care during a public health disaster or emergency. The findings were published in 2005[24] and should serve as a standard against which to measure decisions for altering patient Standards of Care. The summary of their findings can be found in Appendix D. The consensus was that the goal will be to provide care that maximizes the number of lives saved and to do this will require alterations in standards of care. Over the course of the disaster, the situation may require changes in approach. The allocation of scarce resources will need to reflect these decisions. One example is the *Utah Pandemic Influenza Hospital and ICU Triage Guidelines for Adults* document prepared by the Utah Hospital and Health Systems Association in collaboration with a number of professional organizations **(**Appendix E). This document can serve as a template for developing triage guidelines for other infections with pandemic or bioterrorism potential.

Assumptions

1. Public health in all three SST Region counties will activate their Department Incident Command System (ICS) and COOP Plan.
2. Salt Lake, Summit, and/or Tooele County Health Department Operations Centers (DOC) will be functioning in their ESF – 8 Health and Medical role.
3. Hospitals involved will activate their COOP Plans and Hospital Incident Command System (HICS)
4. Salt Lake, Summit, and Tooele County Emergency Operations Centers (EOC) will be activated
5. Level of activation will reflect type of event, and scope of damage/illness.
6. Hospital requests for assistance will flow through proper ICS channels (LHD DOCs).
7. Care at any level, including palliative, is under the purview of the acute care system.
8. Hospitals will initially activate and staff their individual triage plans.
9. As the number of ill/injured patients requiring in-patient acute care increases, hospital resources will be taxed in both acute and critical care services.
10. Hospitals will implement internal surge plans that include early patient discharge and cancellation of elective surgeries as much as possible to meet surge needs before requesting assistance through their local public health department.

[23] Utah Code (UC) 63-2-304(11) permits security and confidentiality of these types of records.
[24] Health Systems ReseAERCh, Inc. (2005). Altered Standards of Care in Mass Casualty Events. Contract Number 290-04-10. Obtained 18 Oct 2010 from: http://www.ahrq.gov/reseAERCh/altstand/altstand.pdf

11. Screening alternate care sites staffed and run by the SST public health agencies will refer all patients needing medical treatments to hospital secondary triage centers.
12. Hospitals will determine type of acute care needed, whether they will provide the care, or refer patients to home health and hospice/palliative care as necessary.
13. Appropriate community partners (Appendix F) will be identified and be willing to assist.
14. Funding will be adequate.
15. The SLVHD, Tooele County Health Department, and Summit County Health Departments will collaborate to meet the Region's public health needs.
16. Hospitals will collaborate to ensure timely service to all who require hospital care.

Levels of Surge

The literature identifies three levels of surge demand on local health departments and hospital services.

Conventional Capacity

Conventional Capacity refers to normal operations. Most hospitals do not function at full capacity on a daily basis. They are able to absorb a certain amount of surge such as that experienced during the seasonal influenza months. Policies and procedures for day to day operations reflecting Standard Operating Procedures as required by accrediting agencies and existing laws are maintained. Depending on the type of emergency, hospitals may be able to continue to function within these parameters.

Local health departments can also handle some surge such as that experienced each summer by increased school immunization demands. Public health demands for services may be met through existing clinics and staffing.

Contingency Capacity

Contingency Capacity refers to a less than 20% surge. For the most part, hospitals are able to handle this surge through current staffing models and facilities. At times, hospitals may be mildly overwhelmed for a short time and rely on Mutual Aid Agreements with other facilities to divert patients. The common example of this would be in-patient surge during a bad seasonal influenza year resulting in a full intensive care unit (ICU). Another example is emergency department surge mildly – moderately ill 2009 H1N1 patients who did not need emergency services or inpatient care. Consistent with THE Emergency Medical Treatment and Active Labor Act (EMTALA) regulations (Appendix C.2), some hospitals opened on-site flu screening clinics to reduce emergency department surge and allow normal activities without breach of Standard Operating Procedures.

Public health agencies are able to deal with the demand through additional staffing in existing clinics and/or bringing a mobile clinic to the people affected. Standard Operating Procedures can be maintained.

Crisis Capacity

During a severe event, the healthcare system will be overwhelmed with a surge of patients seeking service through emergency departments and requiring in-patient care. While hospitals will implement their usual procedures for dealing with surge, these may not be adequate for the scope of the problem. In addition to large numbers of severely affected individuals who

appropriately need hospital services, large numbers of walking wounded who require minimal care or worried well who require support and reassurance will surge the system.

For public health, the demands on services provided by the health department will either impact more than one service area, e.g. immunization and environmental health, and/or public health will need to expand services to include managing alternate care sites for triage and/or first aid or collaborating with acute care to manage a minimal care site supervised by hospital staff but located off hospital grounds.

Concept of Operations

Public Health Roles

The Salt Lake Valley, Tooele County, and Summit County Health Departments will function under ESF – 8 Public Health and Medical Services Annex to their County Emergency Response Plans which charge public health to **coordinate overall health and medical response** with the Utah Hospital Association (UHA), EMS, and other partners as it applies to ESF-8 all hazards response which includes:

1. Assessment of health/medical needs;
2. Health surveillance;
3. Medical care personnel;
4. Health/medical equipment and supplies;
5. Patient evacuation;
6. In-hospital care;
7. Medication/Vaccine safety;
8. Worker health/safety;
9. Mental health care; and
10. Public health information.

The SST health departments will coordinate provision of ESF – 8 functions through their local EOC through collaboration between the SST public health departments and integration into a network of community resources (Appendix G). The SST health departments will collaborate to identify and fund resources to assist hospitals with their mission to provide acute health care.

The SST Health Departments will:

1. Assist hospitals in locating temporary space, supplies, and staff to meet surge demands for minimal and palliative care.
2. Plan, staff, and conduct all activities necessary to provide first level assessment in alternate care sites or support minimal/palliative care sites in Salt Lake, Summit, and Tooele Counties.
3. Ensure public and professional communication providing information about alternate care sites is disseminated through the Joint Information Center (JIC) in a timely manner.

Hospital Roles

Hospitals will:

1. Attempt to meet surge through internal processes and Mutual Aid Agreements with other hospitals.

2. Follow the ICS structure through their county local health department and EOC to request assistance (supplies, equipment, staff, and alternate care sites).
3. Provide second level triage of patients referred by public health as needing some form of care, and determine type of care needed.
4. Provide staff to supervise licensed Medical Reserve Corps volunteers and/or agency contract staff providing minimal / palliative care in an alternate care site serving as an extension of in-hospital care.

Direction and Control

This plan will be activated by the local Health Department Director or his/her designated representative. If the Director/Designee is unavailable, the county Emergency Manager may initiate the plan. Chain of command maintains that all disasters/emergencies are local. Response begins at the local level and moves up the chain as additional resources are needed. There are two routes for access:

County EOC not activated

During the 2009 H1N1 pandemic, the county and state EOCs were not activated. If the EOCs are not activated for the response, all contact for ESF-8 activities begins with the LHD-DOC. The LHD DOC will coordinate mass surge/alternate care activities associated with the emergency that are beyond conventional capacity and contingency capacity. If hospitals are functioning in crisis capacity, the LHD DOC can:

1. assist HICS hospitals with obtaining certain supplies and medications previously purchased with federal grant funds or provided through the SNS,
2. activate and manage triage/first aid sites off hospital grounds to relieve surge on EDs, and
3. activate and manage minimal care sites off hospital grounds. **Note that patient care is a hospital function must be supervised by hospital personnel** although Medical Reserve Corps and staffing agency personnel may provide care.

In this situation, hospital HICS will work directly through their LHD DOC for resources. The LHD DOC will ensure that the Emergency Services Coordinator at the county EOC remains informed. If the local hospital resources are exhausted and/or assistance is needed, the following steps should be taken.

1. The HICS requests assistance from the LHD DOC.
2. If the LHD DOC cannot fill the request, the next step is for the LHD DOC to request assistance from the Coalition partner LHDs. The Coalition coordinates public health resources for its region.
3. If the Coalition is unable to fill the request, the request is forwarded to the UDOH ECC. The UDOH is responsible for informing the State EOC.

If the UDOH ECC is unable to fill the request, and the state EOC is not activated, a request is to the Centers for Disease Control and Prevention (CDC).

County EOC activated

If EOCs are activated, hospitals will coordinate activities through their ESF-8 Liaison at their county EOC. The lead agency for ESF-8 is the local health department. As such, the liaison is usually a representative from the LHD. The liaison will coordinate resource needs through the LHD.

In addition to submitting information and requests to the local EOC, hospitals should expect to be asked to submit periodic situation reports and Incident Action Plans (IAP) to the EOC which will be used by local EOC personnel to facilitate overall response coordination and decision making.

Many disasters can be handled completely at the local level. If additional assistance is needed, the state EOC will be activated to ensure that informational and material resources continue to be available to the local area. Most disasters can be handled at the state level, but when state resources are taxed, the federal government is contacted for further assistance.

Local and State Health Departments

Local health departments will be responsible for continued monitoring and assessment of casualty care in their jurisdictions. They will provide information and recommendations to the UDOH ECC with respect to responses to anticipated changing conditions during the event. The local health department will initiate any required quarantine actions determined to be appropriate in collaboration with the State Epidemiologist or designee from the State Office of Epidemiology.

The UDOH serves as the contact point for the Strategic National Stockpile (SNS) if necessary. At the request of the local health department, UDOH members will be responsible for requesting this resource and assisting the LHD with implementing mass immunization and mass administration of prophylaxis medication if required. The UDOH is also responsible for contacting and requesting the use of resources available through the National Disaster Medical and Public Safety Sensitive 20 Systems (NDMS). See the Utah Department of Health plan for further details.

Stratified Model of Surge Management

Activating alternate care sites is one method for handling healthcare system surge. There are a number of models for alternate care that are variations in location and services depending on the nature of the disaster. Regardless of the specific location and services provided, the purpose for use of one or more alternate care sites is the same and includes:

1. Facilitating access to the appropriate levels of care for persons who are adversely affected by the event
2. Alleviating the demand placed on emergency departments (ED) or inpatient services.
3. Managing the mild to moderately ill or injured to allow the acute care facilities to care for those with life-threatening illnesses or injuries.
4. Effectively use limited resources to maximize healthcare system capacity.

Not all disaster events will require the same degree or type of response. A scaled approach to surge capacity implementation in the hospital and surrounding community is appropriate. For example, the 2009 H1N1 did not stress in-patient services, but did stress emergency departments and public health clinics. Implementing activities to maximize acute beds was not appropriate. On the other hand, an airliner crash with 300 passengers injured could stress both the emergency department and in-patient services but have little impact on public health. Four levels of care occur in a stratified model of healthcare delivery:

1. Delivery of hospital and healthcare facility services
2. Community based triage
3. Home healthcare

4. Alternate care facilities

Delivery of hospital and healthcare facility services

This first level focuses on actions within the hospital that maximizes its ability to care for critically ill patients within normal standards of care. Hospital based surge activities include maximizing beds within the facility and opening minimal care sites to relieve in-patient surge or triage locations on-site to relieve emergency department surge.

Two studies in particular have demonstrated that discharging patients to home with home health supervision can maximize available beds while not causing adverse effects to patients. A 2005 study[25] determined that 33% of currently hospitalized patients could be sent home within 24 hours of the incident occurrence and 50% could be sent home within 72 hours. In addition, 25% of patients could be sent to an on-site nursing facility. A 2009 study[26] concluded that 44% of patients evaluated were deemed to not require critical intervention and were suitable for early discharge. The researchers estimated that the potential, net surge capacity was between 66% and 81% for the three hospitals that could be made available between 24 and 48 hours after the disaster. These data were based on the assumptions that routine discharges, continuance of non-victim emergency admissions, and full use of staff and facilities would occur. The researchers concluded that hospital surge capacity may be greater than previously thought if "reverse triage" is appropriately used. Reverse triage and discharge has been used by a number of hospitals with positive outcomes[27,28]. Various tools are available online that can be used to determine whether patients can be discharged early or moved to less acute facilities.

Community-based triage

Community-based triage absorbs pressure place on emergency departments, outpatient clinics, and the private provider community. Virtual (phone triage) and on-site triage options can be used to assess the need for service, determine level of medical care needed, and provide information that can assist persons to determine their own level of medical need. In addition, depending upon the nature of the disaster, an on-site satellite pharmacy may provide prescriptions and/or medications. On-site can be conducted anywhere there is adequate space and accessibility.

Home Health Care

Returning patients home early is the foundational approach to maximizing acute care resources. Home health may or may not be required depending upon the patient's support systems and their ability to care for the patient. Self-care requires that patients are discharged with written instructions for self-care and specific instructions about what to do if conditions worsen. A plan for follow-up evaluation must be developed that could include a daily phone call. In situations

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[25] Davis DP, Poste, JC, Hicks T, et. al. (2005, May-June). Hospital Bed Surge Capacity in the Event of a Mass-Casualty Incident, *Prehospital and Disaster Medicine, 20*(3), 169-76.

[26] Kelen, GD, McCarthy, ML, Kraus, CK, et. al. (2009). Creation of surge capacity by early discharge of hospitalized patients at low risk for untoward effects. *Disaster Medicine and Public Health Preparedness,3(Suppl):S10-16.*

[27] Satterthwaite, PS & Atkinson, CJ (28 October 2010). Using 'reverse triage' to create hospital surge capacity: Royal Darwin Hospital's response to the Ashmore Reef disaster. *Emergency Medicine Journal.* Obtained 10 December 2010 at http://emj.bmj.com/content/early/2010/10/28/emj.2010.098087.fulltext

[28] Shepperd S, Doll H, Broad J. Early discharge hospital at home. Cochrane Reviews. Obtained 10 December 2010 from http://www2.cochrane.org/reviews/en/ab000356.html.

where support system ability to follow a treatment regimen is questionable, or there is a lack of support, referral to a home health agency will be critical to maintain the patient's well-being. Consistent with triage protocol and consistent with strategies guiding the delivery of care in an environment of scarce resources, persons who are critically affected with questionable outcomes, will be discharged home for palliative care with a hospice agency. Of fundamental importance is to instill confidence in the community that any patient discharged to home have not been abandoned by the medical system. Expansion of home health services will be vital to the success of these efforts.

Alternate care facilities

Alternate care facilities serve as an option for patients deemed not sick enough to remain in the hospital but not well enough to return home under home health supervision. In this regard, alternate care facilities are an alternative to an on-site hospital-run surge option. In addition, these facilities can be primary admission sites for patients triaged, deemed too sick to return home, but not sick enough to require acute hospital care. Alternate care sites may be long term care facilities, existing vacant buildings, temporary buildings (Blue Med) and/or inflatable tents. These facilities need t o be extensions of hospitals to be included in any licensure waivers.

Practical Aspects of Activating a Surge Site

Location

Facilities may be located on hospital grounds in existing buildings used for other purposes or temporary facilities erected specifically for this function or off-campus in a location determined either before or after the event. The choice of whether services will be provided on-site or off-site is dependent on the type and size of the disaster or public health emergency.

1. Limited scope. Most disasters occurring in Utah, other than earthquakes, are of limited scope and can be handled by EMS diversion of severely injured to other facilities for emergency and in-patient care since a limited number of hospitals will be impacted. On-site services may be activated to relieve ED surge to allow for routine services and designed to serve the mildly injured arriving on their own.

2. Broad scope. Biological emergencies such as pandemic disease have either broad or uncertain scopes. Uncertainty results in panic and many worried well. All hospitals will be impacted to a greater or lesser extent. The variable in this case is disease severity. If in-patient surge is experienced, off-site triage and minimal care facilities that can serve a number of acute care facilities may be necessary.

Number

One site or multiple sites are both alternate care options. The number of sites will be determined by the nature and scope of the disaster.

Level 1: Single Location Site

A single location is a viable option for a county when:

1. The emergency is a communicable disease with a:
    a. short incubation period, patients may or may not be symptomatic (mild symptoms), medication is used for treatment only, and the goal is to relieve pressure on emergency departments caused by mildly ill persons who do not need ED services; and

b. long incubation period, patients are not symptomatic, and prevention only (medication or vaccination) depends upon exposure, and the goal is to identify persons at risk for developing disease depending upon exposure (epidemiology) in a timely manner.

2. The emergency is a localized disaster affecting only one limited location such as a building explosion.

A single site plan was developed by the SLVHD for the H1N1 pandemic of 2009. The specific model can be used, however, by any county or region for any situation requiring a single triage site. The model was developed as an assessment, education, and referral center that can be organized under the local or regional ICS to support relieve pressure on EDs and hospital staff to care for severely ill patients. The single location model can easily be adapted to any facility, any services, and most communicable disease situations. Appendix H chart demonstrates how a floor plan can be used to model patient flow through the services provided in an Assessment, Education and Referral Center (AERC).

Assessment / Referral Clinic

It is assumed that not everyone with disease symptoms or injuries will be served by an AERC. Very ill/injured persons should be encouraged to contact their heath care providers or the ED depending upon symptoms.[29] Public print and visual media will encourage the very ill/injured to seek medical attention from their primary care physicians. Very ill/injured persons who do present at the AERC, should be diverted to a "Quick Assessment" area for assessment (Appendix I, red footprints). EMS should be called to transport any patients in need of medical support if necessary and acceptable to the patient. The Quick Assessment Center should also serve ill/injured persons with mild to moderate problems who are frail and might find it difficult to proceed through the regular assessment process (Appendix I, blue footprints). Greeters can serve as gatekeepers in this decision.

If the reason for activating an AERC is illness, actions to limit transmission between sick and well should begin when persons arrive at the door. All persons, ill or not, should be given surgical masks to wear while at the center. In addition, alcohol-based hand sanitizers should be offered upon admission and frequently while at the AERC. Hand sanitizer pumps should be strategically placed throughout. People who accompany ill adults and who are not sick themselves, will be offered seating in a waiting area away from Ill persons and encouraged to continue wearing their masks (Appendix I, green footprints).

The majority of the patients will be the worried well and mildly to moderately ill/injured who need professional judgment and instruction in self care, and those who may be unsure if further care is needed. The flow charts in depict a typical patient flow through an AERC. These persons should receive the following services:

1. For disease:
   a. Thorough review of health history relating to symptoms,
   b. Analysis of vital signs including temperature, pulse, respirations, and PO_2.

[29] Symptoms for direct MD or ED visit: **Adults**: Shortness of breath or difficulty breathing, chest pain or pressure, rapid breathing, sudden dizziness, confusion, and/or severe or persistent vomiting, Children: Increased fever, cyanosis, not drinking enough fluids, difficulty waking up or not interacting, irritability and resistance to being held, flu-like symptoms improve then return with fever and worse cough, and/or fever with a rash.

c. Instructions about symptoms that would indicate the need for immediate medical attention and how to best obtain that care.
d. Education on illness prevention for the worried well who need support and guidance; education on how to take care of the flu at home for the patient and caregiver.
e. A prescription for medication according to the CDC recommendations, if the patient has completed the medical screening form indicating no health conditions that would contraindicate taking the medication.
f. Referral to Voluntary Organizations Active in Disasters (VOAD) for community support if an ill person lives alone without anyone to monitor well-being. VOAD will coordinate support such as a daily phone call, Meals on Wheels, etc.
g. Referral to a hospital where a second level triage can be performed if the assessor determines the need for treatment beyond assessment and education, such as short term symptomatic interventions, hospitalization or palliative care.

2. For injury:
   a. Thorough review of systems to determine level of injury,
   b. Analysis of vital signs including temperature, pulse, respirations, and PO_2.
   c. Instructions about symptoms that would indicate the need for immediate medical attention and how to best obtain that care.
   d. Provision of minimal non-invasive first aid.
   e. Education about wound/injury care and infection prevention.
   f. A prescription for medication according to standing orders, if the patient has completed the medical screening form indicating no health conditions that would contraindicate taking the medication.
   g. Referral to VOAD for community support if an injured person lives alone without anyone to monitor well-being. VOAD will coordinate support such as a daily phone call, Meals on Wheels, etc.
   h. Referral to a hospital where a second level triage can be performed if the assessor determines the need for treatment beyond minimal first aid including invasive intervention or setting of bones, hospitalization or palliative care.

Pharmacy Services

Consider providing on-site pharmacy services to fill prescriptions over-the-counter medications and other supplies that a person with disease or injury might require such as tissue, cough medicine, aspirin-free fever medication, dressings, etc. The pharmacy should be equipped to provide private/insurance-paid medications as well as government owned/free medications. A number of pharmacies are equipped to provide satellite services to locations using trailers or go-kits.

Vaccination Module

If a disease is vaccine preventable, a vaccination service can be provided. Those wishing to be vaccinated, but not ill, can be guided to a section of the facility set aside for this purpose.

Assessment Protocols

Protocols for assessment / prevention or treatment are under development for each threat taking into consideration differences related to age. Protocols must consider the circumstances under which individuals will be referred to the hospital or home health/hospice. Appendix J contains age-specific H1N1 assessment decision trees that can be used as templates for other pandemic illnesses.

Standing Medication Orders

Standing medication orders will be written as protocols are developed and will be available on-site for any medications or vaccines required by epidemic/pandemic, natural and human-caused disasters. In addition, orders should be available to cover emergency situations that might occur in the center such as anaphylactic shock. The Medical Director or relief must be available during hours of operation to provide consultation for medical questions and to assist with emergency situations.

Level 2: Minimal Care Sites (MCS)

AERCs can relieve the surge on ED relating to assessment and education of the worried well and treatment of those with minor illness or injury, but cannot completely relieve the ED from minimal care such as intravenous infusion for dehydration. Public Health is not licensed to provide care for ill/injured patients. If AERC sites are needed the best location is on hospital grounds to avoid licensure issues. If this is not possible, a temporary facility can be arranged off-site and equipped by the LHD, but licensure issues and at the minimum, supervisory staffing must be handled by the hospital. Additional staff can be arranged by the LHD through the Medical Reserve Corps (MRC) or similar volunteer organization or through a staffing agency with which Memorandums of Understanding (MOU) have been developed. The MRC site arrangement is an expansion of the AERC model with an added module for minimal care.

Staffing Models and Staff Estimates

While there is potential for huge numbers of people to visit an AERC, there is no way of knowing public response. The number of staff needed will depend upon numbers of clients seeking services, number of stations provided, and hours of service. Since availability of licensed staff who can conduct assessment or administer first aid may be limited, volunteers will be sought through partner agencies, the MRC, and staffing agencies. MOUs have been established with staffing agencies for vaccination clinics to augment community resources and can be expanded if needed to cover AERC and Minimal Care Site needs.

While there is no data available for throughput in a mass assessment site for a communicable disease in a community setting, one local hospital system opened an on-site, free-standing flu triage area. One technician, one physician, and one registered nurse staffed eight triage rooms and were able to see 250 patients a day for a throughput of 5 to 10 patients per hour for licensed staff. The SST Regional Staffing Model, found in Appendix K, is based on this throughput data. It is imperative that any staffing plan includes provisions for scalable staffing based on modules that can be activated and deactivated as necessary.

Two variables significantly impacting throughput that will guide staffing decisions are surge (numbers seeking service) and the ratio of support staff to the critical service providers. For the Assessment Team, critical positions are vital signs, assessment, and post-assessment. Double or triple the numbers of other support staff will not improve throughput if these positions are at maximum capacity. It is assumed that one registration clerk, vital sign taker and post-assessment clerk can serve three assessors, if more than three assessors are needed, additional critical support positions will be needed.

The Team Staffing Plan consists of two modules. Each team consists of a primary and secondary module that together provides the ability to expand or contract staffing as necessary. The “core” (Module A) places one person in each position. The two remaining members of

Module A, both assessors, remain on alert status and are expected to respond within six hours if activated. Once Module A is completely activated, Module B is placed on stand-by. Module B provides additional resources in the critical areas of vital signs, assessment, and post-assessment functions with the addition of one assessor. Two additional assessors are placed on alert status to respond within 6 hours of activation. If surge requires additional personnel, repeat the modular pattern. If the second Team is not required for the first week, this team will be the primary staff for the second week.

Since the staffing ratios are based on limited data from an acute care setting, the staff composition of modules may change. If more than three assessors can be supported by one vital sign taker and one post-assessment clerk, the modules can easily be altered to reflect this.

Three team staffing models have been developed: The Assessment Team, the Quick Assessment Team, and the Vaccination Team. Each team consists of primary and secondary modules that together provide the ability to expand or contract services as necessary. Qualifications and job duties for team members are described in Appendix L. Estimates of staff needed for each team and module have been developed and should be adjusted to reflect actual throughput and needed services **(**Appendix M).

Assessment Team

Positions on the Assessment Team are:

1. Greeter
2. Registration Clerk
3. Room Monitor
4. Vital Signs Taker
5. Assessor
6. Post-assessment Clerk

Quick Assessment Team

The Quick Assessment Team is a streamlined version of the Assessment Team. It is designed to handle fewer patients with limited movement in a quicker manner.

The positions for the Quick Assessment Team are:

1. Greeter
2. Registration Clerk
3. Assessor
4. Post-Assessment Clerk

By removing the wait time between stations and combining some tasks, the Quick Assessment process is streamlined to get frail or very ill/injured persons in and out of the AERC as quickly as possible. The placement of the Quick Triage location should take into account ease of patient pick-up, limited distance to walk to services. **Appendix I** illustrates this concept.

It is anticipated that public communication will assist in having very ill/injured patients go directly to their health care professional or local hospital. If so, the clientele for the Quick Assessment area should be limited. However, a second team that mirrors the first should be identified. If not needed the first week, the second team will staff the Quick Assessment section.

Vaccination Team

A Vaccination Clinic might be offered onsite for those worried well and relatives/friends of the ill/injured person who provided transportation. The Vaccination area should be located separate from ill patients. If the vaccination clinic exists for vaccinating injured patients, the location in the AERC does not matter.

The positions for the Vaccination Clinic Team are:

1. Greeter
2. Registration/Finance Clerk
3. Screener
4. Vaccinator Assistant
5. Vaccinator
6. Post-Vaccination Clerk
7. Roamer

Patient Tracking

Inventory Resource Management System (IRMS) developed and marketed through UPP Technologies Incorporated has been purchased by the SLVHD for use in patient tracking and recordkeeping for the SST Region. This product is a web-based technology accessed by anyone who has the appropriate credentials and password. The system tracks services provided and patient location during alternate care services through final disposition (death, home, home with home health services, transport and arrival at acute care facilities) in real time. If the Internet is unavailable, records are stored in computer memory onsite and can be uploaded when the Internet is up. The system is compatible with WebEOC.

Supplies and Equipment

Inventory Management System/ Supply Ordering Procedures

The LHD will supply what is needed to conduct illness assessment and injury triage. The IRMS Warehousing System has been purchased by the SLVHD for use in Regional inventory management and can be extended to hospital inventories if requested. This product is a web-based technology accessed by anyone who has the appropriate credentials and password. The warehouse management module tracks inventory supply and use down to the POD or hospital level.

Ordering procedures will be developed after the program is installed and LHD staff oriented (APPENDIX N.1)

Salt Lake County

Alternate care sites will be supplied by the SLVHD. Most of what is needed to stand up a triage or vaccination site has been stockpiled in “Go-Kits.” Seven “Go Kits” are stored at the SLVHD City Clinic. Three additional ones have been stocked. Three Vaccination “Go Kits” will provide adequate supplies for the SLVHD AERC located currently at Granite High School with the addition of a few non-disposable equipment items: temperature measuring devices, sphygmomanometers, stethoscopes, pulse oxymeters, oxygen tanks, one AED, and 15 privacy screens. Large equipment items, such as tables and chairs are located at Granite High School and the SLVHD.

Unless additional federal funding is forthcoming to support hospital preparedness, the cost burden for the supplies will remain with the SLVHD. These will be provided by the SLVHD and delivered by SLC. Specific supply and equipment availability lists for AERCs can be found in Appendix N.2 Estimates of disposable and non-disposable supplies are listed in Appendix N.3

Forms

AERC patient tracking forms for potential bioterrorist events and natural disasters are in development.

Summit County

Under development

Tooele County

Under development

Security

Security will be provided by the LHD with jurisdiction over the AERC site. The Salt Lake County Sheriff's Department provides security in Salt Lake County according to the SNS plan. The MOU is signed and in place. Scope and responsibility are outlined in Appendix O.

Safety

A safety plan is site specific. Therefore a template incorporating elements to consider in a safety plan will be developed. For pre-designated sites, safety plans will written and located in Appendix P.

Activation

Trigger for opening an AERC

Salt Lake County

When five of the hospitals in Salt Lake County are unable to locate resources to deal with surge from within their own systems or using MOUs with other systems and move from level 3 to level 4 pandemic response, the SLVHD Incident Commander will activate the AERC. Participating partners will be notified through regular channels that the AERC will be activated in 48?? hours.

Summit

Under development

Tooele

Under development

Activating Partners

The LHDs will monitor hospital surge closely. As the hospitals exhaust their internal and external methods of dealing with surge, LHDs will implement a three-tiered approach in notifying responding agencies and volunteers to allow for the best use of preparation time for response:

Alert
Partner agencies involved in the county's surge response will be informed of the possibility of activation and encouraged to make arrangements that might be necessary. Alert notice will be given no less than 96 hours (four days) ?? before notice of activation.

Standby
As the need for activating the AERC response is almost assured, partners should be prepared and organized to move equipment, supplies, and human resources to the site in order to open it within 48 hours ?? of the activation notice.

Activate
This notice will be given to partner agencies 48 hours before clinic opening. Partners must have equipment, supplies, people, etc. onsite and ready to function when the doors open. If the participation provided is as a referral source, agencies will be ready to accept referrals.

ALERT	At least 96 hours (4 days) out
STANDBY	At least 72 hours out
ACTIVATE	At least 48 hours out

Hours of AERC Operation

The AERC will stand up within 48 hours of notice from Incident Command. Hours of operation will be scalable to the needs of the community. Staffing requirements will vary depending upon the hours of operation and number of stations. Various staffing number estimates for the AERC are located in **Appendix Q – Staffing Estimates.**

County Incident Command

Salt Lake Valley Health Department
If a central assessment site is required, the pandemic will be severe enough in terms of the numbers of ill that resources of all types will likely be over extended. For acute care, implemented COOP plans have not been enough to relieve the surge on the system, and broader solutions must be applied. It is assumed that the EOC of all three counties will be activated and available to assist in coordination of resources. The SLVHD will activate its ICS and COOP in order to free staff time to activate the AERC.

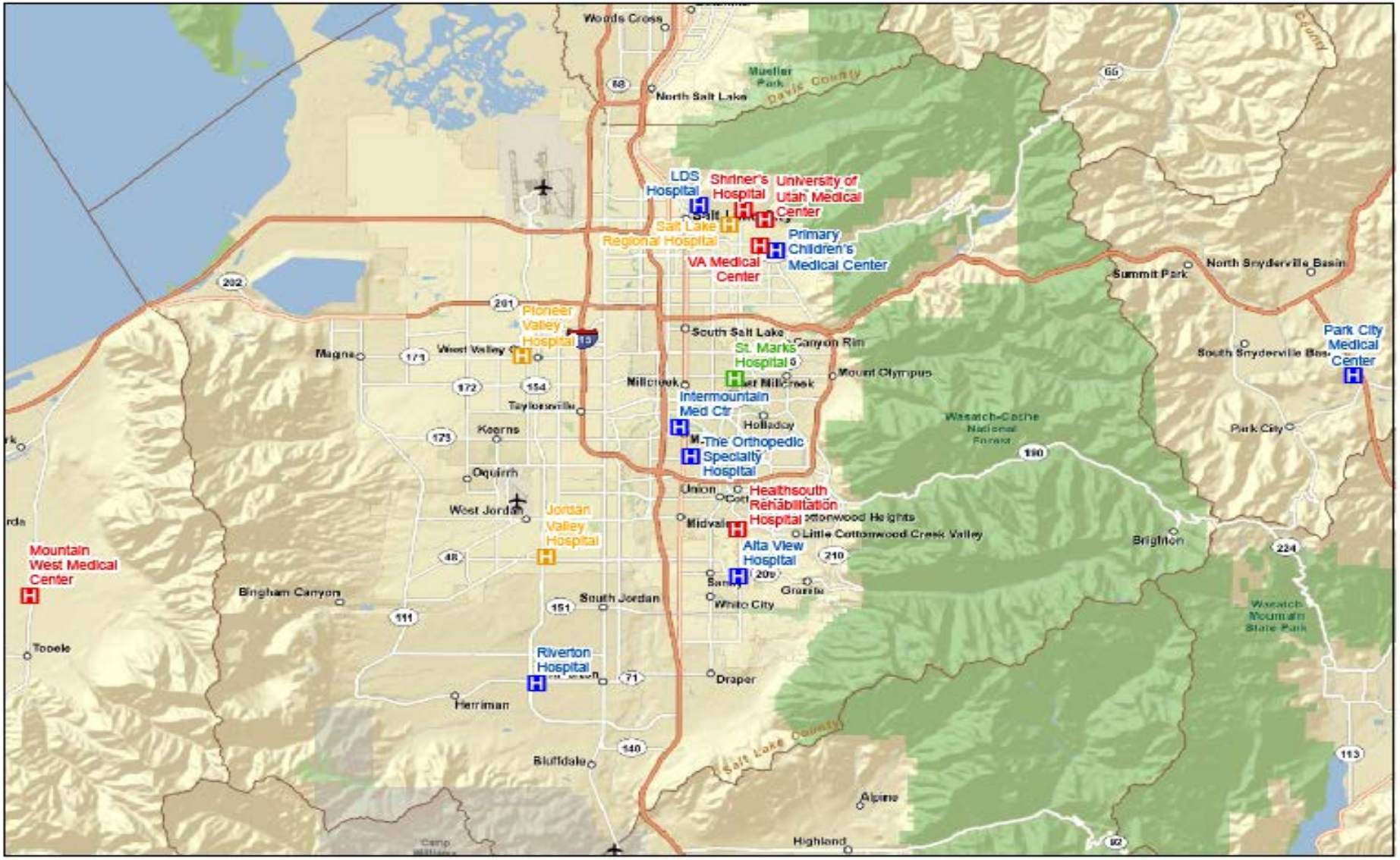
SLVHD's IC structure (**Appendix R – SLVHD IC Structure)** will be scalable according to need. The roles and functions of positions in the ICS structure vary from traditional roles since the function of the ICS initially is collaborating with agencies to plan the AERC.

1. Goal: ICS provides the operational component of the activated AERC
    a. will be activated if and when the assessment site is activated
2. Primary responsibility of this IC structure is ensuring that:
    a. The SLVHD COOP plans have been implemented.
    b. A fully operational AERC has been activated and continues to function well during activation.
    c. Communication with the public, hospitals, partners, and the media is timely and provides a consistent message.

Summit County Health Department
Under development

Tooele County Health Department
Under development

APPENDIX A.1 – Map of Region and Hospital Partners



APPENDIX A.2 – Coalition Membership

Hospital Members (16 votes)	Community Healthcare System Members (14 votes)
Intermountain Medical Center	Salt Lake Valley Health Department
The Orthopedic Specialty Hospital (TOSH)	Summit County Health Department
LDS Hospital	Tooele County Health Department
Alta View Hospital	Utah Department of Health
Riverton Hospital	
Primary Children's Medical Center	Unified Fire Salt Lake County
Park City Medical Center (Summit Co)	Park City Fire District
	Tooele County Fire (?)
Salt Lake Regional Medical Center	
Pioneer Valley Hospital	Indian Walk-In Center
Jordan Valley Hospital	Community Health Clinics
St. Marks Hospital	Utah Health Care Association
University Medical Center	Utah Hospital Association
Veteran's Hospital	Utah Association for Home Care
Mountain West Medical Center (Tooele Co)	Utah Ambulatory Surgical Center Association
HealthSouth Rehabilitation Hospital	
Shriners' Hospital	Emergency Services – Salt Lake County EOC

APPENDIX B – Comparison of Threats Related to Surge

Comparison of Impacts Disasters Potentially have on Resources

Challenges	Anthrax	Smallpox	Pandemic Flu	Chemical Spill	Earthquake	Explosion	Radiation
Surge capacity							
Hospital	Those in area of impact may surge	Few may surge at multiple locations depending on extent of disbursement	Many will surge nationally if virus is virulent	One or two may surge in area of spill and if plume-moderately localized impact	All that remain will surge in the impacted areas – regional impact	Those in the area of impact will surge – highly localized impact	Those in the area of impact and hot zone will require evacuation; surrounding facilities will surge
Emergency Departments	A few in area impacted will surge with many worried well	A few in multiple areas impacted will surge with many worried well	All may surge with many worried well depending on virulence	One or two may surge with slightly to moderately injured	All that remain will surge in the impacted areas with severe to minor injuries not needing ED, but requiring first aid	Those in the area of impact will surge with severe to minor injuries not needing ED, but requiring first aid	Those in the area of impact and hot zone will surge and require diversion; surrounding facilities will surge
Community	Possibly a few Urgent Care Centers in impacted areas; private providers unlikely	Possibly a few Urgent Care Centers in impacted areas; private providers unlikely	Yes, some to many private providers as well as Urgent Care Centers depending on virulence	Possibly Urgent Care Centers for those with mild symptoms	Probably Urgent Care Centers since problem is injury rather than disease related; private providers unlikely	Probably Urgent Care Centers since problem is injury rather than disease related; private providers unlikely	Probably urgent care centers for those with mild symptoms
Public Health	PH will surge: Intensive epi investigations to ID those exposed; Mass public health countermeasures locally; SNS as needed	PH will surge: Intensive epi investigations to ID those exposed; Ring vaccination in areas of outbreak likely; SNS as needed	PH will surge: Mass medical countermeasures locally and nationally; SNS as needed	PH will not surge: Environmental Health; SNS / Chempack supplies if needed	PH will surge: PH ESF-8 has responsibility for medical special needs shelters; vaccine distribution (TT, DTaP, potentially others); Environmental Health involvement for	PH will likely not surge.	Public Health will surge depending on scope: Medical Special Needs Shelters and other ESF-8 responsibilities

Challenges	Anthrax	Smallpox	Pandemic Flu	Chemical Spill	Earthquake	Explosion	Radiation
					water safety, chemical spills;		
Scope							
Narrow	Yes	Yes	No	Yes	Probably	Yes	Likely
Broad	Unlikely	Unlikely	Yes	No	Possibly, unlikely	No	Possibly
Secondary / long term effects							
Short incubation / time until symptoms	Yes	No	Yes	Yes	No	Yes – immediate injuries	Yes - burns
Long incubation / time until symptoms	No	Yes	No	Possibly	No	Yes – exposure to airborne environmental toxins	Yes – radiation poisoning
Timeframe (onset/length of response)							
Rapid[30]	Yes	No	No	Yes - e.g. overturned transport carrying toxic substance	Yes	Yes	Yes
Slow[31]	No	No	Yes	Yes (BP Gulf Oil situation)	Yes – Potential aftershocks	No	Yes – plume dissemination
Short term[32]	No	Yes	No	Yes – depending on scope (overturned tanker)	No	Yes - injury	Yes – immediate short term remediation
Long term[33]	No	Depends on scope	No	Yes – Massive toxic waste dumping over time requiring Superfund clean-up	Yes – clean-up and rebuilding	Yes - clean-up and rebuilding	Yes – long term remediation and environmental protection

[30] 48 hours or less

[31] >48 hours

[32] Effects occurring during first 2 week

[33] Greater than two weeks

Challenges	Anthrax	Smallpox	Pandemic Flu	Chemical Spill	Earthquake	Explosion	Radiation
Impact on Resources:							
Beds	Yes some in immediate areas but amount depends on scope	Yes some in immediate areas but amount depends on scope	Yes	Probably not	Yes severely surged	Yes some in immediate areas but amount depends on scope	Yes, both for injured and hospital evacuees from impacted areas
Equipment/ supplies	Yes a few, but it depends on scope and virulence	Yes a few, but it depends on scope and virulence	Yes, but it depends on virulence	No	Yes severely surged	Possibly – supplies easily attainable from neighboring facilities	Yes
Staff	Yes in impacted area, but scope small enough staff should be available from close-by resources.	Yes in impacted areas; definite impact on both public health and hospital staff	Yes. Both hospital and public health	No	Yes, severely surged	Some – may need to activate prn or extra shifts	Yes
Support							
Local	Yes – depending on scope	Yes - depending on scope	No	Yes	No	Yes	Yes - depending on scope
Regional	Probably – no secondary infection	Possibly – depending on areas impacted	Not likely	Yes but probably not needed	Probably depending on scope	Yes	Probably depending on scope
State	Yes	Yes	Not likely	Yes but probably not needed	Yes	Yes but probably not needed	Yes
Federal	Yes	Yes	Depends on severity and how early in the pandemic the area was impacted.	Yes but probably not needed	Yes – likely declared a public health emergency	Yes but probably not needed	Yes – likely declared a public health emergency

APPENDIX C.1 – Emergency Authorities Matrix

EMERGENCY AUTHORITY MATRIX

(Current to October 2010)

Public Health Emergency (PHE)	Addition of National Emergencies Act (NEA) Declaration to PHE	Stafford Act - Emergency Declaration
Authority: SEC/HHS authorized to declare a Public Health Emergency under the PHSA, 42 U.S.C. § 247d. **Duration:** 90 days or until SEC/HHS declares emergency no longer exists. **Geographical Restriction:** A designated geographic area as specified in the declaration.	**Authority:** POTUS may declare unilaterally a National Emergency under the NEA. 50 U.S.C. §§1601-1651. This NEA allows an important section of the PHSA to become effective, called HHS's section 1135 waiver authority. **Duration:** 1 year (declaration). "1135 waivers" issued by HHS under the Social Security Act generally last for the duration of the public health emergency; HIPPA and non-pandemic related EMTALA waivers under section 1135 last 72 hours after a hospital implements its disaster response plan. **Geographical Restriction:** None required by the National Emergencies Act.	**Authority:** POTUS may declare an Emergency upon gubernatorial request or unilaterally if he determines the incident is within the primary responsibility of the U.S. Government, *etc.* 42 U.S.C. § 5191(b). For emergency declaration requirements, see 44 C.F.R. 206.35. **Duration:** As specified in the declaration. **Geographical Restriction:** As specified in the declaration or as amended by FEMA.
Relief Authorized <u>without</u> a PHE declaration: HHS has broad authority under other sections of the PHS Act and other laws administered by HHS to assist states and other entities during an emergency even without a formal PHE declaration under section 319. For example, under section 311 of the PHS Act, the secretary may, at the request of a state or local authority, extend temporary assistance to states or localities to meet health emergencies that warrant federal assistance.14 Other examples include: promoting research and studies into the causes, diagnosis, treatment, control, and prevention of diseases under section 301 of the PHS Act; establishing isolation and quarantine under section 361 of the	**Relief authorized under the NEA alone:** None. *See* 50 U.S.C. § 1631. The NEA authorizes the President to declare a national emergency and activate existing statutory provisions that authorize the exercise of special or extraordinary power. **The NEA is a procedural device—it does not provide any specific emergency authority on its own.** **Relief authorized when NEA is coupled with a Public Health Emergency declaration:** Section 1135 of the Social Security Act [42 USC §1320b–5]	**Assistance to States/ Localities and, Indirectly, to Individuals:** As specified in the new Disaster Assistance and Disaster Operations Fact Sheet on Pandemic Influenza 9580.106 signed 22 OCT 2009. • Emergency Protective Measures (Category B) may be available from the federal government and its agencies and departments to assist state and local governments and certain private non-profit organizations. These include Category B Emergency Protective Measures for which the state will incur a 25% cost share. These measures include:

NOTE: This matrix is a synopsis of the authorities discussed in it, and it is not intended to be used as comprehensive legal guidance.

Public Health Emergency (PHE)	Addition of National Emergencies Act (NEA) Declaration to PHE	Stafford Act - Emergency Declaration
PHS Act; maintaining and deploying the Strategic National Stockpile under section 319F-2 of the PHS Act; and deploying National Disaster Medical System teams under section 2812 of the PHS Act and select members of the Medical Reserve Corps under section 2813 of the PHS Act. **Relief authorized under a PHE declaration (without either a National Emergency Act proclamation or Stafford Act Declaration):** SEC/HHS may take appropriate actions to respond to the emergency such as: making grants; entering into contracts; making temporary hiring appointments; conduct/support an investigation into the cause, treatment, or prevention of the disease or disorder; and make disbursements from the Public Health Emergency Fund. 42 U.S.C. § 247d. The Secretary may grant extensions or waive sanctions relating to submission of data or reports required under HHS laws. A Public Health Emergency declaration can be a necessary step in enabling the secretary to take a variety of discretionary actions under other authorities to respond to the PHE. For example, she may: waive certain prescription and dispensing requirements; exempt for up to 30 days a person from select agents requirements; adjust Medicare reimbursement for certain Part B drugs; waive certain Ryan White HIV/AIDS grant program requirements; and declare an emergency justifying emergency use of an investigational product under section 564 of the Federal Food Drug and Cosmetic Act. **Relief authorized under a PHE declaration (when there is either National Emergency Act proclamation or a Stafford Act Declaration):** See next column describing National Emergencies Act.	permits the Secretary of Health and Human Services to waive certain regulatory requirements for healthcare facilities in response to emergencies. Two conditions must be met for the Secretary to be able to issue such "1135 waivers": first, the Secretary must have declared a Public Health Emergency; second, the President must have declared a National Emergency either through a Stafford Act Declaration or National Emergencies act Declaration. If these conditions are met, then HHS may issue specific waivers or modifications under section 1135 in response to particular needs, and only within the geographic and temporal limits of the emergency declarations. The Secretary will issue waivers or modifications under section 1135 for specific requirements to match the specific situational needs. The requirements that may be waived include certain requirements related to Medicare, Medicaid or the Children's Health Insurance Program (CHIP), the Emergency Medical Treatment and Active Labor Act (EMTALA), and the Health Insurance Portability and Accountability Act (HIPAA). These requirements provide important protections for patients during normal day-to-day operations, but they may impede the ability of healthcare facilities to fully implement disaster operations plans that enable appropriate care during emergencies. In addition, requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA) prohibit hospitals from sending an individual to an off-campus location for an appropriate screening.	Emergency medical care (non-deferrable medical treatment of disaster victims in a shelter or temporary medical facility and related medical facility services and supplies, including emergency medical transport, X-rays, laboratory and pathology services, and machine diagnostic tests); Temporary medical facilities (for treatment of disaster survivors when existing facilities are overloaded and cannot accommodate the patient load); Purchase and distribution of food, water, ice, medicine, and other consumable supplies; Management, control, and reduction of immediate threats to public health and safety (e.g., to include sanitizing eligible public facilities) ;Movement of supplies and persons; Security, barricades and fencing, and warning devices; Congregate sheltering (for disaster survivors when existing facilities are overloaded and cannot accommodate survivors' needs); Communicating health and safety information to the public; Technical assistance to State and local governments on disaster management and control; Search and rescue to locate and recover members of the population requiring assistance, and to locate and recover human remains; and Recovery and disposal of animal carcasses (except if another federal authority funds the activity - e.g., U.S. Department of Agriculture, Animal, Plant and Health Inspection Service provides for removal and disposal of livestock).

NOTE: This matrix is a synopsis of the authorities discussed in it, and it is not intended to be used as comprehensive legal guidance.

APPENDIX C.2 – EMTALA

Centers for Medicare & Medicaid Service, 7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Emergency Medical Treatment and Labor Act (EMTALA) &
Surges in Demand for Emergency Department (ED) Services During a Pandemic

I. What is EMTALA

- EMTALA is a Federal law that requires all Medicare-participating hospitals with dedicated EDs to perform the following for all individuals who come to their EDs, regardless of their ability to pay:
    - An *appropriate* medical screening exam to determine if the individual has an Emergency Medical Condition. If there is no Emergency Medical Condition, the hospital's EMTALA obligations end.
    - If there is an emergency medical condition, the hospital must:
        - Treat and stabilize the emergency medical condition within its capability (including inpatient admission when necessary); ***OR***
        - Transfer the individual to a hospital that has the capability and capacity to stabilize the emergency medical condition.
- Hospitals with specialized capabilities (with or without an ED) may not refuse an appropriate transfer under EMTALA if they have the capacity to treat the transferred individual.
- EMTALA ensures access to hospital emergency services; it need not be a barrier to providing care in a disaster.

II. Options for Managing Extraordinary ED Surges Under Existing EMTALA Requirements (No Waiver Required)

A. Hospitals may set up alternative screening sites on campus

- The MSE does not have to take place in the ED. A hospital may set up alternative sites on its campus to perform medical screening exams.
    - Individuals may be redirected to these sites after being logged in. The redirection and logging can even take place outside the entrance to the ED.
    - The person doing the directing should be qualified (e.g., an RN) to recognize individuals who are obviously in need of immediate treatment in the ED.
- The content of the medical screening exam varies according to the individual's presenting signs and symptoms. It can be as simple or as complex, as needed, to determine if an emergency medical condition exists.
- MSEs must be conducted by qualified personnel, which may include physicians, nurse practitioners, physician's assistants, or RNs trained to perform medical screening exams and acting within the scope of their State Practice Act.
- The hospital must provide stabilizing treatment (or appropriate transfer) to individuals found to have an emergency medical condition, including moving them as needed from the alternative site to another on-campus department.

B. Hospitals may set up screening at off-campus, hospital-controlled sites.

- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for influenza-like illness. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the MEDICAL Screening Exam.*
- Unless the off-campus site is already a dedicated ED of the hospital, as defined under EMTALA regulations, EMTALA requirements do not apply.
- The hospital should not hold the site out to the public as a place that provides care for emergency medical conditions in general on an urgent, unscheduled basis. They can hold it out as an ILI screening center.

- The off-campus site should be staffed with medical personnel trained to evaluate individuals with ILIs.
- If an individual needs additional medical attention on an emergent basis, the hospital is required, under the Medicare Conditions of Participation, to arrange referral/transfer. Prior coordination with local EMS is advised to develop transport arrangements.

C. Communities may set up screening clinics at sites not under the control of a hospital

- There is no EMTALA obligation at these sites.
- Hospitals and community officials may encourage the public to go to these sites instead of the hospital for screening for ILI. *However, a hospital may not tell individuals who have already come to its ED to go to the off-site location for the* medical screening exam*.*
- Communities are encouraged to staff the sites with medical personnel trained to evaluate individuals with ILIs.
- In preparation for a pandemic, the community, its local hospitals and EMS are encouraged to plan for referral and transport of individuals needing additional medical attention on an emergent basis.

III. EMTALA Waiver

§489.24(a)(2)

- When a waiver has been issued in accordance with Section 1135 of the Act that includes a waiver under Section 1135(b)(3) of the Act, sanctions under this section for an inappropriate transfer or for the direction or relocation of an individual to receive medical screening at an alternate location, do not apply to a hospital with a dedicated emergency department if the following conditions are met:
    - The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period.
    - The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan.
    - The hospital does not discriminate on the basis of an individual's source of payment or ability to pay.
    - The hospital is located in an emergency area during an emergency period, as those terms are defined in Section 1135(g)(1) of the Act.
    - There has been a determination that a waiver of sanctions is necessary.
- A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided under Section 1135(e)(1)(B) of the Act.

Interpretive Guidelines: §489.24(a)(2)[34]

What can be Waived Under Section 1135?

- In accordance with Section 1135(b)(3) of the Act, hospitals and CAHs operating under an EMTALA waiver will not be sanctioned for:
    - Redirecting an individual who "comes to the emergency department," as that term is defined at §489.24(b), to an alternate location for an MSE, pursuant to a State emergency preparedness plan or, as applicable, a State pandemic preparedness plan. Even when a waiver is in effect

[34] Centers for Medicaid and Medicare Services. State Operations Manual. Rev. 60, 07-16-10, Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases. Obtained 18 Oct 2010 from: http://www.cms.gov/manuals/Downloads/som107ap_v_emerg.pdf

there is still the expectation that everyone who comes to the ED will receive an appropriate MSE, if not in the ED, then at the alternate care site to which they are redirected or relocated.
    - Inappropriately transferring an individual protected under EMTALA, when the transfer is necessitated by the circumstances of the declared emergencies. Transfers may be inappropriate under EMTALA for a number of reasons.
- However, even if a hospital/CAH is operating under an EMTALA waiver, the hospital/CAH would not be exempt from sanctions if it discriminates among individuals based on their ability to pay for services, or the source of their payment for services when redirecting or relocating them for the MSE or when making inappropriate transfers.
- All other EMTALA-related requirements at 42 CFR 489.20 and EMTALA requirements at 42 CFR 489.24 continue to apply, even when a hospital is operating under an EMTALA waiver. For example, the statute does not provide for a waiver of a recipient hospital's obligation to accept an appropriate transfer of an individual protected under EMTALA. (As a reminder, even without a waiver, a hospital is obligated to accept an appropriate EMTALA transfer only when that recipient hospital has specialized capabilities required by the individual and the requisite capacity at the time of the transfer request.)
- Waiver of EMTALA requirements in accordance with a Section 1135 waiver does not affect a hospital's or CAH's obligation to comply with State law or regulation that may separately impose requirements similar to those under EMTALA law and regulations. Facilities are encouraged to communicate with their State licensure authorities as to the availability of waivers under State law.

When Can a Waiver Be Issued?

- In accordance with Section 1135 of the Act, an EMTALA waiver may be issued only when:
    - The President has declared an emergency or disaster pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and
    - The Secretary has declared a public health emergency (PHE) pursuant to Section 319 of the Public Health Service Act; and
    - The Secretary has exercised his/her waiver authority pursuant to Section 1135 of the Act and notified Congress at least 48 hours in advance of exercising his/her waiver authority.
- In exercising his/her waiver authority, the Secretary may choose to delegate to the Centers for Medicare & Medicaid Services the decision as to which Medicare, Medicaid, or CHIP requirements specified in Section 1135 should be temporarily waived or modified, and for which health care providers or groups of providers such waivers are necessary. Specifically, the Secretary may delegate to CMS decision-making about whether and for which hospitals/CAHs to waive EMTALA sanctions as specified in Section 1135(b)(3).
- In addition, in order for an EMTALA waiver to apply to a specific hospital or CAH:

- The hospital or CAH must activate its disaster protocol; and The State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan. It is not necessary for the State to activate its plan statewide, so long as it is activated in the area where the hospital is located. It is also not necessary for the State plan to identify the specific location of the alternate screening sites to which individuals will be directed, although some may do so.

How Long Does an EMTALA Waiver Last?

- Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's/CAH's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, application of this general authority to a specific hospital/CAH or groups of hospitals and CAHs may limit the waiver's application to a date prior to the termination of the PHE declaration, since case-specific applications of the waiver authority are issued only to the extent they are necessary, as determined by CMS.
- Furthermore, if a State emergency/pandemic preparedness plan is deactivated in the area where the hospital or CAH is located prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date. Likewise, if a hospital or CAH deactivates its disaster protocol prior to the termination of the public health emergency, the hospital or CAH no longer meets the conditions for an EMTALA waiver and that hospital/CAH waiver would cease to be in effect as of the deactivation date.

What is the Process for Seeking an EMTALA Waiver?

- Section 1135 provides for waivers of certain Medicare, Medicaid, or CHIP requirements, including waivers of EMTALA sanctions, but only to the extent necessary, to ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid, and CHIP beneficiaries. The waivers also ensure that health care providers who provide such services in good faith but are unable to comply with one or more of the specified requirements may be reimbursed for such items and services and exempted from sanctions for noncompliance, absent any fraud or abuse.
- When the Secretary has exercised his/her waiver authority and delegated to CMS decision-making about specific EMTALA waivers, CMS policy in exercising its authority for granting EMTALA waivers is as follows:
    - **Localized Emergency Area:** In the case of localized disasters, such as those related to floods or hurricanes, CMS may exercise its discretion to advise hospitals/CAHs in the affected areas that they are covered by the EMTALA waiver, **without requiring individual applications for each waiver.** However, hospitals or CAHs that activate their disaster protocol and expect to take advantage of the area-wide waiver must notify their State Survey Agency at the time they activate their disaster protocol
    - **Nationwide Emergency Area:** In the case of a nationwide emergency area, CMS may also exercise its discretion to advise hospitals/CAHs in a specific geographical area(s) that they are covered by the EMTALA waiver **for a time-limited period**. CMS expects to do this only if the State has activated its emergency or pandemic preparedness plan in the affected area(s), and if there is other evidence of need for the waiver for a broad group of hospitals or CAHs. CMS will rely upon SAs to advise their CMS Regional Office whether and where a State's preparedness plan has been activated, as well as when the plan has been deactivated.
- In the absence of CMS notification of area-wide applications of the waiver, hospitals/CAHs must contact CMS and request that the waiver provisions be applied to their facility. In all cases, the Act envisions that individuals protected under EMTALA will still receive appropriate MSEs somewhere (even if the MSE is not conducted not at the hospital or CAH where they present), and that individuals who are transferred for stabilization of their emergency medical condition will be sent to a facility capable of providing stabilizing services, regardless of whether a waiver is in effect

- Unless CMS advises otherwise, in cases of a public health emergency involving pandemic infectious disease, hospitals/CAHs in areas covered by time-limited, area-wide applications of the EMTALA waiver that seek to extend the waiver's application to a later date within the waiver period (that is, within the period of the PHE declaration) must submit individual requests for extension. The requests must demonstrate their need for continued application of the waiver. Such requests must be received at least three calendar days prior to expiration of the time-limited waiver. Extensions of an EMTALA waiver in emergencies that do not involve pandemic infectious disease are not available.

Waiver Request Process

- Hospitals or CAHs seeking an EMTALA waiver must demonstrate to CMS that application of the waiver to their facility is necessary, and that they have activated their disaster protocol. CMS will confirm with the SA whether the State's preparedness plan has been activated in the area where the hospital or CAH is located. CMS will also seek to confirm when the hospital activated its disaster protocol, whether other measures may address the situation in a manner that does not require a waiver, and other factors important to the ability of the hospital to demonstrate that a waiver is needed.

What will CMS do in response to EMTALA complaints concerning events occurring during the waiver period?

- EMTALA enforcement is a complaint-driven process. CMS will assess any complaints/allegations related to alleged EMTALA violations concerning the MSE or transfer during the waiver period to determine whether the hospital or CAH in question was operating under an EMTALA waiver at the time of the complaint, and, if so, whether the nature of the complaint involves actions or requirements not covered by the EMTALA waiver and warrants further on-site investigation by the SA.

APPENDIX D – Ethical Principles and Altered Standards of Care

The key findings that emerged from the experts' discussion of the provision of health and medical care in a mass casualty event are summarized below. These findings are discussed in greater detail in Chapters 2 and 3.

1. The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved.

2. Changes in the usual standards of health and medical care in the affected locality or region will be required to achieve the goal of saving the most lives in a mass casualty event. Rather than doing everything possible to save every life, it will be necessary to allocate scarce resources in a different manner to save as many lives as possible.

3. Many health system preparedness efforts do not provide sufficient planning and guidance concerning the altered standards of care that would be required to respond to a mass casualty event.

4. The basis for allocating health and medical resources in a mass casualty event must be fair and clinically sound. The process for making these decisions should be transparent and judged by the public to be fair.

5. Protocols for triage (i.e., the sorting of victims into groups according to their need and resources available) need to be flexible enough to change as the size of a mass casualty event grows and will depend on both the nature of the event and the speed with which it occurs.

6. An effective plan for delivering health and medical care in a mass casualty event should take into account factors common to all hazards (e.g., the need to have an adequate supply of qualified providers available), as well as factors that are hazard-specific (e.g., guidelines for making isolation and quarantine decisions to contain an infectious disease).

7. Plans should ensure an adequate supply of qualified providers who are trained specifically for a mass casualty event. This includes providing protection to providers and their families (e.g., personal protective equipment, prophylaxis, staff rotation to prevent burnout, and stress management programs).

8. A number of important nonmedical issues that affect the delivery of health and medical care need to be addressed to ensure an effective response to a mass casualty event. They include:
    a. The authority to activate or sanction the use of altered standards of care under certain conditions.
    b. Legal issues related to liability, licensing, and intergovernmental or regional mutual aid agreements.
    c. Financial issues related to reimbursement and other ways of covering medical care costs.
    d. Issues related to effective communication with the public.
    e. Issues related to populations with special needs.
    f. Issues related to transportation of patients.

APPENDIX E – Utah Pandemic Influenza Hospital and Triage Guidelines

To Be Inserted

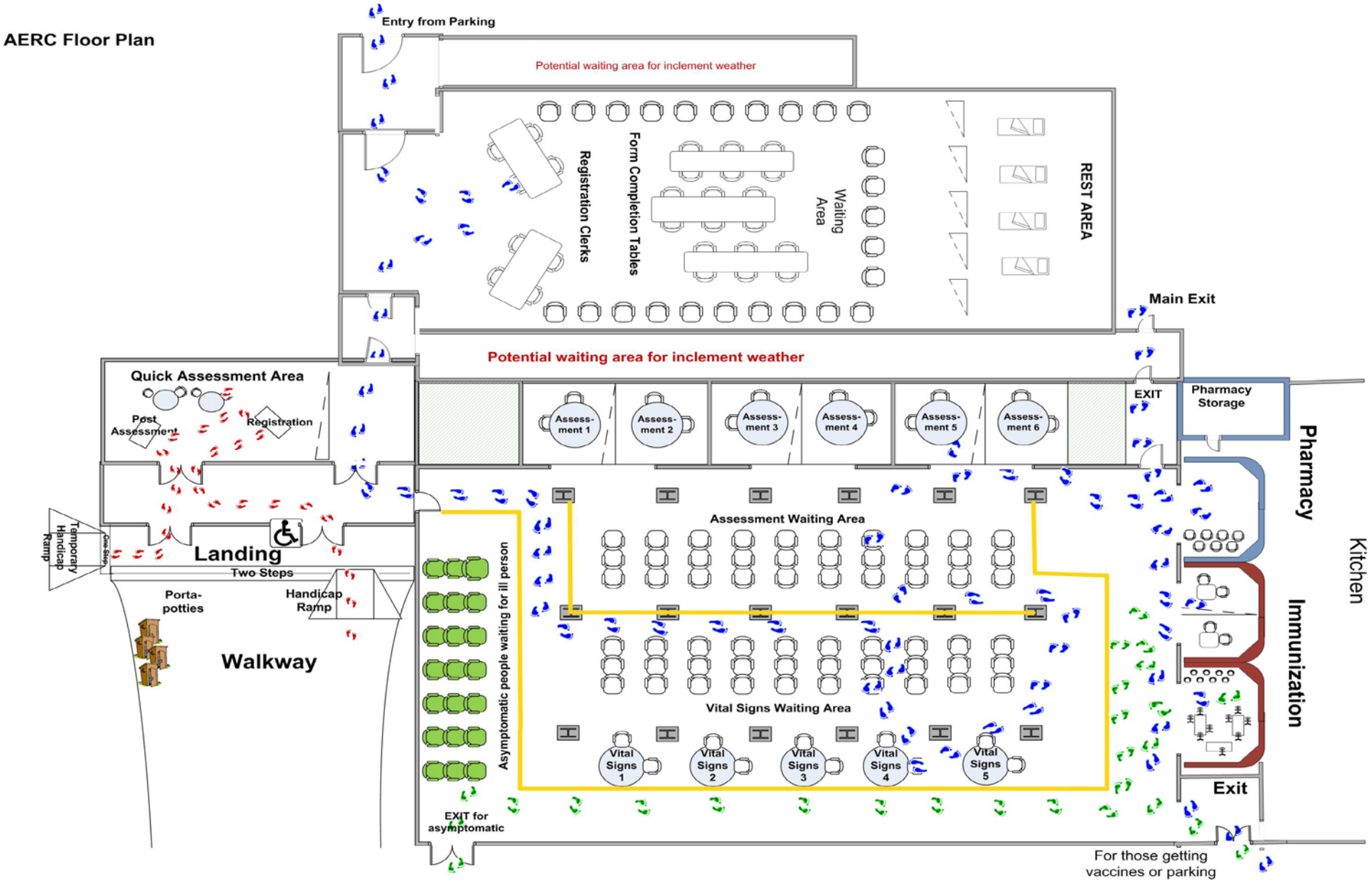
APPENDIX F – Community Partners

AGENCY	CONTACT	SERVICE
Hospitals	Varies, see Appendix A.2	• Minimal & acute care • Palliative (or refer)
Various associations of professionals and facilities	Varies, see Appendix A.2	• Minimal care at home • Palliative/hospice • Hospitals • Long Term Care
Granite School District	Kieth Bradshaw (801)646-4594 kcbradshaw@graniteschools.org	• Provide building, custodial services
Utah Department of Health	Kevin Macauley 801-273-6662 kmacauley@utah.gov	• TA related to HPP and PHER funding
Emergency Medical Services	Cathy Bodily 743-7116 cbodily@ufa-slco.org Matthew Hurtes 743-7131 mhurtes@ufa-slco.org	• Conduct assessments? • Transportation of ill??
Volunteer Organizations Active in Disasters (VOAD)	Wade Gayler W (801) 964-2299 C (801) 703-8734 wgayler@msn.com Lorna Koci 2-1-1 Senior Services Dir. Utah Food Banks	• Support for ill at home alone such as meals, errands, daily phone call
Sheriff's Office	Lt. Bill Robertson W 801-743-5874 C 801-831-6601 P 801-743-9537 WRobertson@slco.org	• Security Assessment • On-site safety for pharmaceuticals • Worker safety
Utah Funeral Directors' Association	Alec Anderson W (801) 756-3564 asmortuary@burnettech.com	• Coordinates services to deal with body surge

Information call centers: 2-1-1 & 9-1-1	Kate Lilja will be the contact and will coordinate	• Messaging to public • Must include that person with ILI be off of fever reducing medications for 4-6 hours prior to visit
Media	nrupp@slco.org Nick Rupp will be the contact and will coordinate	• Messaging to public • Must include that person with ILI be off of fever reducing medications for 4-6 hours prior to visit
County EOC	Cathy Bodily 743-7116 cbodily@ufa-slco.org	• Assist in obtaining resources

APPENDIX G – ESF-8 Membership

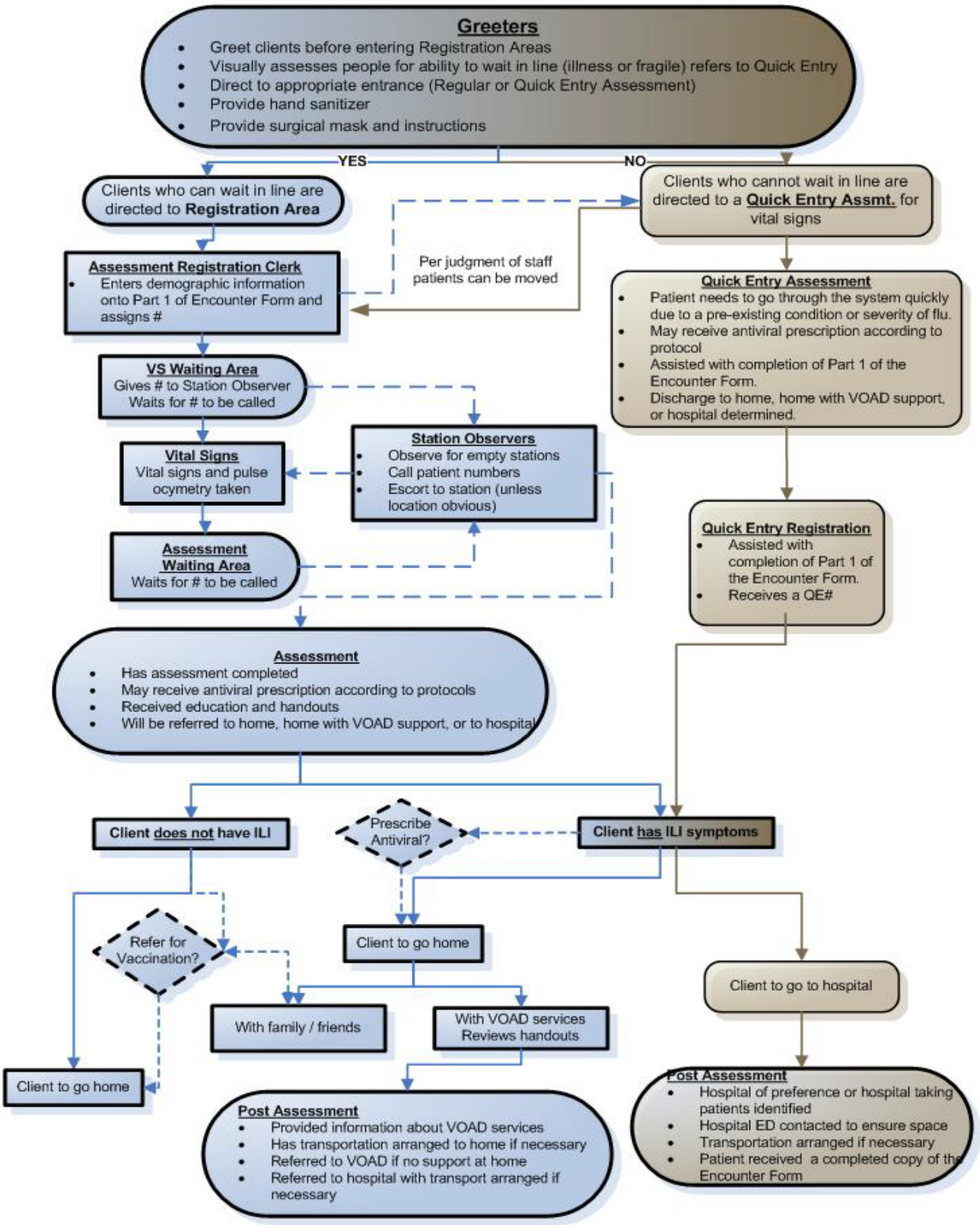
APPENDIX H – AERC Floor Plan



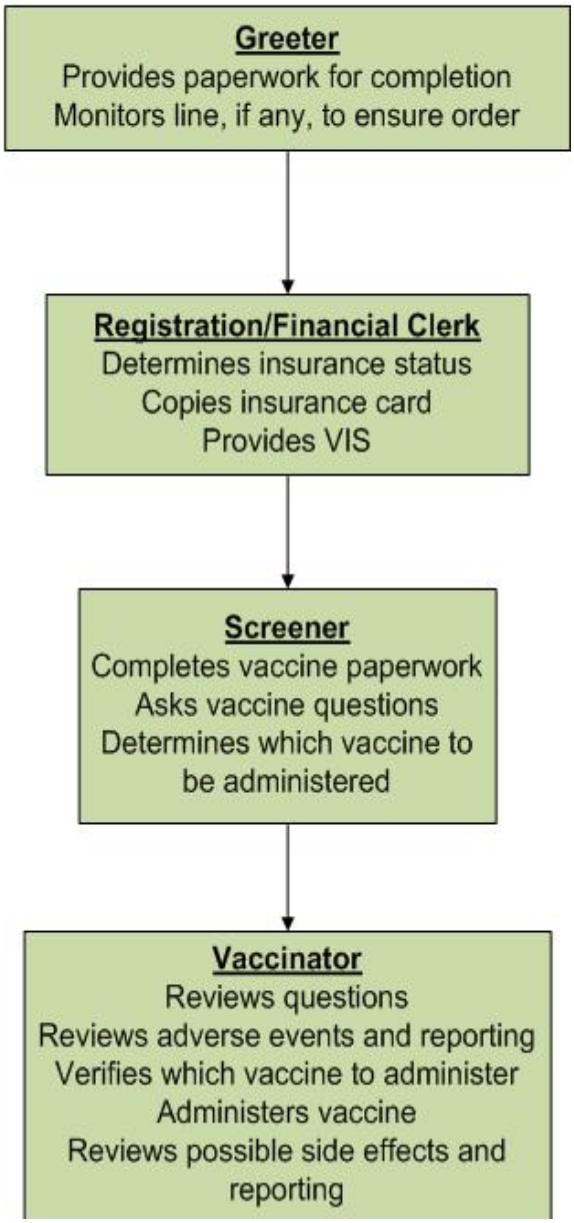
APPENDIX I – FLOW CHARTS

Influenza Triage Flow Chart

Flow Chart **– alter for all CDs with treatment; alter for epi and prevention service; alter for first aid**

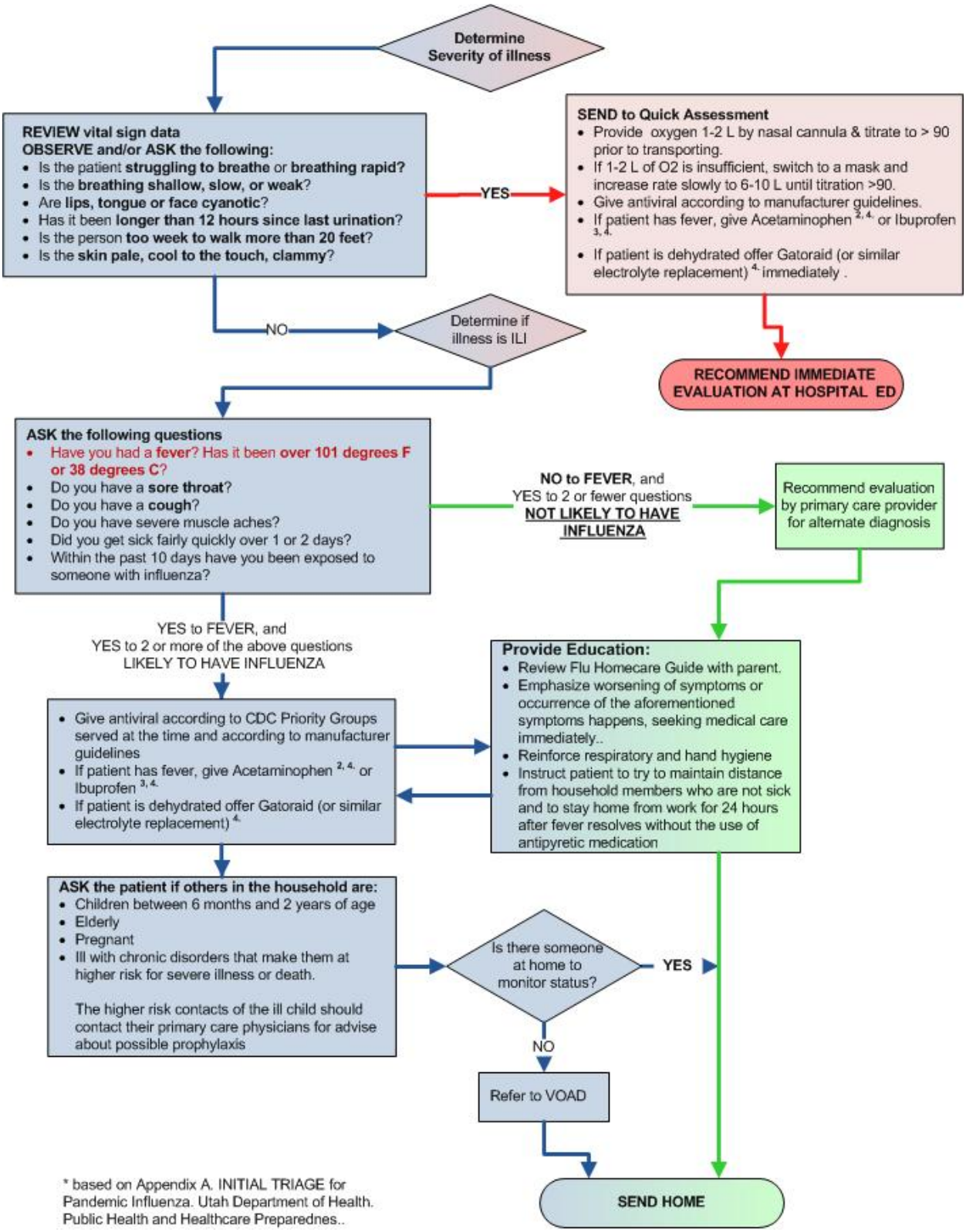


Vaccine Client Flow Chart

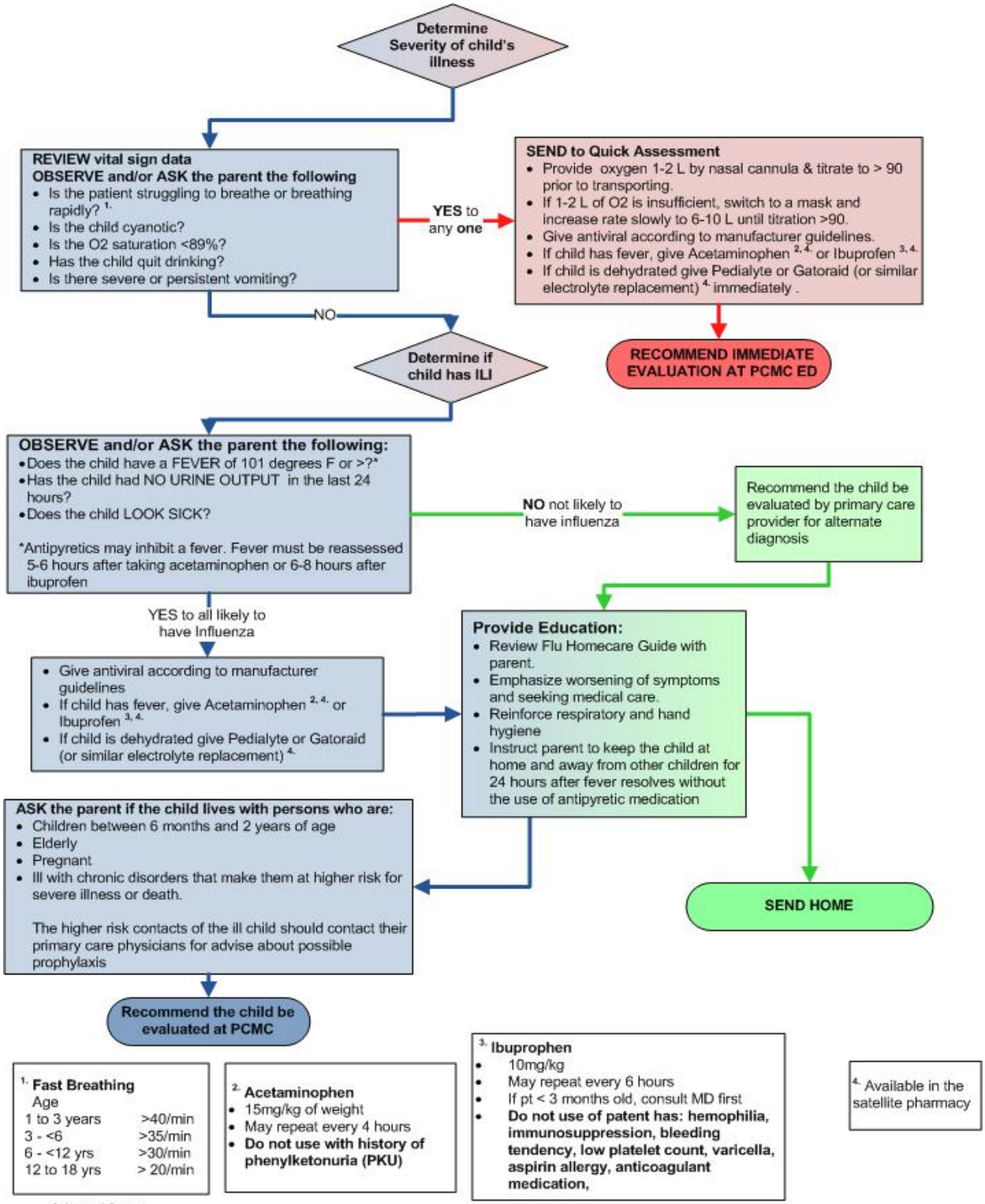


APPENDIX J – Assessment Protocols

Assessment Protocols - Adult

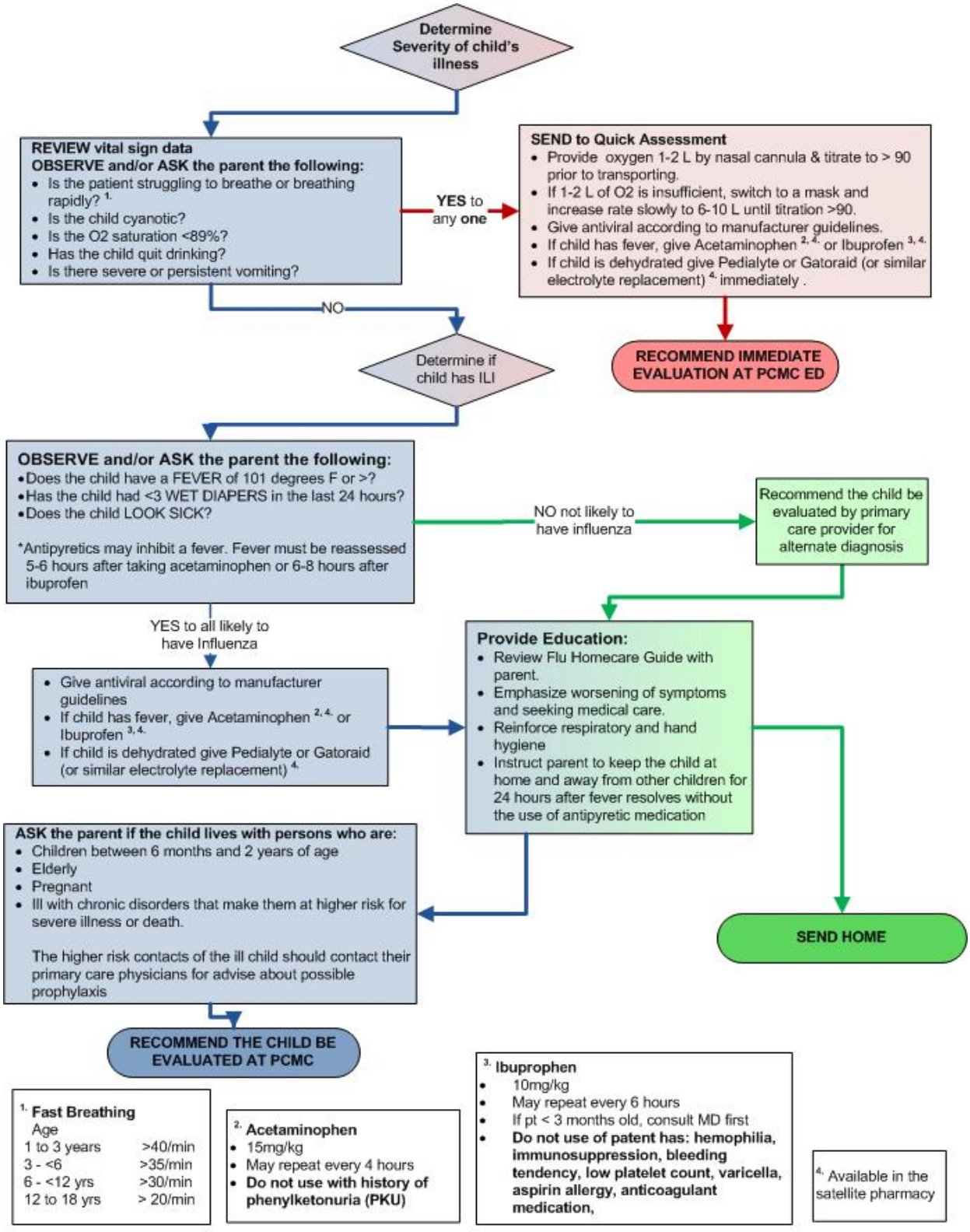


Assessment Protocols – Children 2 to18 years



Adapted from:
CDC & American Academy of Pediatricians (2009). *2009-2010 Influenza Season Triage Algorithm for children (<18 years) With ILI.*
Review and suggestions from Doug Nelson, MD PCHC ED & Nancy Mecham APRN, FNP, CEN Clinical Nurse Specialist PCMC

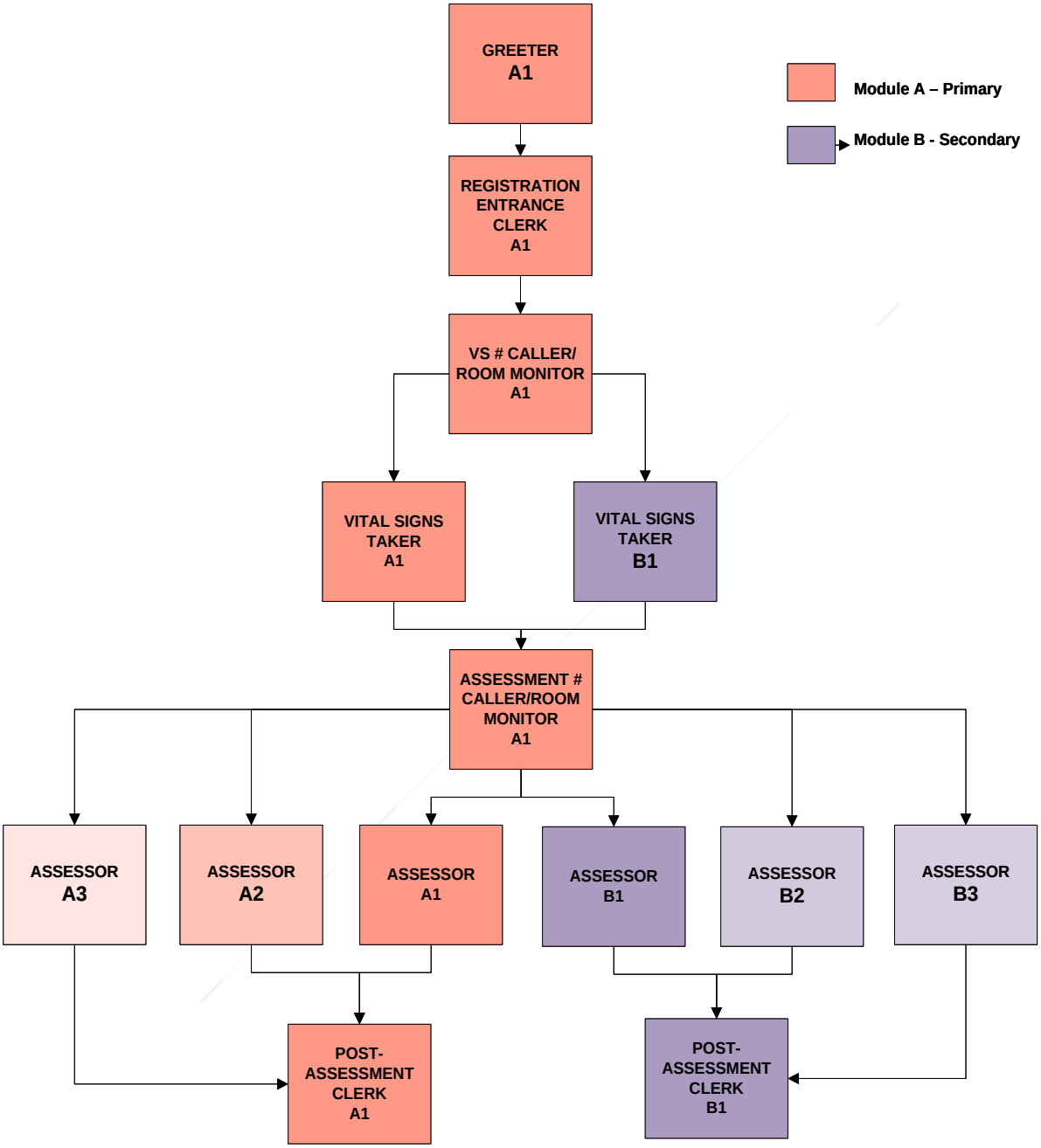
Assessment Protocols – Children under 24 months



Adapted from:
CDC & American Academy of Pediatricians (2009). *2009-2010 Influenza Season Triage Algorithm for children (<18 years) With ILI.*
Review and suggestions from Doug Nelson, MD PCHC ED & Nancy Mecham APRN, FNP, CEN Clinical Nurse Specialist PCMC

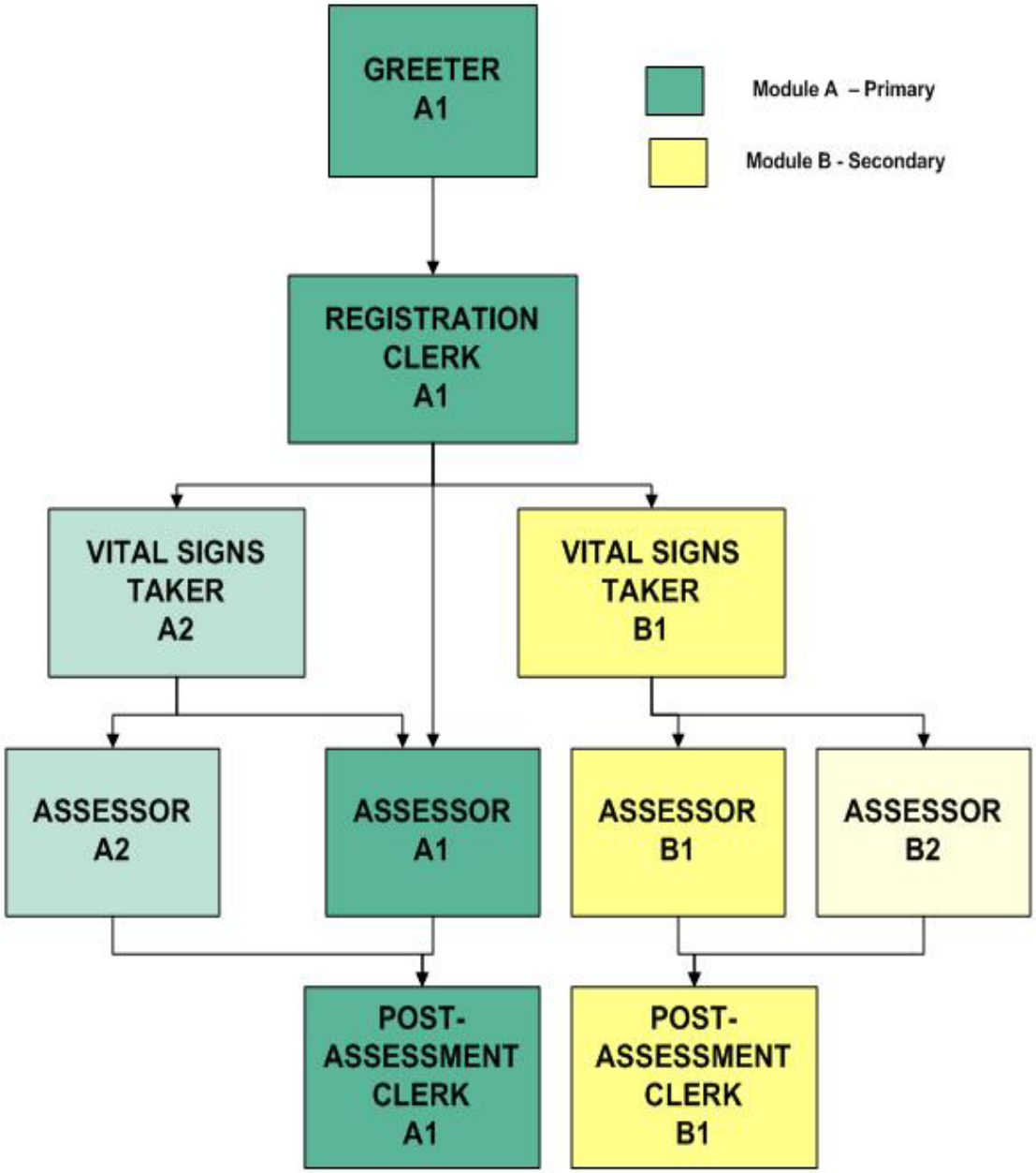
APPENDIX K – Modular Staffing

Assessment Team



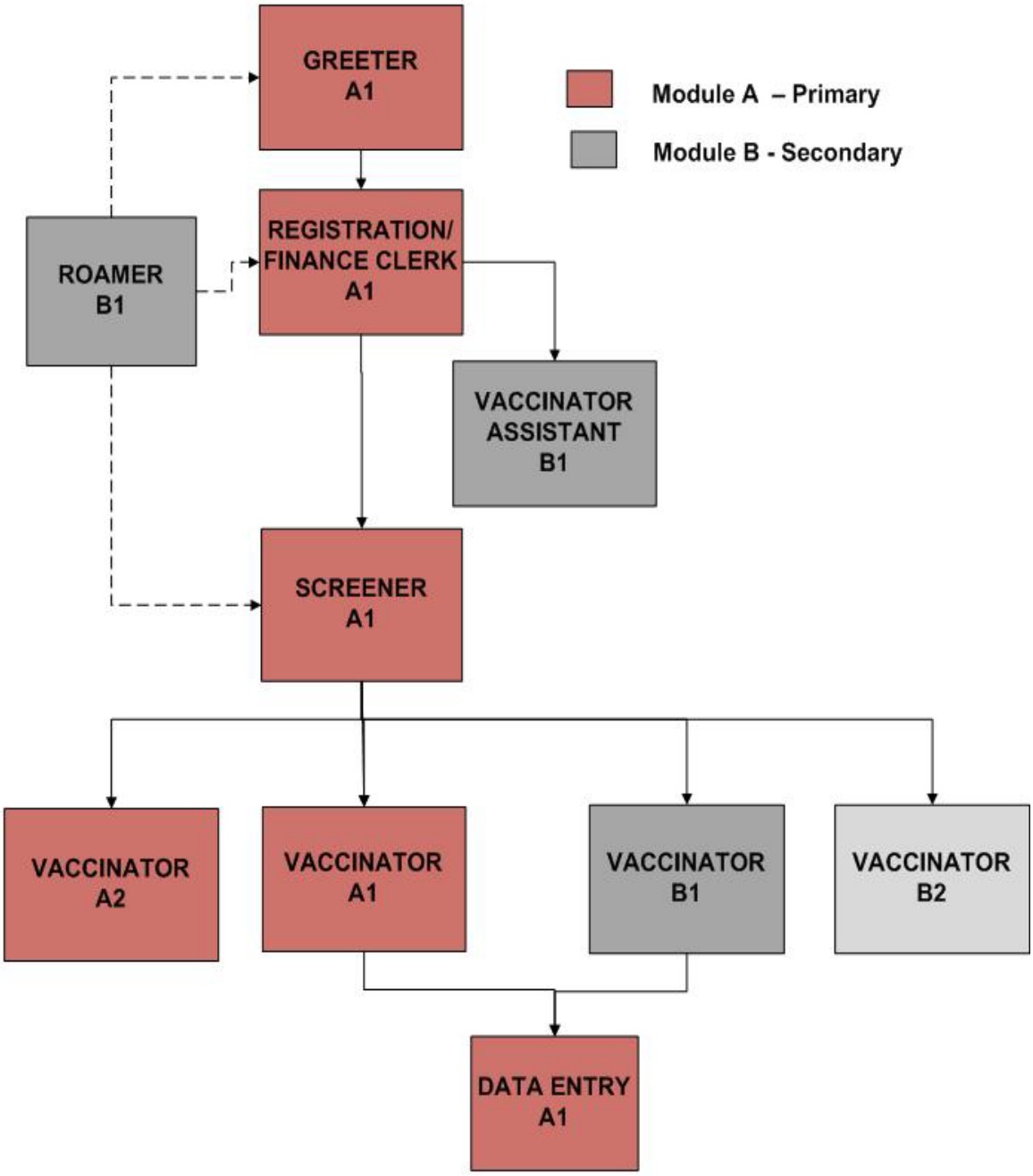
*Repeat this staffing pattern as needed for surge; downsizes by reversing the pattern sending people home that have been there the longest.

Quick Assessment Team*



*Repeat this staffing pattern as needed for surge; downsizes by reversing the pattern send g people home that have been there the longest

Vaccination Team*



*Repeat this staffing pattern as needed for surge; downsizes by reversing the pattern sending people home that have been there the longest.

APPENDIX L – Job Action Sheets

ASSESSMENT BRANCH

AERC Section Chief

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

Organize and direct aspects relating to the Operations Section. Carry out directives of the Incident Commander. Coordinate and supervise all Units of the Operations Section. Ensure the functions of the AERC are carried out including coordination of response with the COOP, Epidemiology, and Vaccine Sections. Provides the contact bridge with the SLVHD IC team; participates in SLVHD ICS as the Operations Section Chief for AERC.

Oversees: Assessment Branch Manager, Logistics Branch Manager, and Vaccine Branch Manager (if activated).

Qualifications

- ☐ Completed ICS 400
- ☐ Skilled manager and supervisor
- ☐ Excellent communications skills
- ☐ Good organizational skills and management experience
- ☐ Familiar with mass clinic operations

Equipment:

- ☐ Cell phone and contact numbers
- ☐ Radio Communication
- ☐ Vest/ID Badge
- ☐ Roster of Clinic staff
- ☐ Loud Speaker or bullhorn
- ☐ Clipboard

Immediate duties

- ☐ Meet with Incident Commander for initial incident briefing
- ☐ Put on vest and clinic identification
- ☐ Read AERC Plan and this entire Job Action Sheet
- ☐ Brief all operations branch directors

Action Items

No.	Action
1	Organize the AERC Section in coordination with all Section Chiefs and the Incident Commander. In coordination with Logistics and Finance Sections, ensure staff, equipment, and supplies are positioned for Alert, Standby, and Activation as the situation requires.
2	Coordinate with the Logistics Section to ensure appropriate and adequate mix of SLVHD staff and volunteer/contract staff according to the modular staffing model.

3	Activate personnel according to Staffing Modules and designate leaders for each Branch: Assessment, Logistics, and possibly Vaccination if included.
4	Meet with Branch leaders and ensure that responsibilities are clearly defined and understood and determine Section's initial Action Planning objectives for each operational period.
5	Ensure supplies and equipment are delivered and set up according to AERC Plan.
6	Participate in regular briefings with the other Section Chiefs and Incident Command
7	Ensure Situation Reports and Incident Action Plans as well as other documentation is timely and accurate. Maintain a Section log of all decisions and actions.
8	Brief relief Branch Managers ensuring that ongoing activities are identified and follow-up activity requirements are detailed and understood.
9	Coordinate with the Logistics and Planning Section Chiefs to provide input regarding the expansion or contraction of Assessment services.
10	Work with the PIO to develop and disseminate risk communication and AERC information messages to the public.
11	Direct the implementation of infection control plans for the AERC to protect staff and clients, in cooperation with the Safety Officer. Ensure that all staff follows the guidelines and procedures.
12	Work with hospital emergency planners to coordinate services to ensure that patients seen at the AERC who require symptomatic or more extensive care are seen in a timely manner.
13	Report medical emergencies to IC
14	Establish and maintain ongoing contact with the Epidemiology Section to coordinate data and analysis of information.
15	Coordinate services with Satellite Pharmacy representatives including appropriate use of government-owned antiviral medications and required recordkeeping.
16	Monitor staff for fatigue and illness.
17	Manage all AERC operations.
18	Complete the After Action Report and participate in debriefings as requested.

Assessment Branch Director

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

The Assessment Branch Director (ABD) is responsible for the overall function of the AERC Assessment Unit including: working with logistics regarding staffing, supplies, and security and overseeing the Incident Action Plan completion for the Clinic. ABD will be responsible for making all Assessment Clinic operational decisions, overseeing staff, and ensuring the clinic workflow is running efficiently. The ABD supervises Unit Leaders and acts as the Assessor Unit Leader if only the Primary Team for Module A staffing is activated. The ABM reports to the Assessment Section Chief.
Oversees: Unit Leaders

Qualifications

- ☐ Maintains licensure allowing decision making related to standing medical orders to institute emergency protocols (RN, LPN, EMT, Paramedic)
- ☐ Skilled in clinic operations and safety procedures
- ☐ Experience in management and supervision
- ☐ Able to provide clear, direct information
- ☐ Ability to multi-task
- ☐ Good communication
- ☐ Completion of ICS 300

Equipment

- ☐ Vest/ID Badge
- ☐ Roster of all staff
- ☐ Cell phone/ radio
- ☐ Copy of clinic layout
- ☐ Copy of the AERC Plan

Report to: Assessment Section Chief

Immediate Duties:

- ☐ rive at assigned site 2.5 hours prior to start time and check in.
- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Receive briefing from AERC Section Chief
- ☐ Coordinated with AERC Logistics Branch manager regarding staffing plan for expansion if necessary
- ☐ Provide orientation and Just-In-Time training for Clinic staff prior to opening
- ☐ Ensure all Clinic areas are set up prior to staff arrival
- ☐ Brief with lead staff, as needed, roles and responsibilities for all other workers.
- ☐ Establish communications and communications protocol, along with lead staff, with all staff members.
- ☐ Establish chain of command and performance expectations
- ☐ Meet with assigned team members to ensure that they are prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Assemble lead personnel for a briefing to include:
    - o Mission as assigned by Incident Commander
    - o Latest event information and clinical and environmental conditions
    - o Any hazards or threats to staff safety and health
    - o Media plan and procedures
    - o Pertinent or unique cultural and local considerations

- Information flow and reporting requirements
- Shift considerations and shift transition instructions to oncoming staff
- Problem solving process and methods for establishing or changing priorities

Action Items

No.	Action
1	Review the AERC Plan. Review site security, medication storage, and traffic flow patterns with Logistics Manager and Safety Manager and Security Manager.
2	Review all Standard Operating Guidelines (SOGs), Standing Orders and clinic plans including site design layout and hours of operation in view of current event situation and projected client numbers.
3	Establish the Branch with appropriate & adequate personnel, equipment & supplies. Work with Logistics Branch to ensure sufficient staffing for subsequent operational periods as needed.
4	Monitor Units and overall clinic functioning to identify problem areas for patient throughput and adjust staffing as needed to correct the problem
5	Coordinate with the Assessment Section Chief and Logistics Branch to provide input regarding the expansion or contraction of Clinical Services.
6	Meet with the AERC Section Chief and review organizational goals and objectives.
7	Meet with staff to ensure that responsibilities are clearly defined and understood.
8	In conjunction with the AERC Section Chief, determine the Assessment Branch initial Action Planning objectives, and for each operational period.
9	Notify the Assessment Section Chief when the Branch is operational.
10	Be proactive - think ahead & anticipate situations/problems before they occur.
11	Ensure that Branch position logs & other necessary files are maintained.
12	Direct the implementation of infection control plans for Assessment Branch sites to protect staff and clients, in cooperation with the Safety Officer. Ensure that all staff follows the guidelines and procedures.
13	Initiate SDO for medical emergencies; document on Encounter form addendum.
14	Notify Physician on call of medical a emergency
15	Provide regular updates to the AERC Section Chief.
16	Monitor staff for signs of fatigue and assist Logistics Branch to find other staff.
17	Brief your relief at shift change, ensuring that ongoing activities are identified and follow-up requirements are detailed and specific in the operational period report.
18	Complete the after action report and participate in the department debriefing.

Greeter

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

To provide an initial positive experience to patients and those accompanying them; observes for conditions that that would qualify patient for Quick Assessment and directs patient appropriately; identifies those needing translation assistance and notifies the Translator; provides a general overview of the process; answers questions knowledgeably; and Initiates the infection control process for clients.

Qualifications

- ☐ Not licensed, but familiar with public health clinics
- ☐ Familiar with clinic operations and safety procedures
- ☐ Good people skills
- ☐ Able to provide clear, direct information
- ☐ Bilingual preferred

Equipment

- ☐ Vest/ID Badge
- ☐ Cones, tapes or other barrier devices

Report to: Greeter Unit Leader or Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Greeter Unit Leader or Assessment Branch Director for incident briefing
- ☐ Identify area where clients will enter the clinic site – both regular assessment and quick assessment
- ☐ Assist with the set-up of the registration area and other areas as requested
- ☐ Ensure crowd control system (cones, ropes, etc) is in place

Action Items

No.	Action
1	Review and familiarize self with site surroundings, workstation locations, lavatories, first aid, waiting areas, pharmacy, and vaccination (if activated).
2	Maintain traffic control around the entrance into the assessment area.
3	Greet clients as they arrive.
4	Attempt to separate well clients from ill clients.
5	If toddlers are brought in ill, ask the age of the child If the child is younger than 24 months and must be seen by a pediatrician or visit a hospital ED or Insta-care
6	Answer general questions; refer patients to vital signs or assessment stations for technical question answers
7	Give everyone entering a mask and explain the requirement; offer hand sanitizer and suggest frequent use as they move through the assessment area.
8	Direct clients as necessary to maintain order at the entry area and client flow into screening station.
9	If at General Entry, visually assess client; refer to Quick Assessment for special needs or appears severely ill.
10	Report any security/safety issues immediately to the area coordinator. Call clinic security for back-up as necessary. Document incidents appropriately
11	Obtain translator or other assistance for special needs clients, if necessary.
12	Notify Assessment Branch Manager if additional greeters are needed to handle the flow of patients.
13	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Assessment Registration Clerk

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

The Registration Clerks will provide and assist clients in completing the Encounter form (Section 1) and provide basic information about the AERC process.

Qualifications

- ☐ Clerical skills
- ☐ Bilingual
- ☐ Knowledge of medical terminology
- ☐ Communication skills people skills.

Equipment

- ☐ Vest/ID Badge
- ☐ Encounter forms
- ☐ Pens/pencils
- ☐ Clipboards

Report To; Registration Unit Leader or Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Registration Unit Leader or Assessment Branch Director for incident briefing
- ☐ Identify area where clients will enter the clinic site – both regular assessment and quick assessment
- ☐ Assist with the set-up of the registration area and other areas as requested
- ☐ Ensure crowd control system (cones, ropes, etc) is in place

Action Items

No.	Action
1	Review and familiarize self with site surroundings, workstation locations, lavatories, first aid, waiting areas, pharmacy, and vaccination (if activated).
2	Provide and assist clients with encounter form completion.
4	Obtain translator or other assistance for special needs clients, if necessary.
5	Review each Encounter form for completeness and accuracy.
6	Assign number to encounter form.
7	Encourage clients and those accompanying them to continue to wear masks and use hand sanitizer
8	Direct client to next station
9	Visually assess client and refer to Quick Assessment if client has special needs or appears very ill.
10	Call clinic security for back-up as necessary.
11	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Assessment Assistant

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

To provide the Assessor with accurate data upon which to make a determination whether or not an ill person has ILI and its severity; notifies the Assessment Branch Manager immediately upon identification of persons with low pO2, fever ≥103ºF, and/or signs and symptoms of severe disease.

Qualifications

- ☐ Licensed as an RN, LPN, EMT, Paramedic, or Medical Assistant
- ☐ Good communication skills
- ☐ Good assessment skills

Equipment

- ☐ Vest/ID badge
- ☐ Client flow sheet
- ☐ Alcohol wipes
- ☐ Non-invasive temperature device,
- ☐ Pulse Oxymeter
- ☐ Pens
- ☐ Paper
- ☐ Hand sanitizer
- ☐ Trash container

Report To: Assessment Assistant Unit Leader or Assessment Branch Director

Immediate Duties

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Assessment Unit Leader or Assessment Branch Director for incident briefing
- ☐ Coordinate with Waiting Area/Monitors who will be directing people to VS stations

Action Items

No.	Action
1	Explain to client what tests you will be doing and why
2	Review Encounter form for completeness and obtain missing information from client
3	Measure temperature, pulse, respirations, pO2, and weight, and document in appropriate area of Encounter form
4	If any results are extremely out of normal range, report immediately to the Assessment Assistant Unit Leader or Assessment Branch Manager.
5	If the patient is a child obtain weight (if child is under 88 lbs) as dosage of antiviral may vary with weight
6	Answer technical questions
7	Clean equipment as appropriate
8	Follow Infection control procedures
9	Encourage client to use hand sanitizer and continue wearing face mask
10	Direct client to Vital signs waiting area.
11	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Waiting Area Monitor

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

To facilitate smooth flow of patients into the Assistant Assessors' areas for vital signs and pulse oxymetry or into the Assessment Stations to speak to the Assessor.

Qualifications

- ☐ Organizational skills
- ☐ People skills to be able to deal with impatient patients and active children
- ☐ Able to track order of patients entering waiting area

Equipment

- ☐ Clip board
- ☐ Pencil/pen
- ☐ 3x5 cards
- ☐ Paper

Report To: Assessment Assistant Unit Leader or Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Assessment Assistant Unit Leader or Assessment Branch Director for incident briefing
- ☐ Coordinate with the Assessment Assistants

Action Items

No.	Action
1	Number 3X5 cards.
2	Give a card to each patient or family group upon arrival in the waiting area
3	Inform patients what will be done at the stations and that they will be sent to an assessment area in number order.
4	Monitor vacant assessment stations
5	Direct patients into assessment stations in number order
6	Be able to answer questions about clinic flow
7	Attempt to keep waiting area as calm as possible
8	Encourage patients and others to wear facemasks at all times while in the clinic and use hand sanitizer frequently
9	Direct clients to Assessment Waiting area
10	Consult with Waiting Area Manager or Assessment Branch Manager if problems occur.
11	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Assessor

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: Using the AERC Assessment Protocols and analysis of the information provided by the Assessment Assistant, determines if the patient has ILI and refer for care and provide resources according to the Clinic's Assessment Protocols; prescribes antiviral medication according to CDC recommendations and guidelines; and ensures patient understands signs and symptoms that require immediate medical attention.

Qualifications:

- ☐ Licensed as an RN, LPN, EMT, Paramedic, or Medical Assistant
- ☐ Good interpersonal skills
- ☐ Good communication skills
- ☐ Good assessment skills

Equipment:

- ☐ Stethoscope
- ☐ Pens
- ☐ Pamphlets

Report To: Assessment Unit Leader or Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Assessment Unit Leader or Assessment Branch Director for incident briefing
- ☐ Coordinate with Waiting Area Monitor(s) for the Assessment area.

Action Items

No.	Action
1	Follow either the Assessment Protocol for Children or the Assessment Protocol for Adults to determine ILI status and appropriate referral.
2	If applicable, provide a prescription for an antiviral and direct the patients to the on-site pharmacy.
3	If the patient **has** a support system at home is sent home for self-care: • Provides *Flu Homecare Guide,* emphasizing symptoms that indicate increasing illness severity, • Instruct patient to seek medical care with a physician or at a hospital ED if symptoms occur • Remind patient to take the AERC Encounter Form to the physician or ED
4	Complete required information on the Encounter Form and retain the copy.
5	If the patient **does not have** a support system at home and is sent home for self-care: • Provides *Flu Homecare Guide,* emphasizing symptoms that indicate increasing illness severity Instruct patient to seek medical care with a physician or at a hospital ED if symptoms occur • Remind patient to take the AERC Encounter Form to the physician or ED • Refer the patient to the Post Assessment Clerk to initiate a VOAD referral.
6	Complete Encounter Form information; send both copies with the patient to the Post Assessment Clerk

7	If the patient is severely ill and requires evaluation at the ED, refer the patient to the Post Assessment Clerk to assist in determining which hospital, transportation needs, etc.
8	Complete Encounter Form information; send both copies with the patient to the Post Assessment Clerk
9	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Post-Assessment Clerk

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: To ensure that patients have the services needed to support recovery at home or in the hospital.

Qualifications:

- ☐ Knowledge of community resources
- ☐ Comfortable with doing outreach to agencies

Equipment:

- ☐ Resource contact information
- ☐ Pens and pencils

Report To: Post-Assessment Unit Leader or Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Post-Assessment Unit Leader or Assessment Branch Director for incident briefing
- ☐ Coordinate activity with Assessors.

Action Items

No.	Action
1	Notify contacts at referral agencies by email that you are the "discharge" coordinator for the shift.
2	Explain to the patient the nature of the service you are referring the patient to (VOAD or EMS) and why it is important.
3	Provide the patient with the information sheet regarding what the services that will be provided.
4	Complete Encounter Form. Keep the copy and send the original with the patient.
5	**VOAD** • Obtain patient's signature on a release of information agreeing that (s)he authorizes you to provide Identifying information to the VOAD resource. • Send the Encounter form home with the patient. If symptoms worsen, instruct the patient to contact the primary care provider or ED and to bring the Encounter Form to the visit.
6	**EMS** • Obtain patient's signature on a release of information agreeing that (s)he authorizes you to provide Identifying and medical information to the EMS service. • Tell patient how long the expected wait might be. • Determine if patient needs to lie down while waiting. • If transport is needed to the Clinic's rest area, request the Roamer to transport.
7	Contact the agency/service with the information.
8	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Roamer

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: To serve as a runner or provide assistance to any station (except Assessment) that is overwhelmed or needs other assistance. Coordinate supply needs with the Logistics Unit. May need to assist logistics unit with crowd management activities

Qualifications:

- ☐ Able to read a Job Action Sheet and quickly understand the functions of the job.
- ☐ Skills in taking vital signs
- ☐ High energy
- ☐ Enjoys diversity

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper

Report To: Assessment Branch Manager

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Assessment Branch Director for incident briefing
- ☐ Coordinate activity with the Greeters, Registration / Post Assessment Clerks, Waiting Area Monitors, Assessment Assistants, and Assessors.

Action Items

No.	Action
1	Meet with each of the team leads and explain your role
2	Determine best way to contact you if your services are needed. For consideration: rounds to each station, cell phone, pager, etc.
3	Orient yourself to the clinic flow and the process at each station except assessment.
4	Meet with the clinic Logistics Unit Leader; orient to supply logistics.
5	If additional staff is needed (e.g. as runner you are running too fast to too many positions), notify the Assessment Branch Director.

Translator / Interpreter

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: To provide interpretation/translation services for non-English speaking clients throughout the process.

Qualifications:

- ☐ Non-medical,
- ☐ Proficiency in both English and Spanish
- ☐ Understands and can translate/interpret medical terminology
- ☐ Able to stand for long periods of time

Equipment:

- ☐ AERC Flow Chart
- ☐ Copies of all forms and educational materials in English
- ☐ Copies of all forms and educational materials in other languages
- ☐ Pens
- ☐ Clipboards
- ☐ Notepad
- ☐ Language dictionary.
- ☐ Communication device with other staff (phone, radio, etc)
- ☐ Contact numbers of station leaders/managers

Report To: Assessment Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Assessment Branch Director for incident briefing
- ☐ Coordinate activity with the Assessment Branch Director
- ☐ Arrive at assigned site 1 hour prior to start time
- ☐ Review and become familiar with all forms and educational materials to enable easier translation.
- ☐ Assist/provide translation of forms and materials, if possible.
- ☐ Maintain contact with staff so they are aware of your availability interpret.

Action Items

No.	Action
1	Requests for interpretation may come from any staff.
2	Work with greeters to identify clients with language barriers requiring translators.
3	Greet the client, introduce yourself, and explain that you are there to provide interpretation/translation to help them through the process
4	Interpret all verbal instructions, questions, education, and translate any written material.
5	Provide assistance with forms.
6	Accompany clients through each station of the clinic process.
7	Maintain log identifying numbers of clients and what non-English languages were served by the translator. Record count of services provided, to include: ☐ Assistance in completing forms ☐ Answering questions

VACCINE BRANCH

Vaccine Branch Director

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

The Vaccination Branch Director (VBD) is responsible for the overall function of the Vaccination Clinic if it is activated during a pandemic response. VBD is responsible for making all vaccine clinic operational decisions, overseeing staff, and ensuring the clinic workflow is running efficiently. The VBD supervises Unit Leaders. The VBD reports to the Assessment Section Chief.

Oversees: Unit Leaders

Qualifications:

- ☐ Maintains licensure allowing decision making related to standing medical orders to institute emergency protocols (RN, LPN, EMT, Paramedic)
- ☐ Skilled in clinic operations and safety procedures
- ☐ Experience in management and supervision
- ☐ Able to provide clear, direct information
- ☐ Ability to multi-task
- ☐ Good communication
- ☐ Completion of ICS 300

Equipment:

- ☐ Vest/ID Badge
- ☐ Roster of all staff
- ☐ Cell phone/ radio
- ☐ Copy of clinic layout
- ☐ Copy of the AERC Plan

Report To: Assessment Section Chief

Immediate Duties:

- ☐ Arrive at assigned site 2.5 hours prior to start time and check in.
- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Receive briefing from AERC Assessment Chief
- ☐ Coordinated with AERC Logistics Branch manager regarding staffing plan for expansion if necessary
- ☐ Provide orientation and Just-In-Time training for Vaccine Clinic staff prior to opening
- ☐ Ensure all Vaccine Clinic areas are set up prior to staff arrival
- ☐ Brief with lead staff, as needed, roles and responsibilities for all other workers.
- ☐ Establish communications and communications protocol, along with lead staff, with all staff members.
- ☐ Establish chain of command and performance expectations
- ☐ Meet with assigned team members to ensure that they are prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Assemble lead personnel for a briefing to include:
    - o Mission as assigned by Incident Commander
    - o Latest event information and clinical and environmental conditions
    - o Pertinent or unique cultural and local considerations

- Any hazards or threats to staff safety and health
- Media plan and procedures
- Pertinent or unique cultural and local considerations
- Information flow and reporting requirements
- Shift considerations and shift transition instructions to oncoming staff
- Problem solving process and methods for establishing or changing priorities

Action Items

No.	Action
1	Meet with the AERC Section Chief and review organizational goals and objectives.
2	Review the AERC Plan. Review site security, medication storage, and traffic flow patterns with Logistics Manager and Safety Manager and Security Manager.
3	Review all Standard Operating Guidelines (SOGs), Standing Orders and clinic plans including site design layout and hours of operation in view of current event situation and projected client numbers.
4	Meet with staff to ensure that responsibilities are clearly defined and understood.
5	Establish the Vaccine Clinic with appropriate & adequate personnel, equipment & supplies. Work with Logistics Branch to ensure sufficient staffing for subsequent operational periods as needed.
6	Monitor Units and overall clinic functioning to identify problem areas for patient throughput and adjust staffing as needed to correct the problem
7	Coordinate with the Assessment Section Chief and Logistics Branch to provide input regarding the expansion or contraction of Clinical Services.
8	In conjunction with the AERC Section Chief, determine the Vaccination Branch initial Action Planning objectives, and for each operational period.
9	Notify the Assessment Section Chief when the Vaccination unit is operational.
10	Be proactive - think ahead & anticipate situations/problems before they occur.
11	Ensure that Branch position logs & other necessary files are maintained.
12	Direct the implementation of infection control plans for Vaccine Clinic to protect staff and clients, in cooperation with the Safety Officer. Ensure that all staff follows the guidelines and procedures.
13	Ensure copies of standing medical orders for medical emergencies are available. Ensure that vaccination staff is familiar with the SDOs.
	If a client has a reaction, ensure that you document the nature of the reaction, what you did, and the client's response on the Encounter Form. Report to VAERS
14	Notify Physician on call of medical a emergency
15	Provide regular updates to the AERC Section Chief.
16	Monitor staff for signs of fatigue and assist Logistics Branch to find other staff.
17	Brief your relief at shift change, ensuring that ongoing activities are identified and follow-up requirements are detailed and specific in the operational period report.
18	Complete the after action report and participate in the department debriefing.

Greeter

Site: _____

Position Assigned To: _____

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager

Mission:

Provides an initial positive experience to patients and those accompanying them; observes for conditions that that would qualify patient for Quick Assessment and directs patient appropriately; identifies and obtains translator for patients needing translation assistance; and provides a general overview of the process

Qualifications:

- ☐ Not licensed, but familiar with public health clinics
- ☐ Familiar with clinic operations and safety procedures
- ☐ Able to provide clear, direct information
- ☐ Bilingual preferred

Equipment:

- ☐ Vest/ID Badge
- ☐ Cones, tapes or other barrier devices

Report To: Greeter Unit Leader or Vaccine Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Greeter Unit Leader or Vaccine Branch Director for incident briefing
- ☐ Identify area where clients will enter the clinic site
- ☐ Assist with the set-up of the registration area and other areas as requested
- ☐ Ensure crowd control system (cones, ropes, etc) is in place

Action Items

No.	Action
1	Review and familiarize self with site surroundings, workstation locations, lavatories, first aid, waiting areas, pharmacy, and vaccination (if activated).
2	Maintain traffic control around the entrance into the assessment area.
3	Greet clients as they arrive.
4	Attempt to separate well clients from ill clients.
5	Answer any questions clients have about the AERC that are not technical
6	Answer general questions; technical questions can be answered at t he vaccine stations.
7	Give everyone entering from outside a mask and explain the requirement; offer hand sanitizer.
8	Maintain order at the entry area and client flow into vaccination station.
9	Report any security/safety issues immediately to the area coordinator. Call clinic security for back-up as necessary. Document incidents appropriately
10	Obtain translator or other assistance for special needs clients, if necessary.
11	Notify Vaccination Branch Manager if additional greeters are needed to facilitate patient flow
12	Report off to the Vaccine Branch Director

Registration/Finance Clerk

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission

To provide and assist clients in completing the Encounter form (Section 1) and provide basic information about the AERC process; copy insurance cards and determine risk group membership

Qualifications

- ☐ Clerical skills
- ☐ Bilingual preferred
- ☐ Communication skills.
- ☐ People skills
- ☐ Knowledge of medical terminology

Equipment

- ☐ Vest/ID Badge
- ☐ Encounter forms
- ☐ Pens/pencils
- ☐ Clipboards

Report To; Vaccination Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Assist in setting up clinic operation
- ☐ Ensure a sufficient number of clipboard packets are prepared and available
- ☐ Meet with Registration Unit Leader or Vaccination Branch Director for incident briefing
- ☐ Identify area where clients will exit the clinic site.
- ☐ Assist with the set-up of the registration area and other areas as requested
- ☐ Ensure crowd control system (cones, ropes, etc) is in place

Action Items

No.	Action
1	Review and familiarize self with site surroundings, workstation locations, lavatories, first aid, waiting areas, pharmacy, and assessment.
2	Give client the vaccine information sheet, medical screening form, and any other required paperwork for completion before visiting the Screener.
4	Provide and assist clients with completing vaccine paperwork.
5	Obtain translator or other assistance for special needs clients, if necessary.
6	Review vaccine paperwork for completeness and accuracy and obtain copies of insurance cards
7	Refer all medical questions to the screener.
8	Complete registration process with potential vaccinee for required dose tracking as appropriate.
9	Assign number to the client.
10	Encourage clients and those accompanying them to continue to wear masks and use hand sanitizer
11	Direct client to next station
12	Call clinic security for back-up as necessary.
13	Provide report to Unit Lead or Branch Director at the end of the shift and sign out.

Screener

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

Review each potential vaccinee's medical history and assess for any contraindications to vaccine.

***NOTE**: A public health physician must be "on call" for any questions and final recommendations/ decisions.*

Qualifications:

- ☐ Nurse, other medical professionals, certified/licensed EMS personnel

Equipment:

- ☐ Pens
- ☐ Notepads
- ☐ Contact numbers of physician on-call and station leaders

Must have access to:

- ☐ Phone.
- ☐ Resources (Physician's Desk Reference Book, Medical Dictionary and others as identified)
- ☐ Communication device with other staff (phone, radio, etc)

Report To: Vaccine Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Vaccine Unit Leader or Vaccine Branch Director for incident briefing

Action Items

No.	Action
1	Review the history form to confirm the client is eligible to receive the vaccine.
2	Confer with physician "on call" if further consultation/evaluation regarding eligibility is needed
3	Answer any medical questions concerning vaccine and reactions.
4	If no contraindications, direct client to vaccination station waiting area.
5	For non-English reading/speaking clients, contact interpreter and obtain information necessary to complete screening form.

Vaccinator

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:
Confirm appropriate documentation prior to injection; administer vaccine

Qualifications:
- ☐ Licensed medical professional,
- ☐ A pharmacist who has received the appropriate training and certification
- ☐ physically able to stand for long periods of time,

Equipment:
- ☐ Pandemic Influenza vaccine
- ☐ Diluent (if applicable)
- ☐ Syringes/needles
- ☐ Biohazard Sharps container
- ☐ Biohazard trash container
- ☐ Non-latex gloves
- ☐ Waterless antiseptic hand wash
- ☐ Antibacterial hand washing solution
- ☐ Hand lotion
- ☐ Gauze/cotton balls
- ☐ Tissues
- ☐ Alcohol pads
- ☐ Hypoallergenic tape
- ☐ Band-Aids
- ☐ Paper towels
- ☐ 1:10 Bleach solution in spray bottle
- ☐ Sharpie permanent marker
- ☐ Pen
- ☐ Emergency kit/cart
- ☐ Appropriate forms

Must have access to:
- ☐ DHEC Standing Order for Pandemic Influenza vaccination
- ☐ DHEC Emergency Standing Orders
- ☐ Contact numbers of physician on-call and station leaders
- ☐ DHEC Pandemic Influenza Vaccination form
- ☐ Communication device with other staff (phone, radio, etc)

Report To: Vaccinator Unit Leader or Vaccination Branch Director

Immediate Duties:
- ☐ Arrive 1.5 hours before start time
- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Vaccine Unit Leader or Vaccine Branch Director for incident briefing
- ☐ Set up vaccination station.
- ☐ Obtain orientation regarding specific tasks and special instructions for specific type of vaccine being used.

☐ Review printed/other materials on injection administration
☐ Obtain and review Standing medical orders for reactions.

Action Items

No.	action
1	Answer final client questions.
2	Review vaccinee history for contraindications, client and medical screener's signature
3	Prepare syringe for vaccine administration, as needed.
4	Address any remaining questions
5	Fill out labels and apply identification number to Screening and Consent Form. Sign consent form as dispenser.
6	Administer vaccination.
7	Observe for immediate reactions/complications.
8	If a reaction occurs, follow the Standing medical orders
9	Request Emergency Medical Staff assistance, as needed.
10	Ensure appropriate documentation: vaccine type, vaccine lot number (as printed on vaccine vial), vaccine manufacturer, date of vaccination, site of vaccination, person administering vaccine, and Vaccine Information Sheet date.
11	Once completed, route Pandemic Influenza Vaccination form to records management/data processing.
12	Direct vaccine recipients to exit.

Vaccinator Assistant

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:
Assist the vaccinators in any way possible to maintain maximum throughput and minimal wait time.

Qualifications:

- ☐ License not required for most assistance
- ☐ If assistance is drawing up vaccine into syringes, the assistant must be licensed or be a nursing student who has completed experience in drawing up medication
- ☐ Good observational and organizational skills

Equipment:

- ☐ Hand sanitizer
- ☐ Gloves (non-sterile)
- ☐ Permanent markers

Report To: Vaccination Unit Leader or Vaccination Branch Director

Immediate Duties:

- ☐ Arrive 1.5 hours before start time
- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Vaccine Unit Leader or Vaccine Branch Director for incident briefing
- ☐ Set up vaccination station.

Action Items

No.	Action
1	Draw up vaccine into syringes if the vaccine comes in a multi-dose vial [if allowed with licensure or education].
2	Clean injection site (if bleeding) and apply band aid to injection site.
3	Act as a runner for supplies needed by vaccinator.
4	Maintain a clean vaccination area.

Roamer

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: To serve as a runner or provide assistance to any station (except Assessment or Vaccination) that is overwhelmed or needs other assistance. Coordinate supply needs with the Logistics Unit. May need to assist logistics unit with crowd management activities

Qualifications:

- ☐ Able to read a Job Action Sheet and quickly understand the functions of the job.
- ☐ Skills in taking vital signs
- ☐ High energy
- ☐ Enjoys diversity

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper

Report To: Assessment Branch Manager

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with Assessment Branch Director for incident briefing
- ☐ Coordinate activity with the Greeters, Registration / Post Assessment Clerks, Waiting Area Monitors, Assessment Assistants, and Assessors.

Action Items

No.	Action
1	Meet with each of the team leads and explain your role
2	Determine best way to contact you if your services are needed. For consideration: rounds to each station, cell phone, pager, etc.
3	Orient yourself to the clinic flow and the process at each station except assessment.
4	Meet with the clinic Logistics Unit Leader; orient to supply logistics.
5	If additional staff is needed (e.g. as runner you are running too fast to too many positions), notify the Assessment Branch Director.

Interpreter / Translator

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission: To provide interpretation/translation services for non-English Speaking clients throughout the process.

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Qualifications:

- ☐ Non-medical,
- ☐ Proficiency in both English and Spanish
- ☐ Understands and can translate/interpret medical terminology
- ☐ Able to stand for long periods of time

Equipment:

- ☐ AERC Flow Chart
- ☐ Pens
- ☐ Language dictionary.
- ☐ Copies of all forms and educational materials in English
- ☐ Copies of all forms and educational materials in other languages
- ☐ Communication device with other staff (phone, radio, etc)
- ☐ Contact numbers of station leaders/managers
- ☐ Notepad
- ☐ Clipboards

Report To: Assessment or Vaccination Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Assessment Branch Director for incident briefing
- ☐ Coordinate activity with the Assessment Branch Director
- ☐ Arrive at assigned site 1 hour prior to start time
- ☐ Review and become familiar with all forms and educational materials to enable easier translation.
- ☐ Assist/provide translation of forms and materials, if possible.
- ☐ Maintain contact with staff so they are aware of your availability interpret.

Action Items

No.	Action
1	Requests for interpretation may come from any staff.
2	Work with greeters to identify clients with language barriers requiring translators.
3	Greet the client, introduce yourself, and explain that you are there to provide interpretation/translation to help them through the process
4	Interpret all verbal instructions, questions, education, and translate any written material.
5	Provide assistance with forms.
6	Accompany clients through each station of the clinic process.
7	Maintain log identifying numbers of clients and what non-English languages were served by the translator. Record count of services provided, to include: ☐ Assistance in completing forms ☐ Answering questions

LOGISTICS BRANCH

Logistics Branch Director

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

The Logistics Branch Director (LBD) is responsible for the overall support for the Assessment and Vaccination Units. The LBD is responsible for making all decisions regarding the environment in which the Assessment and Vaccination Units function. The LBD supervises Unit Leaders. The LBD reports to the Assessment Section Chief.

Oversees: Unit Leaders

Qualifications:

- ☐ Experience in management and supervision.
- ☐ Experience in staffing for emergency situations
- ☐ Able to provide clear, direct information
- ☐ Ability to multi-task
- ☐ Good communication
- ☐ Completion of ICS 300
- ☐ Functions well with new assignments – enjoys a challenge
- ☐ No special licensure is required

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper
- ☐ AERC floor plan
- ☐ Outside traffic plan
- ☐ Safety Plan

Report To: Assessment Section Chief

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Receive briefing from AERC Assessment Chief
- ☐ Coordinate with AERC Assessment and Vaccine Branch managers regarding staffing plan for expansion if necessary
- ☐ Provide orientation and Just-In-Time training for Logistics staff prior to opening
- ☐ Brief with lead staff, as needed, roles and responsibilities for all other workers.
- ☐ Establish communications and communications protocol, along with lead staff, with all staff members.
- ☐ Establish chain of command and performance expectations
- ☐ Meet with assigned team members to ensure that they are prepared, self-sufficient and adequately equipped to perform their assignments.
- ☐ Assemble lead personnel for a briefing to include:
    - o Mission as assigned by Incident Commander

- o Latest event information and clinical and environmental conditions
- o Any hazards or threats to staff safety and health
- o Media plan and procedures

Action Items

No.	Action
1	Organize and operate the Logistics Branch in support of the incident response. This includes providing communication services, acquiring equipment, supplies, personnel, facilities, transportation services, and food.
2	Notify the Assessment Section Chief when the Logistics Unit is operational.
3	Meet with the AERC Section Chief, and Assessment and Vaccination Branch Directors to review organizational goals and objectives. Ensure that these are accomplished during the operational period identified.
4	Coordinate closely with the Assessment and Vaccination Branch Directors to establish priorities for resource allocation during the response.
5	Review the AERC Plan. Review site security, medication storage, and traffic flow patterns with the AERC Section Chief, Branch Directors, and Security/Safety Unit Leader.
6	Meet with staff to ensure that responsibilities are clearly defined and understood.
7	Work with Branch Directors to ensure adequate staffing and supplies
8	Ensure that the internal and external environments are monitored for safety and security issues..
9	Coordinate with the Assessment Section Chief and Assessment and Vaccination Branch Directors regarding the expansion or contraction of AERC Services.
10	In cooperation with the Safety Officer, direct, the implementation of infection control plans for the Logistics Branch And ensure that all staff follows the guidelines and procedures.
11	Be proactive - think ahead & anticipate situations/problems before they occur.
12	Compiles the Situation Reports and Incident Action Sheets for submission to Incident Command
13	Monitor staff for signs of fatigue and assist Logistics Branch to find other staff.
14	Brief your relief at shift change, ensuring that ongoing activities are identified and follow-up requirements are detailed and specific in the operational period report.
15	Complete the after action report and participate in the department debriefing.

Staffing

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

In collaboration with the Logistics Section Chief on the Command Staff, provides adequate staff with appropriate skill sets to carry out the mission of the AERC

Qualifications:

- ☐ Experience in staffing
- ☐ Established relationships with contracted staff and volunteer coordinator
- ☐ Organized

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper
- ☐ AERC floor plan
- ☐ Current list of scheduled staff for that day plus one week.
- ☐ Phone numbers of contractors and county employee volunteers

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing

Action Items

No.	Action
1	Review site design layout and hours, current event situation, and projected client numbers.
2	Oversees on-site staff credentialing/identification in collaboration with the Volunteer Coordinator
3	In conjunction with Unit Leaders, determines staffing needs.
4	In collaboration with the staffing person in the Logistics Section of the SLVHD Incident Command, acquires appropriate staff resources
5	Implement personnel activations
6	Oversee staffing schedule and assignments
7	Ensure all staff has signed in and out.
8	Track changes in staffing and report to Logistics Branch Director as well as the Assessment and Vaccination Branch Directors
9	Provide the Finance Unit with staff time documentation

Facilities

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

Ensure the safety of staff and clients. Identify actual and potential problems with the facility and bring to the attention of facility staff. If the problems cannot be taken care of on-site, elevate the issue to the Logistics Section Chief on the Command Staff.

Qualifications:

- ☐ Experience with facilities management or inspection preferred
- ☐ Keen eye for actual and potential problems
- ☐ Able to stand for long periods of time
- ☐ Able to handle potentially contentious exchanges

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper
- ☐ AERC floor plan
- ☐ Digital Camera
- ☐ Phone numbers of facility custodians and contractors (porta-potty, etc.)

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist``
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing

Action Items

No.	Action
1	Tour the building to identify problems existing at opening and routinely
2	Notify the AERC Section Chief, custodian, facilities management, and/or or contractors of any safety `problems ASAP.
3	If the problem cannot be handled at the Clinic level, Notify the Logistics Section of the SLVHD Incident Command
4	Maintain building sanitation including supplies in bathrooms, etc.
5	Monitor property damage and notify the Logistics Section of the SLVHD Incident Command.

Security/Safety – Indoors

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

Ensure safety of clients and staff.

Qualifications:

- ☐ Safety/security experienced preferred.
- ☐ Ability to solve problems
- ☐ Organized

Equipment:

- ☐ Pens/pencils/paper
- ☐ Clip board
- ☐ AERC floor plan
- ☐ Cell phone and contact numbers
- ☐ Radio communications

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing
- ☐ Meet with AERC Section Chief and Branch Directors for safety briefing related to actual/potential safety issues
- ☐ Meet with parking and security personnel to coordinate response and communications

Action Items

No.	Action
1	Ensure adequate inventory of safety supplies and personal protective equipment (PPE) Issue PPE to site staff.
2	Request additional supplies as needed from Emergency Operations Center (EOC).
3	Provide safety training as may be appropriate.
4	Monitor compliance with wearing PPE
5	Ensure medical and biohazard waste is properly handled and disposed of.
6	Document all clinic staff or client accidents/injury on designated city/county forms
7	Monitor clinic site for safety concerns on a continual basis.
8	Correct identified hazards immediately. Notify AERC Section Chief of hazards which cannot be corrected immediately. Isolate hazards which cannot be corrected, if possible.
9	Order supplies through channels determined by the Emergency Operations Center
10	Supply all stations with needed equipment, supplies, forms, etc. related to safety issues
11	Maintain interior security of Clinic including the pharmacy storage area
12	Assists Outdoor Safety/Security if needed

Security/Safety – Outdoors

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

To promote safety and security on the premises by assisting with crowd control, setting up barriers, securing the building, and providing protection for the dispensing/clinic site workers and the public.

Qualifications:

- ☐ Security experience

Equipment:

- ☐ Pens/pencils/paper
- ☐ Clip board
- ☐ AERC floor plan
- ☐ Cell phone and contact numbers
- ☐ Radio communications

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing
- ☐ Meet with AERC Section Chief and Branch Directors for safety briefing related to actual/potential security issues
- ☐ Meet with Internal Safety and Security personnel to coordinate response and communications

Action Items

No.	Action
1	Supervises Outdoor Security Staff; coordinates clinic outdoor security, ingress, egress and parking issues with local law enforcement.
2	Make staffing assignments for Security stations. Distribute job action guidelines for assigned staff.
3	Maintain perimeter security of Clinic
4	Calls campus security and/or County Sheriff's office for assistance as necessary
5	Sets traffic pattern and parking according to Security Plan
6	Routes traffic to appropriate areas
7	Coordinate the acquisition of any access passes/badge required by the affected local jurisdiction and the delivery of such items to the staff members.
8	Offer assistance and/or advice regarding evidence processing and custody to the agency of the affected jurisdiction charged with that responsibility.
9	Review sanitation issues as they arise and report concerns to the Security Coordinator.
10	Ensure that evacuation signals and routes are labeled appropriately.
11	Investigate accidents and write accident reports. Submit to Security Coordinator.
12	Assists with crowd control at entries and exits
13	Assists Internal Security when called upon to do so.

Supply

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

To ensure supplies are available to Units in a timely manner.

Qualifications:

- ☐ Non-medical
- ☐ Shipping/receiving, inventory control, warehouse management background preferred
- ☐ Organizational skills

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper
- ☐ AERC floor plan

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing

Action Items

No.	Action
1	Coordinate with section managers at the beginning of each shift to determine supply needs.
2	Ensure PPE is consistently available for staff and patients and hand sanitizer is readily available
3	Maintain an inventory of AERC supplies
4	Supply all stations with needed equipment, supplies, forms, etc.
5	Order supplies through channels determined by the Salt Lake County Emergency Operations Center (EOC) if stood up or the SLVHD ICS.
6	Provide reports at directed intervals to Logistics Unit Leader.
6	Upon demobilization, recover all remaining SNS assets and prepare for return as directed.

Food

Job Shift(s): _____

You Report To: _____, Unit Coordinator or Assessment Branch Manager
(Name)

Mission:

To ensure that there are adequate food and beverages for site personnel

Qualifications:

- ☐ Non-medical
- ☐ Food service experience preferred
- ☐ Organizational skills required

Equipment:

- ☐ Pens/pencils
- ☐ Clip board
- ☐ Paper
- ☐ AERC floor plan

Report To: Logistics Branch Director

Immediate Duties:

- ☐ Sign Personnel Checklist
- ☐ Put on vest and clinic identification and wear both at all times
- ☐ Read Job Action Sheet
- ☐ Familiarize yourself with the AERC
- ☐ Meet with the Logistics Branch Director for incident briefing

Action Items

No.	Action
1	In coordination with Safety Officer, provide necessary fluids for clients.
2	Coordinate all food, beverages and food service support from community or outside resources.
3	Coordinate serving times with section managers.
4	Ensure proper food temperature, sanitation and garbage disposal at all times.
5	Document donations and/or purchases.
6	Ensure premises for food preparation and storage are cleared and cleaned.

APPENDIX M – STAFFING REQUIREMENTS

Assessment Staff Estimate

POSITION	SKILLS NEEDED	NUMBER STAFF NEEDED					
		Main Area			Quick Area		
		A	B	PRN**	A	B	TOTAL
Greeter	• Enjoys public • Interpersonal skills • Able to judge whether patient should be seen in regular or Quick Assessment	2	0	(2)	1	0	3 (2)
Assessment Registration Clerk	• Interpersonal skills • Organizational skills • Able to review notations on the Encounter Form and ensure completeness.	2	0	(2)	1		3 (2)
Waiting Area Monitor	• Able to stand for long periods of time • Conflict resolution • Organizational skills	2	0	(2)	0		2 (2)
Assessment Assistant	• Licensed/Certified to take vital signs • Familiarity with pulse oxymeter	2	2	(2)	1	1	6(2)
Assessors	• Trained in assessing individuals • Certified or licensed in a healthcare profession	3*	3*	(2)	1	1	8 (2)
Post-Assessment Clerk	• Able to summarize patient needs identified by the assessor and verify with client • Comfortable making referrals to VOAD • Comfortable calling EMS • Able to review notations on the Encounter Form and ensure completeness. • Able to do data entry as necessary	2	2	(2)	1	1	6 (2)
Roamer	• Clerical Skills (no area requiring license) • Ability to organize • High energy • Copes well with change	1	1	(1)			2 (1)
Translator	• Able to translate medical language • One Spanish, one Vietnamese or ??	1	1	(1)			2 (1)
TOTALS		15	9	(14)	5	3	32 (14)

*Modules A are the core modules providing one of each type of position needed. Modules B are on alert that they will be called in if the surge necessitates it.
**PRN is the stand-by pool of staff that will be called in if either team needs additional help in specific areas.
***There should not be many that arrive sick or frail enough to require Quick Assessment so a number of positions are not staffed in the core staff. If the numbers become overwhelming, additional staff can be pulled from the PRN staff.

Vaccine Staff Estimate

POSITION	SKILLS NEEDED	Module A	Module B
Greeter	• "Wal-mart greeter" personality and enthusiasm • Interpersonal skills • Pre-screen for eligibility for vaccine • Distributed forms	1	
Registration/ Finance Clerk	• Interpersonal skills • Organizational skills • Able to review notations on the Encounter Form and ensure completeness. • Experience with handling immunization insurance	1	1
Screeners	• Experience with 2009 Influenza H1N1 screening	1	
Vaccinator Assistants	• Able to draw vaccine into syringes using aseptic technique. • Attention to details to monitor doses/bottle • Responsible for vaccine safety at vaccination station • Responsible for ensuring cold chain for vaccine	1	1
Vaccinators	• Certified or licensed to give injections • Experience in determining if client has contraindications to influenza vaccine • If the Clinic is minimally staffed, assumes the duties of the vaccine assistant.	2	2
Post-vaccination clerk	• .Vaccination data entry as necessary	1	1
Roamer	• Able to do registration/finance and screening • Fills in as necessary	1	1
Translator / Interpreter	• Able to translate medical language • Spanish-speaking	1	
TOTALS		9	6

APPENDIX N.1 – Inventory Ordering Policies and Procedures

Under Development

APPENDIX N.2 – Equipment and Supplies

Equipment and Supplies for AERC

ITEM	DESCRIPTION	QUANTITY
Name Badges	3.5”x 2.5”, 12 per pack	9 packs
Accordion files		4
Ammonium sulfate ampoules	10/box	10 boxes
Badge neck straps	Black 35”x 3/8” 100/pk	1 pack
Badge strap clips	12 per pack	9 packs
Batteries	For flashlights	4-2 pks
Black ink pens	Papermate	6 dozen
Blankets		8
Bullhorns	Deluxe Street Thunder	3
Calculators		10
Clipboards	12.5”x9”, brown board	48
Colored arrows		10
Dry- erase markers	4-color set, low odor	4
Dry-erase boards	24”x 36”	4
Duct tape		1 case
Emesis bags		50
Emrgcy-alert radios		4
Extension cords	100 ft	8
Face masks	Disposable, 50 per box	32 boxes
Flashlights	9-volt	8
Gloves	Nitrile, 100 per box	16
Hand sanitizer	4-oz bottles	24/case

ITEM	DESCRIPTION	QUANTITY
Batteries	C Size Packs of 12	5
Batteries	AA Size 16/Pack	7
Batteries	D Size Packs of 12	5
Caution Tape	3" x 1000' Rolls	6
Epi Pen	Junior Size	4
Epi Pen	Regular Size	10
Extension Cords	50' Long	30
Disposable Cloths	Container of 60 x-large Germicidal	10
Masks - N95 Regular	Box of 120 Masks	225
Masks - N95 Small	Box of 120 Masks	22
Orange Cones	Tall, Skinny Cones with Base	10
Oxygen Masks	Individually Packaged	14
Privacy Curtains*		9*
Step Latter	4-Step Latter	1
Surge Protectors	Packs of Two	15
Tongue Depressors	Box of 500 Senior Size	1
Tongue Depressors	Box of 500 Junior Size	1
Tool Kits	Various General Tools in One Container	30
Ultra Sense Rubber Gloves	Box of 100 Large Size	5
Ultra Sense Rubber Gloves	Box of 100 Medium Size	5
Ultra Sense Rubber Gloves	Box of 100 Small Size	1
Vests	Purple	150

Highlighters	Assorted colors 12/pkg	1 pkg
Kleenex		8
Laptops w/ aircards		1-2
Large trash bags	50-gallon, 100/case	1 case
Medical equipment	Stethoscopes BP Cuffs	44
Paper clips	10 boxes/per case	1 case
Paper towels	2-ply	30
Permanent markers	Sharpee Professional	12
Portable copiers	HP all-in-one	4
Post-it Notes	3"x3"	12
Power strips	6-outlet surge	8
Red barrier tape	Danger Do Not Enter	1 case/12
Red ink pens	Papermate	6 dozen
Rubber bands	1/8"x3	8 boxes
Scissors	8"	4-2 pks
Scotch tape	3-roll packs	4 packs
Sign easels		4
Staplers	With 5000 staples	4
Traffic cones	28", 10 per case	10 cones
Trash bags	8-gallon	8
Trash cans w/ wheels	50-gallon	2
Walkie-talkies	6-mile, rechargeable	8-2 pks
Waste cans	8-gallon	8

Vests	Yellow	78
Vests	Blue	150
Wheelchairs	Room B-4 of City Clinic Basement	2
AED		1
AED replacement supplies		4
Blankets		6
Cots	Regular Barriatric	3 3
Extra large cuffs		5
O2 canisters	Portable	5 (rent)
O2 masks	child adult	6 6
O2 Nasal cannulas-child	child adult	6 6
O2 tank Regulators	1/4 to 8 liters at least	3
Pediatric cuffs		5
Pillow cases	Disposable	24
Pillows	Non-allergenic	6
Privacy screens*		15 or 6*
Pulse oxymeters		10
Sphygmo-manometers		10
Stethoscopes		10
Surgical Masks		2 cases
Thermometers		10
Wheelchair ramps**	Portable - may have to be built	2**

SNS "Go Kit" **City Clinic Basement** **AERC "Tool Kit"**

Content of Mass Clinic "Go Kits"

Item	Description	Quantity	Item	Description	Quantity
Name Badges	3.5"x 2.5", 12 per pack	9 packs	Waste cans	8-gallon	8
Badge strap clips	12 per pack	9 packs	Trash bags	8-gallon	8
Badge neck straps	Black 35"x 3/8" 100/pk	1 pack	White copy paper	10 reams per case	2 cases
Vests	***Need to discuss***		Scotch tape	3-roll packs	4 packs
Whistles	Orange w/ cord, 12/cs	1 case	Paper towels	2-ply	30
Bullhorns	Deluxe Street Thunder	3	Kleenex		8
Red barrier tape	Red, Dgr Do Not Entr	1 case/12	Duct tape		1 case
Traffic cones	28", 10 per case	10 cones	Accordion files		4
Portable copiers	HP all-in-one	4	Colored paper		4 packs
Emrgcy-alert radios		4	Biohazard bags	6"x9", 50 per pack	4 packs
Extension cords	100 ft	8	Bio-sharp cntr	1-gallon	8
Power strips	6-outlet, power surge	8	Disposable cups	5-oz, 100 per pack	4
Flashlights	9-volt	8	Sign easels		4
Batteries	For flashlights	4-2 pks	Label makers=		4
Calculators		10	Labels=	Refills, white	8
Clipboards	12.5"x9", brown board	48	Thermometers	1- sec, ear	8
Dry-erase boards	24"x 36"	4	Candy	M&M's (plain & w/ peanuts)	8
Dry- erase markers	4-color set, low odor	4	Staplers	With 5000 staples	4
Adult scales		4	Rubber bands	1/8"x3	8 boxes
Bike flags	Orange	8	Scissors	8"	4-2 pks
Red ink pens	Papermate	6 dozen	Paper clips	10 boxes per case	1 case
Black ink pens	Papermate	6 dozen	Highlighters	Assorted colors 12/pkg	1 pkg
Walkie-talkies	6-mile, rechargeable	8-2 pks	Permanent markers	Sharpee Professional	12
Large trash bags	50-gallon, 100/case	1 case	Post-it Notes	3"x3"	12
Trash cans w/ wheels	50-gallon	2	Lanterns	14-hr rechargeable	6

Medical equipment	Stethoscopes BP cuffs	4 4		Gloves	Nitrile, 100 per box	16
Laptops with ***internet access		1-2		Blankets		8
Tool kit	Tool kit	1		Hand sanitizer	4-oz bottles	24/case
Refrigeration for liquid medication		1		Face masks	Disposable, 50 per box	32 boxes
Emesis bags		50		Pre-made signs****		
Ammonium sulfate ampoules	10/box	10 boxes		Chairs	Folding	100
Official Distribution Site banner		1		Tables	8 foot collapsible	20
				Colored arrows		10

**Kits are being updated and revised beginning 19 Oct. 2009

Items needed for AERC

City Clinic Basement

Item	Package Description	Quantity
Alcohol Dispensers	Brown Bottles	15
Alcohol Prep Pads	Box of 200	15
Ammonia Inhalants	Boxes of 10	10
Antiseptic Hand Gel	4 fl oz bottles	96
Ballpoint Pens	Office Depot Boxes of 12	50
Ballpoint Pens	PaperMate Boxes of 12	34
Bandages	Boxes of Various Bandages	8
Batteries	C Size Packs of 12	5
Batteries	AA Size Packs of 16	7
Batteries	D Size Packs of 12	5
BD Sharps Collector		6
Binders	4" 3 Ring Binders	7
Biohazard Bags	Red Plastic Bags with Biohazard Label	100+
Bioject C02 Cartridges		240
Bioject Signs		7
Bioject Syringes	Size #4, Box of 100	24
Bioject Syringes	Size #2, Box of 100	8
Caution Tape	3" x 1000' Rolls	6
CaviCide	24 fl oz Bottles	20
Clipboard		158
Courtesy Tissues	Packages of 10 packs	82
Disposable Gowns	Packages of 10 Gowns	2
Emesis Basins	500 cc Capacity	53
Epi Pen	Junior Size *(All Epi Pens are Expired)*	4
Epi Pen	Regular Size *(All Epi Pens are Expired)*	10
Exam Gowns (White)	Packages of 50 Gowns	1
Exam Rolls	21" x 125' Rolls	12
Extension Cords	100' Long	5
Extension Cords	50' Long	30
Flash Lights	Battery Operated	37
Folding Lanterns	Battery Operated	15
Germicidal Disposable Cloths	Container of 60 x-large Cloths	10
Hand Sanitizer	18 fl oz Bottles	51
Igloo Coolers	Individually Packaged	4
Kleenex Facial Tissues	Box of 100 Tissues	25
Lotion	18 fl oz Bottles	14
Masks - N95 Regular	Box of 120 Masks	225
Masks - N95 Small	Box of 120 Masks	22

Masks - Regular Surgical	Box	32
Merck Facial Tissues	Box of 100 Tissues	28
Nu Gauze Sponges	2" x 2" Sponges in Packages of 200	37
Orange Cones	Tall, Skinny Cones with Base	10
Oxygen Masks	Individually Packaged	14
Paper Towels	Box of 15 Rolls of Paper Towels	48
Pen Light Pens	Packages of Six	2
Privacy Curtains		9
Protective Goggles	Individually Packaged	6
Protective Towels	Box of 500 3-ply Towels	3
Radio/Flashlights	Solar/Hand Crank Operated	9
Rubber Gloves	Box of 100 Medium Size	18
Rubbing Alcohol	32 fl oz Bottles	12
Soap Dispenser Refills	100 ml Bags	12
Step Latter	4-Step Latter	1
Stethoscopes	Individually Packaged	2
Surge Protectors	Packs of Two	15
Surgical Scissors	Individually Packaged	10
Surgical Tape	Individual Rolls	15
Tegaderm	Box of 100 6cm x 7cm Pads	12
Terumo Surguard Syringe	Includes Needle	150
Thermo Scan Probe Covers	Box of 200	12
Tongue Depressors	Box of 500 Senior Size	1
Tongue Depressors	Box of 500 Junior Size	1
Tool Kits	Various General Tools in One Container	30
Ultra Sense Rubber Gloves	Box of 100 Large Size	5
Ultra Sense Rubber Gloves	Box of 100 Medium Size	5
Ultra Sense Rubber Gloves	Box of 100 Small Size	1
Vests	Purple	150
Vests	Yellow	78
Vests	Blue	150
Vests	Navy	21
Vests	Green	100
Vests	Red	15
Vests	Orange	30
Vests	White	15
Wheelchairs	Room B-4 of City Clinic Basement	2

Items needed to stand up the AERC

Items to re-supply AERC

APPENDIX N.3 – AERC Specific Supply Estimates

ITEM	NUMBER
Surgical Masks	2 cases
AED	1
AED replacements supplies	4
Thermometers	10
Stethoscopes	10
Sphygmomanometers	10
- extra large cuffs	5
- pediatric cuffs	5
Pulse oxymeters	10
Privacy screens*	15
Regulators for O2 tanks (1/4-8L/hr)	3
O2 Nasal canulas - adult**	6
O2 nasal canulas - pediatric	6
O2 masks - adult**	6
O2 masks - pediatric**	6
Cots – Regular	3
Cots – Bariatric	3
Blankets	6
Pillows	6
Pillow cases	6
Sheets	6
Wall hanging for height measurement	4
Scales (digital)***	4
Wheelchair ramps	
-1 portable wheelchair ramp for N side of landing for easy exit of quick screened people and for ambulance access (2 steps). -1 portable wheelchair ramp for E. side entrance (2 steps).	2

*Inventory lists 9 “privacy curtains.” Depending on what these are, we may only need 6.
**Basement supplies refer to “oxygen masks.” If not expired, we don’t need more.
*****Health promotion has one which may be sensitive enough for children.**

APPENDIX N.4 – Minimal Care Site Specific Supply Needs

Under Development

APPENDIX O – Security Plan

SECURITY AND PROTECTION PLAN FOR LOCAL LAW ENFORCEMENT: STATEGIC NATIONAL STOCKPILE (SNS) MASS CLINICS THROUGH POINTS OF DISPENSING (POD) AND ASSESSMENT, REFERRAL, and/or FIRST AID POINTS OF SERVICE POS)

PURPOSE

The purpose of this Security Plan is to provide a framework to assist local law enforcement in providing support to the Salt Lake Valley Health Department during a public health emergency. Types of the SLVLHD response activities included under ESF 8 Health and Medical include mass clinics that provide life-saving medication and/or vaccinations in a short period of time, and assessment and referral or first aid centers that provide first level triage or first aid to mildly or moderately affected persons to relieve burden on hospital emergency departments and the acute care system in general. This Security Plan establishes the roles and responsibilities of local agencies involved in law enforcement activities during an emergency incident.

MISSION

Man-made or natural disasters may cause devastating results within a community. The mission of law enforcement authorities during a disaster or public health emergency is to maintain law and order, protect life and property, provide traffic control and law enforcement support, guard essential facilities/supplies, and coordinate mutual aid. By signing an MOU, authorities will ensure adequate staffing to provide security services to the SLVHD.

CONCEPT OF OPERATIONS

During an emergency mass clinic, law enforcement/safety measures may be needed to protect life, property and maintain public order. During a man-made disaster, natural disaster, or disease outbreak, PODs and/or Points of Service (POS) will be established to provide health screening and referral, first aid, and distribute medicine and/or vaccine. A law enforcement presence at the PODs/POSs may be necessary to preserve orderly conduct. Law enforcement may need to:

- staff control points and road blocks to expedite traffic to the POD/POS
- provide patrols/surveillance to prevent property damage and insure the safety of citizens and staff,
- provide 24 hour protection /safeguarding of stockpiled medications and/or vaccine
- prevent civil disturbances that may result in injuries/damages,
- provide escort services when necessary for materiel deliveries
- identify facilities that may be used as alternatives if the primary facility / location becomes unavailable, and
- develop mutual aid procedures for supporting POD security with adjacent local, state or federal law enforcement agencies, and to participate in the mutual aid /collaborative compacts.

Emergency operations should be carried out in conformity with the local law enforcement agency's Policy and Procedures. Each agency should have a liaison officer who is responsible for collaborating with the local Health Authority and insuring that coordinating efforts and plans are reflected in the agency's Policy and Procedure manual. Agency plans should include a designated Safety Officer to oversee safety issues at the POD. The Safety Officer is part of the POD command staff within the ICS structure. This allows the safety issues at the POD to be brought directly to the POD commander.

APPENDIX P – Safety Plan

Under development

APPENDIX Q - SLVHD ICS Structure

Category	Who Assigned	Level 1 Function
Incident Commander		
Command Team		
Medical Director	Dagmar Vitek, MD	• Provides medical expertise related to pandemic influenza to IC • Assists in response to medical emergencies • Consults in AERC decision making
PIO	Kate Lilja	• Maintains timely communication with media • Transmits changes in general public information to appropriate partners
Liaison Officer	Darrin Sluga	• Liaisons with community partners: o Hospitals regarding bed availability o VOAD regarding referral process
EOC Coordinator		• Maintains communication to keep EOC informed • Coordinates SLVHD response
Safety Officer		• Supervises the demobilization plan
Policy Team		• Continues to develop policies as needed • Provides legal, programmatic, etc. expertise to the IC
Planning Section		
Planning Section Chief		

Documentation Unit		Operational Period • Daily for activation period Situation Reports • Obtain reports from Command Staff and all Sections to compile a Sit-Rep that: • Keeps the EOC, IC and all Sections appraised of: o Numbers of clients assessed o current status of surge in hospitals both for in-patient beds and triage sites • issues that develop Incident Action Plans • Contains objectives and strategies to meet the objectives with measureable deliverables for the next operational period
Demobilization Unit		• Develop the Site's demobilization plan
Operations Section		
AERC Section Chief		• Supervises POD function
Operations Team		• Scales Point of Dispensing (POD) operations up or down as situation requires • Monitors equipment function and needs Identify supplies needed for the AERC • Monitors numbers of staff needed for AERC operations • Conducts Just in Time training to staff as needed • Monitors supplies • Elevates supply and equipment needs to Logistics Branch as necessary • Elevates issues to Clinical Services Branch Manager

Logistics Team		• Monitors POD supplies – elevates shortages to Logistics Section Supply Unit • Monitors security and safety of staff including breaks, stress, etc. • Works with Logistics Section Staffing Unit to obtain additional staff or reassign staff • Determines need for hydration and nourishment
Logistics Section		
Logistics Chief		
Facilities Unit		<u>Facility</u> • Monitors facility function • Elevates building issues to Granite School District • Provides reasonable solutions to facility problems <u>Equipment</u> • Monitors equipment function • Arranges repair or replacement of broken equipment • Returns equipment to appropriate locations when Site closes
Staffing Unit		• Collaborate with POD Managers to identify staff to meet POD needs; work with supervisors for approval • Obtain external staffing resources when SLVHD resources are inadequate to meet staffing needs (County or contracted)
Supply Unit		• Monitors supplies • Reorders as necessary
Traffic Unit		• Ensures traffic flow to optimize parking and client flow • Returns equipment to appropriate locations when Site closes
o Communications Unit		• Monitors communication equipment function • Arranges repair or replacement of broken equipment

		• Returns equipment to appropriate locations when Site closes
o Food Unit		• Provides food to staff as appropriate
Finance/ Administration Section		
Finance/ Administration Chief		
o Procurement Unit		• Tracks equipment • Obtains replacement equipment • Compiles a list and develops a final report of items used and items that need to be replenished
o Cost Unit		• Tracks site-related costs
o Time Unit		• Maintain staff records • Maintain time sheets
o Compensation/Claims Unit		• Tracks worker compensation claims for HR Pays bills ??